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The role of the caseworker with the alcoholic at the Washingtonian Hospital.

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THE ROLE OF THE CASEWORKER WITH THE ALCOHOLIC AT THE WASHINGTONIAN HOSPITAL

A Thesis

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CHAPTER I

INTRODUCTION

Purpose of the Study

The purpose of this study was to determine the role of the caseworker in a hospital for the treatment of alcoholic patients. Related to this are the following considerations:

1. The major areas in which the caseworker functions.

2. Other forms of help besides direct contact with the patient.

3. The caseworker's function with the alcoholic in conjunction with other members of the agency team.

Justification of the Study

> It is estimated that there are 70,000,000 people in the United States who use alcoholic beverages. Of this number seven per cent, or 4,900,000 are problem drinkers. About 1,000,000 of these problem drinkers can be classified as alcoholics. The Commonwealth of Massachusetts alone has among its population 100,000 problem drinkers and 35,000 to 40,000 alcoholics.[1]

In view of the serious threat to the individual and

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1 David Landau, M. D., "The Medical and Psychiatric Aspects of Alcoholism," A Course on Problems of Alcoholism in Industry and Business at the Boston University Evening Division, September, 1954.

society, it can be agreed that every available method should be used in the counteraction of this rapidly increasing social phenomenon.

As a formal study of the role of the caseworker with the alcoholic at the Washingtonian Hospital has never been attempted, it may be predicated that a research project in this area at this institution could give some limited insight into the utilization of social casework as one method of treatment with the alcoholic in this type of setting.

Sources of Data

Data were taken from contact with members of the agency team who worked with the cases under study, case records from the files of the Washingtonian Hospital, literature on alcoholism with the stress on previous studies on the role of the caseworker with the alcoholic.

Methods of Procedure

As background for this study, Chapter II will present details of the setting in which the caseworker treats the individual alcoholic. This will include a history of the hospital, the history of the social service department, with the stress on current functioning; current services offered by the hospital, a description of treatments offered by the hospital.

Chapter III will discuss casework with the alcoholic. The chapter will include a description of the alcoholic personality and a discussion of the areas of casework as they relate to the treatment of the alcoholic. Chapter IV will present factual data on the alcoholic patients, eight appropriate tables, an analysis and interpretation of the data presented, a study of eight relatives of patients and their role in casework. In Chapter V three cases with an analysis of the caseworker's role will be presented. Chapter VI will include a summary of pertinent data and conclusions reached on the basis of the material set forth in the preceding five chapters.

Scope of the Study

This is a study of twenty cases taken from one hundred and eighty cases in the social service files of the Washingtonian Hospital. These cases were opened during the twelve-month period from September 1, 1953 to August 31, 1954. These patients were from both the in and out-patient departments of the hospital; eight relatives of these patients seen in the out-patient department by the caseworker were studied as a separate group.

Limitations of the Study

This study dealt with a limited number of cases. As a result, the group studied included a very limited number of

certain types of cases, such as only one example of casework with a patient receiving Conditioned Response Treatment, one of the major types of treatment at the hospital. Therefore, no over-all statement concerning the role of the caseworker with a total number of alcoholics seen at the hospital can be made.

CHAPTER II

THE SETTING

History of the Washingtonian Hospital

"The Washingtonian Hospital is, perhaps the oldest institution in the United States dedicated to the care of the chronic alcoholic patient."[1] It began as the Washingtonian Home in 1857. It was known as "The Home for the Fallen," and was focused on a moral and religious approach as a means to abstinence in the rehabilitation of the alcoholic. Soon the medical and scientific approach became evident, and in 1876 the superintendent of the Washingtonian Home stated, "Alcoholism is to be a disease instead of a moral perversion."[2]

In 1939, the Washingtonian Home became the Washingtonian Hospital and under its present director, Dr. Thimann, assumed a basic psychiatric approach to all patients in treatment for chronic addiction to alcohol. This approach was offered through psychiatry, social service and therapy in medicine. The hospital's progress in this direction in three years was noted as follows:

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1 E. A. L. Corwin and Elizabeth V. Cunningham, "Institutional Facilities for the Treatment of Alcoholism," Quarterly Journal of Studies on Alcohol, Vol. 15, No. 1, June 1944, p. 9.

2 Ibid., p. 10

> The Washingtonian Hospital is by no means a perfect institution. Its reorganization came about at a difficult time from the point of view of availability of professional personnel. It is located in an old building in a poor neighborhood; it accepts no women in-patients; it has no affiliation with a general hospital. Despite these deficiencies, however, it represents a forward step in the treatment of alcohol addiction since it offers treatment on terms that are acceptable to a large group of middle-class alcoholics and, at the same time, aims to maintain a scientific attitude toward its work.[3]

In view of the advancement made since the time of the report cited above, part of the more recent report of the American Hospital Association is again noted.

> The Washingtonian Hospital represents a forward step in the treatment of alcohol addiction, since it aims to maintain a scientific attitude toward its work. This is probably the most outstanding of all institutions which information has been made available to us.[4]

There is now a competent professional staff. The hospital has recently moved from its old location in the south end of Boston to a modern, completely reconditioned building overlooking the parkway in Jamaica Plain, and it now admits women on an in-patient basis.

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3 The Research Council on Problems of Alcohol; "Institutional Facilities for the Treatment of Alcoholism," - Research Report No. 7, New York, 1944, p. 53.

4 American Hospital Association, Report of the Council on Professional Practice, 1947.

History of the Social Service Department

> The social service department of the Washingtonian Hospital was opened on January 1, 1941. After a survey of the hospital and its needs, a plan was set in operation to assist the staff physicians in the treatment of alcoholism by maintaining therapeutic contact with patients, their relatives and employers in cases where social problems are prominent. The social worker serves as a link between the hospital and the patient's family. While the doctor treats the patient, the social worker helps members of the family understand the patient's problem and treatment.[5]

The functions of the social service department as set forth by the supervisor, Miss Price, follow.

> The first of these is to establish relationships with close relatives of the patients and to use these relationships to further the interests of the patient's rehabilitation. Social service also gives direct attention to those problems of the patients which are derived from environmental and social breakdowns, such as loss of employment, financial insecurity and marital discord. It is responsible for the administration of the outpatient services of the hospital; prepares and screens all applicants for such services. This includes the three weekly psychiatric clinics and the night-hospitalization plan, described below. The social service department also provides field work opportunities for supervised professional practice and research by social work students in training. In addition, it assumes certain responsibilities for public relations through participation in community committees and studies, through lectures to lay and professional groups, by appearance on occasional radio and television programs, and through publications.[6]

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5 Washingtonian Hospital, Annual Report, 1941, p. 14.

6 Gladys M. Price, Orientation for the Social Service Department, Washingtonian Hospital.

Current Services

The hospital now offers in-patient service to both male and female patients. This includes medical treatment for detoxication and drug therapy. Psychiatric evaluation and casework services are offered through the social service department. Hospitalization for a fifteen-day period is available without expense to a limited number of medically indigent patients under the State Division on Alcoholism. Provisions are made under the Department of Mental Health to admit non-voluntary patients for "temporary care" as inebriates when referred by a responsible relative, a physician or a police officer. Special rates are available for hospital and agency referred cases. Psychotherapy, casework, drug therapy and night hospitalization are offered on an out-patient basis under the direction of the social service department, with particular emphasis on casework with relatives of patients.

Treatments Offered

There are three basic types of treatment offered to patients by the hospital: psychiatric, medical and environmental. Casework constitutes an important part of psychiatric treatment. In addition to working with relatives and with their part in the recovery of the patient and in helping the patient to use the resources of the hospital, the social worker has, in recent years, taken on more responsibility for direct treatment of the

alcoholic patient.

Psychotherapy is offered for the purpose of treating the patient's emotional difficulties. Both group therapy by the medical director and individual therapy by three consulting psychiatrists are offered. The kind or intensity of this treatment varies from one hour a week with the psychiatrist to supportive therapy on a environmental level with the psychiatric caseworker. There is a group therapy session under the direction of the medical director for an unlimited number of Conditioned Response patients. In addition, patients taking this treatment are seen by the medical director for individual psychotherapy.

Conditioned Response Treatment consists of establishing a reflex eliminating the compulsive craving for alcoholic beverages. This treatment is based on the experiment of Pavlov and the dogs.

> Utilized for treatment of alcohol addiction, the neutral or conditioned stimulus of the ringing bell was replaced by alcoholic beverages, the natural or unconditioned stimulus of food by an emetic. It was to be expected that, after an adequate number of conditioning sessions, the presentation of alcoholic beverages alone would provoke the same responses as the emetic, (the sight, smell, taste or even the thought of alcoholic beverages would cause nausea and emesis), or at least there would be enough association with the treatment to prevent any desire for alcohol.[7]

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7 Joseph Thimann, "Conditioned Reflex Treatment of Alcohol Addicts," Clinical Medicine, Vol. 53, No. 8, August, 1946, p. 221.

It consists usually of twelve treatment sessions spread throughout the year. The initial series usually takes about a week and must be followed by four weeks in bed in the hospital. This rest in bed is a precaution against the possible side effect of the drugs used. The remaining treatments are usually referred to as reinforcements or "boosters." They are usually given in single sessions for which the patient must be hospitalized twenty-four to thirty-six hours. Dr. Thimann states:

> The establishment of a Conditioned Response is only one element in a tripartite plan of treatment, the other two elements of which are a part-time protective environment and supplemental psychotherapy.[8]

Therefore, in addition to the hospitalization mentioned above, the treatment is supplemented by weekly interviews with Dr. Thimann and by attendance at the group meetings referred to previously. A patient having completed the Conditioned Response Treatment, may discontinue his interviews, if the doctor agrees but is expected to keep up his attendance at the Conditioned Club group meetings for an indefinite period of time.

> This treatment has been administered at the hospital since 1942, and is the treatment with which there has been the most experience and most success to date.[9]

A prerequisite to the treatment is a thorough physical examination including an electrocardiogram by the hospital consultant on internal medicine.

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8 Ibid., p. 220.

9 Ibid., p. 221.

Antabuse, as an adjunctive treatment, implies a "threat" to the patient. He is given tablets to take, and he knows that if he drinks within a period of twenty-four hours, he will suffer unpleasant physical reactions. These patients must also have a thorough physical examination, as for the Conditioned Response Treatment. If physiologically or psychologically indicated, an individual patient may undergo five "test sessions" for which he is hospitalized from one to two days. These sessions are to test the patient's tolerance for the drug, and to give him the experience of what his reaction might be should he drink after having taken the medication.

> It provides disagreeable symptoms which follow the ingestion of alcohol by individuals. However, there should be two phases of treatment: (1.) administration of "Antabuse" which induces the patient to shun drinking; and, (2.) psychotherapeutic care, which supports the patient in his desire to continue medication, to readjust himself medically, and finally to make necessary changes in his habits.[10]

Following the necessary test sessions, this treatment is given on an out-patient basis for an indefinite period of time. It is usually accompanied by psychotherapy. The Antabuse Treatment is a very popular treatment at the present time, and is the one used at most of the local alcoholic clinics. It is sometimes called the Danish Treatment. It has been given at the hospital since 1949, with some success. It is usually given in

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10 Eric Glud, "The Treatment of Alcoholic Patients in Denmark with Antabuse," Quarterly Journal of Studies on Alcohol, Vol. X, No. 1, September, 1949, p. 85.

conjunction with psychotherapy.

The "night-hospitalization" plan is another adjunctive treatment offered to patients who are in casework in the out-patient department of the hospital.

> ------- is a system for working patients; that is to say, the patient while still under treatment returns to his former occupation (or finds a new job), but spends all his spare time at the hospital. This arrangement has a number of advantages. The patient is in a protected environment during his free time. His evenings and nights are spent at the hospital if he is working in the day time, or vice versa if he is working at night. He is under the shelter of the hospital over the weekends, time difficult to bridge if he is living outside, because of the temptation to seek the conviviality of a tavern in his loneliness and because he has nothing to do. He is, moreover, removed from the emotional instability of a home environment in which wife and mother may have little understanding of his problem, and from the company of drinking companions. It has been found that such an environment should be continued by other therapies.[11]

Under this plan, the patient is afforded an opportunity to contribute financially to his own rehabilitation. With the support of the social worker, the patient is able to readjust to a protective environment and have the interest and confidence to participate in a treatment plan.

In summary, treatment at the Washingtonian Hospital consists of three elements. First is the elimination or at least the reduction of the addictive craving for alcohol. The second

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11 Joseph Thimann, "Part-time Protective Environment and Working Parole as an Adjunct in the Treatment of Alcoholics," New England Journal of Medicine, Vol. 231, No. 1, 1944, p. 9.

element is the psychiatric approach through casework or intensive psychotherapy as indicated. The third is manipulation of the patient's environment through a part-time protective environment.

CHAPTER III

CASEWORK WITH THE ALCOHOLIC

Alcoholism

In the broad sense, alcoholism is a sickness that compels the individual to drink to the point where his excessive drinking interferes with some important aspect of his life--his job, his homelife, his health.

E. M. Jellinek, who has drawn up a concept of phases of alcohol addiction, after administering a questionnaire to some 2,000 alcoholics over a period of years, gives the following picture of the development of the illness which leads to the alcoholic personality.

> The subcommittee has distinguished two categories of alcoholics, namely, "alcohol addicts" and "habitual symptomatic excessive drinkers." For brevity's sake the latter will be referred to as non-addictive alcoholics. Strictly speaking, the disease conception attaches to the alcohol addicts only, not to the non-addictive drinkers. In both groups, the excessive drinking is symptomatic of underlying psychological or social pathology, but in one group after several years of excessive drinking, "loss of control" over the alcohol intake occurs, while in the other group this phenomenon never develops. The group with the "loss of control" is designated as "alcohol addicts." The disease conception of alcohol does not apply to the excessive drinking, but solely to the "loss of control" which occurs in only one group of alcoholics and then only after many years of excessive

drinking. There is no intention to deny that the non-addictive alcoholic is a sick person; but his ailment is not the excessive drinking, but rather the psychological or social difficulties from which alcohol intoxication gives temporary surcease.[1]

Pre-Alcoholic Symptomatic Phase

The very beginning use of alcoholic beverages is always socially motivated in the prospective addictive and non-addictive alcoholic. In contrast to the average social drinker, however, the prospective alcoholic soon experiences a rewarding relief in the drinking situation. The relief is strongly marked in his case because either his tensions are much greater than in other members of his social circle, or he has not learned to handle those tensions as others do. Nevertheless his drinking does not result in overt intoxication, but a stage of surcease from emotional stress. Alcohol provides specially rewarding relief. Many excessive drinkers never go beyond this point:

(a) More drinking episodes.
(b) Drinks more at each episode.

This type of drinking behavior may last from several months to two years, according to circumstances, and may be designated as the pre-alcoholic phase, which is divided into stages of occasional relief-drinking and constant relief-drinking. This phase may last from several weeks to several months.

The Prodromal Phase

The sudden onset of a behavior resembling the "blackouts" in anoxemia (loss of oxygen in the blood) marks the beginning of the prodromal phase of alcohol addiction. The drinker who may have had not more than 50 or 60 grams of absolute alcohol and who is not showing any signs of intoxication may carry on a reasonable conversation or may go through

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1 E. M. Jellinek, "Phases of Alcohol Addiction," Quarterly Journal of Studies on Alcohol, Vol. 13, No. 4, December, 1952, pp. 673-684.

quite elaborate activities without a trace of memory the next day, although sometimes one or two minor details may be hazily remembered. This amnesia (...) is not connected with loss of consciousness (...). The frequency of "palimsets" (blackouts) and their occurrence after medium alcohol intake are characteristic of the prospective alcohol addict.

1.) Blackout
    Drinking for effect of alcohol per se
2.) Surreptitious drinking
3.) Preoccupation with alcohol
4.) Gulping first drinks
5.) Guilt about drinking
6.) Avoids conversation about alcohol
7.) Proportion of blackouts to drinking episodes increases

This phase may last from six months to two years or more.

The Crucial Phase

(Does not appear in the non-addictive drinker) "Loss of Control" means that any drinking of alcohol starts a chain reaction which is felt by the drinker as a physical demand for alcohol. ----The bout may not be started by an individual need of the moment, but by a "social drink." After recovery from intoxication, it is not the "loss of control"-- i.e., the physical demand, apparent or real--which leads to a new bout after several days or several weeks; the renewal of drinking is set off by the original psychological conflicts or by a simple social situation which involves drinking. The "loss of control" is effective after the individual has started drinking, but it does not give rise to the beginning of a new drinking bout. The drinker has lost the ability to control the quantity once he has started, but he can still control whether he will drink on any given occasion or not. This is evidenced by the fact that after the onset of "loss of control" the drinker can go through a voluntary period of abstinence ("going on the water wagon"). The question of why the drinker returns to drinking after repeated disasterous experiences is often raised. Although he will not admit it, the alcohol addict believes that he has lost his will power and that he can and must regain it.

He is not aware that he has undergone a process which makes it impossible for him to control his alcohol intake. To "master his will" becomes a matter of the greatest importance to him. When tensions rise, "a drink" is the natural remedy for him and he is convinced that this time it will be one or two drinks only. Symptoms of the Crucial Phase follow:

8.) Loss of control--drinks to intoxication
9.) Rationalizing and alibis
10.) Social pressures increase; compensation
11.) Grandiose behavior; for loss of esteem
12.) Aggressive behavior
13.) Persistent remorse and guilt
14.) Periods of total abstinence
15.) Changing patterns of drinking
16.) Social relationships drop
17.) Loss of employment
18.) Behavior becomes alcohol-centered
19.) Loss of outside interests
20.) Reinterpretation of personal relations
21.) Marked self-pity
22.) Geographic escape
23.) Changing family relationships
24.) Unreasonable resentments
25.) Protecting supply of alcohol
26.) Neglect of nutrition
27.) First hospitalization
28.) Decrease in sexual drive
29.) Alcoholic jealousy
30.) Regular matutinal drink

During the crucial phase intoxication is the rule but is limited to the evening hours. It should be noted that the "physical demand" involved in the "loss of control" results in continual rather than continuous drinking. Particularly the "matutinal drink" which occurs toward the end of the crucial phase shows the continual pattern. The first drink at rising, let us say at 7:00 a.m., is followed by another drink at 10:00 or 11:00 a.m. and another drink around 1:00 a.m., while the more intensive drinker hardly starts before 5:00 p.m. The onset of "loss of control" is the beginning of the disease process of alcohol addiction. Progressively this disease process undermines the morale and the physical resistance of the addict. This phase may last from two to six years or longer.

The Chronic Phase

The increasingly dominating role of alcohol and the struggle against the "demand" set up by matutinal drinking, at last breaks down the resistance of the addict and he finds himself for the first time intoxicated in the daytime and on a weekday and continues in that state for several days until he is entirely incapacitated. This is the onset of prolonged intoxications, referred to in the vernacular as "benders." This latter drinking behavior meets with such unanimous social rejection that it involves a grave social risk. Only an originally psychopathic personality or a person who has in later life undergone a psychopathological process would expose himself to that risk. Symptoms of the chronic phase follow:

31.) Binge and bender
32.) Ethical deterioration
33.) Reversible deterioration in thinking
34.) Alcoholic psychosis (10 per cent)
35.) Social deterioration in companions
36.) Recourse to "technical products"
37.) Loss of alcoholic tolerance
38.) Indefinable fears
39.) Tremors (persistent)
40.) Psycho-motor inhibitions
41.) Obsessive drinking
42.) Vague religious desires
43.) Rationalizations fail (admits defeat)
44.) Solitary drinking (at any point)

Formerly it was thought that the addict must reach the stage of utter defeat in order to be treated successfully. Clinical experience has shown, however, that this "defeat" can be introduced long before it would occur of itself and that even incipient alcoholism can be intercepted. As the latter can be easily recognized, it is possible to attack the problem from a preventative angle.[2]

It is evident from the foregoing that alcoholism is a symptomatic behavior disorder arising within an individual as

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2 Ibid., pp. 674-683

the result of some physiological or psychological maladjustment. The fact that "loss of control" does not occur in a large group of excessive drinkers would point toward a predisposing factor in the addictive alcoholics. In any event, alcoholism is either a disease or the symptom of a disease. Therefore, the alcoholic, the bearer of this illness, is a sick person.

The Alcoholic Personality

It has been defined in a generic way as to what fundamental pathological entity the alcoholic presents to the caseworker. What sort of individual is this "alcoholic personality"?

As defined by one writer a decade ago:

> Every person with an alcoholic problem has a personality difficulty--a neurosis. Every alcoholic is an immature, insecure, oversensitive and anxious person who is suffering from marked feelings of inferiority, unable to meet and enjoy people socially or unable to get on with his work without the support of alcohol in fairly large quantities. This sounds like a serious indictment against the alcoholic, but with rare exceptions, it is a true one.[3]

Recent studies are quite consistent in the point of view that no uniform personality pattern has been found that would characterize all intemperate drinkers, though there are several patterns which may be presumed to characterize large

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3 O. Spurgeon English, M. D., and Gerald H. J. Pearson, M. D., Emotional Problems of Living, p. 356.

numbers of alcoholics.

Jellinek discusses the alcoholic personality in the following way:

> The aggressions, feelings of guilt, remorse, resentments, withdrawal which develop in the phases of alcohol addiction, are largely consequences of the excessive drinking, but at the same time they constitute sources of more excessive drinking.
>
> In addition to relieving, through alcohol, symptoms of an underlying conflict, the addict now tends to relieve, through further drinking, the stresses created by his drinking behavior. By and large, these reactions to excessive drinking--which have quite a neurotic appearance--give the impression of an "alcoholic personality," although they are secondary behaviors superimposed over a large variety of personality types which have a few traits in common, in particular, a low capacity for coping with tensions. There does not emerge, however, any specific personality trait or physical characteristic which inevitably would lead to excessive symptomatic drinking. Apart from psychological and possibly physical liabilities, there must be a constellation of social and economic factors which facilitate the development of addictive and non-addictive alcoholism in a susceptible terrain.[4]

Such a picture is presented by the individual who, because of anxiety, usually on the unconscious level, is prevented from achieving the productiveness consistent with his underlying abilities. Because he deviates from the normally accepted patterns of behavior, he is shunned by society and, therefore, feels lonely and inferior.

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4 Jellinek, op.cit., p. 683

Another statement of the prevailing point of view is given by Berreman who says:

> Addiction itself is not a simple varying phenomenon but a complex form of behavior which varies in its meaning and its function for different individuals. No simple monistic theory can, therefore, be expected to account for it.[5]

Tiebout makes the suggestion that:

> During the course of the alcoholic illness, there develops a personality pattern with a characteristic, hostile coloring. (....) Included in this pattern is a tendency to be:
>
> 1.) Tense and depressed
> 2.) Oppressed with a sense of inferiority, at the same time secretly harboring feeling of superior worth
> 3.) Aggressive or at least quietly stubborn
> 4.) Perfectionistic and rigidly idealistic
> 5.) Weighed down by an overpowering sense of loneliness and isolation
> 6.) Egocentric and all that it implies in the way of a basically self-centered orientation
> 7.) Defiant, either consciously or unconsciously
> 8.) Walled off and dwelling, to a large extent, in a world apart from others[6]

According to Tiebout, alcohol illness does not create these patterns, but alcoholism mobilizes and focuses these tendencies in the persons who become addicted to alcohol.

Another current writer states:

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5 J. V. Berreman, "The Escape Motive in Alcoholic Addiction," Resident Studies, State College, Washington, Vol. 18, 1950, pp. 139-43.

6 Harry M. Tiebout, "Conversion as a Psychological Phenomenon" (In the Treatment of the Alcoholic), Pastoral Psychology, Vol. II, Chapter 13, April, 1951, pp. 28-34.

1.) The alcoholic is between the psychoneurotic and the psychopath, and somewhat nearer the latter than the former.
2.) His principal characteristic is incapacity to stand strain and tension. This means that he cannot persevere and overcome difficulties and disappointments; when he reaches adolescence he cannot meet the responsibilities of adult life, for he lacks inner directivity.
3.) He wants to do things in a big way, but he fails to achieve in spite of ability because he cannot persevere.
4.) He suffers from anxiety and guilt feelings in contrast with the psychopath.
5.) He is self-centered, lacks emotional warmth, makes poor adjustments in his social and interpersonal situations; he is a highly constricted person, stereotyped and pedantic.
6.) These characteristics amount to a regression to a lower level as an escape from difficulties.[7]

Psychoneurosis as seen in the alcoholic is in the form of a mild abnormality of the cognitive, emotional and motor processes which are only partially incapacitating. In his case the basic symptoms are often connected with anxiety. The psychopathic personality as seen in the alcoholic is a person of bizarre behavior and rather disorganized thinking. Their attitude toward the social group seems to be lacking in ethical feeling. Because of this lack of feeling for ethical and traditional ideals, they are unable to learn and profit by experiences. They are apt to act out their primitive impulses

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7 Edwin H. Sutherland and others, "Personality Traits and the Alcoholic--A Critique of Existing Studies," Quarterly Journal of Studies on Alcohol, Vol. XI, December, 1950, pp. 547-61.

on the spur of the moment. They do this without apparent regard for the rules and regulations laid down by the society in which they live, in this case principally by drinking to excess.

Regression in the alcoholic is, as in others, a reversal of the ordinary progressive sequence of development and a return to a more primitive level. In his case there is need for dependency and inability to cope with competition, a return to the oral level of development through the excessive use of alcohol.

The varieties of alcoholic personality can be described as follows: The immature person who dislikes responsibility, lacks initiative and self-direction and is a willing follower; the person who is characterized by nervousness, tension, anxiety, and is lonely, shy and fearful; the person with marked antisocial behavior who "wants what he wants when he wants it" regardless of the consequences or the rights of others.

We have seen that alcoholism is not just a diagnosis but a symptom which may appear under a wide range of different conditions. Therefore, it is necessary that the social worker be aware of the social and economic pressures involved in the particular alcoholic's problem. It is also necessary to know the relationship between pressures within the person himself and those coming from the environment.

These pressures might include the attitudes and aggravating behavior of the alcoholic's family, the attitude of the

spouse in the "alcoholic marriage" or the unavailability of satisfactory employment due to lack of training or achievement in keeping with ambitions. Boggs states:

> While the external, social and economic pressures are seldom if ever fundamentally causative, they do play a contributory part in many instances. The caseworker strives to effect greater personality integration through appealing to and building around the more healthy parts of the personality, relieving anxiety that derives from the conflict going on in the less healthy areas, but in the main reinforcing whatever strength and inner capacity exist to enable the individual to exert some measure of control over his conflicts rather than let them blindly control him.[8]

Areas in Casework with the Alcoholic

The first area to be discussed is family relationships. Often the alcoholic, as a child, may have been frustrated by not having his needs met on his own terms, and so reacted with hostility, fear and tension. As an adult, he continues his childish drives and reacts in the same cycle, resorting to alcohol to avoid facing his responsibilities. As a result, he is often disdained, pitied or looked down on by the parents whom he, at least unconsciously, feels are the cause of his problem. He may project his hostilities on to them and deceive himself into thinking his difficulties are due to the way he

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8 Marjorie H. Boggs, "The Role of Social Work in Treatment of Inebriates," Quarterly Journal of Studies on Alcohol, Vol. IV, No. 4, p. 557.

is treated by them. It may often seem that his pride in his children or siblings might be a source of appeal to him. However, it often develops that they may be the last persons he would choose to benefit or from whom he would seek support. He may see them as competitors whom he is unable to live up to or reminders of the adult responsibility he is seeking to avoid. So it may be the role of the caseworker to work directly with the disrupting relative to lessen the tensions in this area through discussion and clarification; or he may help the alcoholic patient to get some limited insight into the reason for his attitudes toward relatives or children.

The second area to be discussed is marital discord. Kephart states:

> Although the rate varies depending upon the class of inebriates studied, divorce and separation were found to be several times more frequent among alcoholics than in the general population. Whether the drinking problem behavior actually "caused" the marital discord, or whether the reverse was true, or whether, perhaps, deeper personality factors resulted in both excessive drinking and marital troubles can only be conjectured.[9]

As marital disruption and drinking are so often related, so marital discord is often the presenting problem of the alcoholic or of the spouse. As stated on page 19 of this chapter, the alcoholic is usually an emotional immature individual and it is the spouse who is most affected by the resultant behavior

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9 William M. Kephart, "Drinking and Marital Disruption. A Research Note," Quarterly Journal of Studies on Alcohol, Vol. 15, No. 1, p. 63.

If the spouse is a fairly well adjusted person who is interested in helping the alcoholic mate, the caseworker's task may be relatively simple. Through a clarifying approach, he may help the spouse to understand the alcoholic's behavior. This will in turn relieve the feeling of blame and need to retaliate so that protective impulses can be used in a constructive manner.

However, the alcoholic often has an unusual ability to marry an equally immature person. In the case of the alcoholic husband he often marries a woman who seems stronger. Though he has a need to be controlled and mothered, he often gets too much of this which threatens his manliness. By his reactionary, critical behavior he pushes his mate to assume more of the responsibility which he in turn resents. Though the wife may claim that she wants a husband whom she can lean on, she usually acts in a contrary manner. Because of her need to keep him ineffectual so that she can feel relatively strong and have apparent justification for her hostility, she continually thwarts his constructive efforts to do something about his drinking. In this way she represses her own conflicts and short-comings.

In the case of the alcoholic wife she often has the need for a strong father figure which she usually does not find in the person of a basically immature husband. She then uses the inability of the immature mate to fulfill this unwanted role

as an excuse for her own behavior. This puts him in a position of having to assume the added responsibility of home and children. Again, although he may claim that he wants a wife who will fulfill her role of companion, housekeeper and mother, he usually acts otherwise. Through a need for obvious justification for the hostility he feels toward his wife because of the shifting of her responsibilities, he continually opposes her attempts to correct her drinking and to assume her natural role.

In either case it is necessary to deal with the pervading hostility. This is stated by Miss Gladys M. Price.

> Unable to face her resentment to the patient, they project it on the hospital and assume the patient's early attitude of hostility toward staff members responsible for restricting him.[10]

The caseworker may treat the alcoholic patient directly by helping him to talk through his problem. In doing this he acts as a supporting person who accepts the alcoholic as an individual and shares his problems though not approving of his behavior. This is usually on the level of helping the patient through clarification and patterning to develop some insight into his attitude and patterns, his relationship with others, and the ways he meets his own needs. In other cases the social worker may function primarily with the spouse, helping him to

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10 Price, op.cit.

play an understanding role. In these cases the patient may receive help in the form of psychotherapy with the psychiatrist or group or drug therapy, or a combination of these treatments.

In any case it is the caseworker's role to make a proper diagnosis with focus on the patient or relative in treatment. To do this he must attempt to find the original goal of each person in the marriage, whether they have the ability to meet each other's demands and if they are capable of making the necessary changes to do this. It is not expected then that the caseworker attempt to completely change the existing pattern, but that he help the individual partner to adjust his method of living out the pattern in a constructive manner.

The third area of help to be discussed is that of employment. Often the alcoholic is holding or has held menial jobs which seem to be beneath his skill and ability. However, looking for any job, much less a better one, is threatening to the alcoholic and can be an obstacle to treatment. Behind this feeling is the fear of success, because the idea of success in employment involves adult responsibility, which, to the immature individual, is frightening and dangerous. It is the caseworker's task to help the patient to meet the problem and face the prospective employer with a recognition of it. The patient is helped to examine the situation and to decide how he wishes to approach the search for employment.

The patient can be supported in this area as described by Miss Gladys M. Price.

> Regardless of his choice in this area, the patient is encouraged to believe that we at the hospital can accept him with his problem and that he must face it with us. The alcoholic is accustomed to censure from himself, as well as from others, and often finds strange the absence of such attitudes in the hospital staff. He learns from everyday experience with us that admitting he is an alcoholic in need of treatment is bearable and that it is the first step in his rehabilitation.[11]

After he has been helped to realize that the fear holding him back is out of proportion in relation to actuality, the alcoholic patient is ready to make use of his ability and obtain satisfaction from occupational achievement. At this point, the caseworker can often offer further help by referral to a guidance counselor, referral to actual sources of employment and by support and encouragement during this difficult period.

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11 Price, Ibid.

CHAPTER IV

PRESENTATION OF STATISTICAL DATA

This chapter will concern itself with an analysis and interpretation of eight tables including: 1.) Source of Referral of Cases to Social Service; 2.) Purpose of Referral of Cases to Social Service; 3.) Patients in Casework by Classification; 4.) Problem Presented to Caseworker by Patients (in Addition to Alcoholism); 5.) Areas of Importance in Casework with Patients; 6.) Contacts in Addition to Those with Patients; 7.) Basic Treatment (s), Alone and with Adjunct (s); 8.) Caseworker as a Member of the Agency Team, as shown in the twenty cases studied.

Included in the twenty cases were fourteen male and six female patients. In reference to the total alcoholic population in the community, the ratio of 30 per cent females in this group is overweighted by about 10 per cent. This may be explained by the fact that, whereas ideally each patient would be active with social service to some degree, in reality this is not so. Although the proportion of males to females is greater in the total number of patients, a larger proportion of the females are active with social service.

The age range of the twenty patients was from thirty-one through fifty-one years. Eight patients, including five males and three females, were within the ages of thirty to thirty-nine. The largest number, eleven patients, including ten males and one female, were within the ages of forty to forty-nine. One patient, a female, was fifty-one years of age. The predominant number of patients were between thirty and fifty years of age, with the majority between thirty and thirty-nine.

The stage of alcoholism of these twenty patients, as defined in Chapter III, was that of crucial or chronic alcoholism, all having passed through the pre-alcoholic and prodromal phases to loss of control or prolonged intoxications.

Two patients, both males, were single. Twelve patients, including seven males and five females, were married. Six patients, including five males and one female, were divorced.

As described in Chapter II, page 8, the out-patient department is an important part of social service and is concerned primarily with offering casework service to the relative of the alcoholic. Because of the important role of the caseworker in this department, eight relatives of the twenty alcoholic patients, who were an integral part of the case, are included as a separate group in part of this study.

Of the eight relatives studied, six were spouses and two were parents of patients. The spouses were evenly divided into three wives and three husbands of patients. The two parents

were mothers of male patients. All contacts with these relatives were brief, extending from one to five interviews. The most extensive casework was with the wife of the patient taking the Conditioned Response Treatment. Four relatives were seen for two interviews each over a one-month period. Two were seen once at intake only. One was seen three times over a six-month period. One, the wife of a C. R. T. patient, was seen five times over a six-week period while her husband was hospitalized.

Table I which follows shows the source of referral of cases to social service.

TABLE I

SOURCE OF REFERRAL OF CASES TO SOCIAL SERVICE

Source	No. of Cases
Social agencies	4
Hospitals	2
Professional persons in community	3
Medical director	2
Staff physician	4
Selected by social service	3
Self	2
Total	20

Of the total of twenty cases referred to social service, the majority, eleven, or 55 per cent, came from some source within the hospital. These were patients who were admitted to

the hospital at their own or a relative or a friend's request. Of the twenty cases, four, or 20 per cent, were referred by a staff physician. Three, or 15 per cent, were selected by the supervisor of social service. Two, or 10 per cent, were referred by the medical director of the hospital, and two, or 10 per cent, of the twenty were referred by the in-patients themselves.

As mentioned in Chapter II, all persons referred to the hospital through community resources are handled by social service. Nine, or 45 per cent, of the twenty cases, were referred from a source outside of the hospital. Four, or 20 per cent, were referred from social agencies. Three, or 15 per cent, were referred by professional persons in the community including a judge, a private physician and a chaplain. The remaining two cases, or 10 per cent, were referred by general hospitals without facilities for alcoholic in-patients.

Table II which follows gives the purpose of referral to social service.

TABLE II

PURPOSE OF REFERRAL TO SOCIAL SERVICE

Purpose	No. of Cases
Rehabilitation plan	9
Exploration	5
Adjustment to hospital: in-patients	4
Contact with other agencies	2
Total	20

Of the total twenty cases taken on by social service, the largest number, nine, or 45 per cent, were referred for the purpose of working out a rehabilitation plan. This included discussion on; possible types of treatment such as Conditioned Response or psychotherapy in addition to casework; continuation of full or part-time hospitalization or out-patient interviews with caseworker or psychiatrist; bringing relatives into social service; finding employment. Five cases, or 25 per cent, were referred for the purpose of exploration, or determining interest of the patients in and motivations for participation in a treatment plan. Four, or 20 per cent, of the cases were referred for the purpose of helping in-patients adjust to the hospital. The patients in this group usually were persons who were temporary care rather than voluntary admissions, as described in Chapter II page 8. Because they were not patients of their own volition, it was often helpful to allow them to express and work out the hostility toward their being confined. Two, or 10 per cent, of the cases were referred for the purpose of co-ordinating contacts with other agencies. These contacts concerned patients who had been in treatment at other hospitals and clinics, and clarification concerning subsequent treatment after recovery from the acute stage of intoxication.

Table III follows and shows the persons in casework by classification.

TABLE III

PERSONS IN CASEWORK BY CLASSIFICATION

Category	No. of Persons
In-patient	10
Out-patient	6
Persons transferred from "in" to out-patient	4
Total	20

Of the twenty persons in casework, ten, or 50 per cent, were in-patients. Six persons, or 30 per cent, were out-patients. Four persons, or 20 per cent, were transferred from "in" to out-patient classification during their contact with social service. This includes patients who were transferred to night hospitalization, which is considered an out-patient adjunctive treatment.

Table IV follows and gives the problem presented to the caseworker by patients in addition to alcoholism.

TABLE IV

PROBLEM PRESENTED TO CASEWORKER BY PATIENTS
(IN ADDITION TO ALCOHOLISM)

Problem	No. Presented
Marital discord	6
Disrupted family relationships	2
Nervous anxiety	4
Reason for drinking	3
Treatment under duress	3
Compulsive dependence on alcohol	2
Total	20

The problem presented to the caseworker by patients (in conjunction with alcoholism) was not necessarily their principal or only problem, but the one they brought to casework.

Six, or 30 per cent, of the twenty patients presented the problem of marital discord--disharmony with the spouse--thought to be caused by, aggravated by or resolved by excessive drinking. Two, or 10 per cent, presented the problem of disrupted family relationships--homes broken up or family members separated or estranged as a result of alcohol. Four, or 20 per cent, presented the problem of the vicious circle of nervous anxiety preceding and following continued use of alcohol in attempting to meet frustrating life situations. Three, or 15 per cent, presented the problem of a need to find the reason for their excessive drinking, as they realized their excessive

use of alcohol but not the "why" for its use. Three, or 15 per cent, presented the problem of their being in the hospital under duress, these being patients who were referred under the classification of temporary care. Two, or 10 per cent, presented the problem of a compulsive dependence on alcohol, which, though an actual problem with many of the patients, often was unrecognized by them. These compulsive drinkers cannot resist the desire to drink even when they try.

It was interesting to note that of the eight relatives, three spouses presented the same predominant problem of marital discord as did the patients and one presented the same problem of disrupted family relationships. Two wives of patients presented the problems of marital discord and disrupted family relationships, whereas the two patients presented the problems of treatment under duress and compulsive dependence on alcohol. The two mothers presented the problems of disrupted family relationships, while the corresponding male patients presented the problems of finding a reason for their drinking and marital discord. The problem presented by the patient and relative often differed from the point of view of the patient and his or her relative.

The predominant similarity of presenting problems was around the area of marital discord between spouses as presented by the patient and his or her spouse. It is also obvious that the mothers of male patients saw the problem differently than did their sons.

Table V follows and gives the areas of help in casework with patients.

TABLE V

AREAS OF HELP IN CASEWORK WITH PATIENTS

Area	No. Worked with in Each Area
Rehabilitation plans	9
Family relationships	8
Factors in drinking and staying dry	6
Marital discord	5
Employment	5
Adjustment to the hospital	4
Financial	2
Total	39

Nine of the twenty patients were helped in the area of rehabilitation plans described on page 34. Eight patients were helped in the area of family relationships described on page 36. Six were helped around factors in drinking and staying dry. This area of help involved discussion of feelings about why the particular patient started drinking and what could be done to help him avoid the use of alcohol. Five patients were helped in the areas of marital discord and employment. Marital discord was discussed on page 36. Help with employment was needed when the patient had lost his job because of drinking or was interested in finding a job as part of his plan for night hospitalization. Four patients were helped in the area

of adjustment to the hospital. Two patients were worked with on financial matters revolving around payments for care or outside responsibilities. The areas of help in casework were often extensions of the underlying reasons for referral or new areas brought out during the casework relationship.

The largest number of patients were helped by the caseworker with plans concerning their principal reason for being in treatment, rehabilitation. The next largest number were helped with problems in family relationships, of prime importance in the treatment of the alcoholic. Help in the area of adjustment to the hospital was needed only by the small number of patients who, as mentioned earlier, were referred for temporary care.

Table VI which follows shows the contacts in addition to those with patients.

TABLE VI

CONTACTS IN ADDITION TO THOSE WITH PATIENTS

Contact	No.
Agencies	8
Relatives	6
Total	14

Contacts were made for eight patients with other agencies for the purpose of securing data from those to whom they were

known previously, and for referrals to others for continued treatment or special services such as physical or psychological tests, securing of hearing aids and other services. Contacts were made for six patients for the purpose of bringing relatives into casework, or, at least, to have them take a constructive interest in the patients and their problems. The other two relatives in casework initiated the contact themselves.

Table VII which follows gives the basic and supplementary treatments received by patients.

TABLE VII

BASIC AND SUPPLEMENTARY TREATMENT (S) RECEIVED BY PATIENTS

Basic and Supplementary Treatment (s)	No. Receiving Treatment (s)
Basic treatment (s):	
Casework only	8
Casework and psychotherapy	4
Casework and Conditioned Response	1
Basic, plus supplementary treatment (s):	
Casework plus night hospitalization	3
Casework plus drug therapy	2
Casework plus night hospitalization plus drug therapy	2
Total	20

Of the treatments given to the twenty patients, casework, psychotherapy and Conditioned Response are designated as basic

treatments. Drug therapy and night hospitalization are designated as supplementary treatments. Certain patients received combinations of these treatments.

Eight, or 40 per cent, received casework only, though seen by the medical director concerning administration rather than treatment. Four, or 20 per cent, received casework and psychotherapy. One, or 5 per cent, received casework and Conditioned Response. Three, or 15 per cent, received casework plus night hospitalization. Two, or 10 per cent, received casework plus drug therapy. Two, or 10 per cent, received casework, plus night hospitalization, plus drug therapy.

As only four patients received casework and psychotherapy, casework would seem to be the major psychologicalthherapy for patients referred to social service. Twelve of the twenty patients received some other basic or supplementary treatment in addition to casework. It is to be noted that the eight relatives of patients received casework only.

Table VIII follows and presents the caseworker as a member of the agency team.

TABLE VIII

CASEWORKER AS A MEMBER OF THE AGENCY TEAM

Team Member	No. of Cases
Caseworker and medical director	6
Caseworker and psychiatrist	5
Caseworker, medical director and psychiatrist	3
Caseworker only	6
Total	20

Of the twenty patients, six, or 30 per cent, were seen by the caseworker in conjunction with the services of the medical director who saw patients and was consulted concerning administrative procedures or the prescribing of medication for out-patients. Five, or 25 per cent, were seen by the caseworker in conjunction with the services of the psychiatrist who saw patients and was consulted concerning psychiatric evaluations or the progress of patients in psychotherapy. Three, or 15 per cent, were seen by the caseworker in conjunction with both the medical director and psychiatrist who saw patients and were consulted for the purposes described above. Six, or 30 per cent, were seen by the caseworker only.

The importance of the team work approach in the treatment of the alcoholic is demonstrated in that the caseworker consulted with one or more members of the agency team concerning fourteen of the twenty patients in casework. The remaining six patients received casework only after it had been determined that they were not in need of further services.

As mentioned previously, the caseworker was the only member of the agency team working directly with the relatives of patients.

CHAPTER V

PRESENTATION OF CASES

In this chapter three cases are presented to illustrate the principles and practices of casework with the alcoholic. The three cases will include examples of casework with; I. an in-patient, transferred to out-patient classification during the course of contact; II. an out-patient; III. a relative of an in-patient later transferred to out-patient classification. All information which might identify the patient has been disguised. First, pertinent background information concerning the patient is given. A summary and interpretation of the caseworker's contact is then given.

Case I

Background Information - Mr. H. is a 45-year old male patient. He is in the eleventh year of his second marriage, the first ending shortly in separation and then divorce due to interference by his wife's parents. He married his present wife, who was thirteen years younger than he and a state ward, "as the right thing to do" after she had become pregnant. They had two children, a boy and girl both of whom had been placed by Mrs. H. Mr. H. never saw the children although he insisted that his wife resisted his interest in them. The patient worked as a meat cutter and restaurant worker.

Mr. H. came from a large family. Little is known of the patient's father who died when the patient was young. His mother was a very strict woman,

who, even when he was attending high school, forced him to wear little boys' clothes. He had to be in the house by nine o'clock and in bed by nine thirty and resented this very much. Mr. H. was the fourth child in a family of eight. The two oldest children were girls. As the father died when the family was quite young, Mr. H. helped to support the family. He is proud of the fact that he "brought up" his baby brother and gave him a great deal. This youngest brother is now a contract engineer. The second youngest boy committed suicide in 1946. All of the younger brothers attended college, of which Mr. H. is somewhat resentful. They are all in the professional field but all have had some social problems. Mr. H. finished high school and went to work in a store and soon became an organizer for a chain of grocery stores.

He did well in school and on going into business earned a good salary although it was in the depression period. He was always a good mixer and a good dancer, and met his first wife through a dance contest in which they both took part. After his break with his first wife, Mr. H.'s family discarded him. He is resentful of this and feels that they owe him something which they have not repaid.

He started drinking about the age of nineteen, as this was during prohibition and "the thing to do." However, he was only a social drinker up until the time of his first marriage. He then experienced interference by his wife's family and started to drink heavily. His drinking subsided after his separation but became heavy again soon after his second marriage.

Mrs. H. took great pride in the fact that her parents had "spoiled her." She described herself as "somewhat of a party girl" who always liked male company. She originally ascribed her attraction to Mr. H. to the fact that he seemed so mature and stable. Although he drank quite heavily, he had seemed to be able to hold his liquor, and that added to her mature picture of him. Although her parents objected to her relationship with Mr. H., this only served to strengthen her determination to marry the patient. She tolerated him for a

long time because she felt guilty that she and not he had been the aggressive partner in the marriage. However, after marriage there seemed to be no mutuality of interests. She had come to see Mr. H. as old and shoddy, and isolated. She showed little interest in taking him back.

After the initial referral to the hospital by the local committee on alcoholism, the patient was referred to social service by a staff physician who had observed patient's depression and had heard of his very complicated life situation. After evaluation by a consultant psychiatrist, it was felt that Mr. H. would profit by social therapy at this time to relieve the pressure of a difficult marital situation, as he continuously accused his wife of infidelity with many men, of being a poor wife and homemaker and the principal reason for his drinking. She showed him no affection, going out every night after providing him with liquor. Mr. H. admitted that he drank to excess, but insisted that he had caught his problem in time. He insisted that a divorce was the only answer to his problem but wanted his wife or someone else to make the arrangements for the action.

With the support of the caseworker on a weekly basis, Mr. H. was able to make plans to be transferred from an in-patient to an out-patient classification after several weeks in the hospital, and to continue as a night-hospitalization patient. During this initial period, the caseworker expressed a sympathetic interest in Mr. H.'s marital situation. The caseworker also expressed an understanding of his feelings that the only thing he could do was to go out and drink and then go home and talk to himself. An attempt was made to help the patient clarify his thoughts and feelings about a divorce action. It was explained to him that the decision was up to him, but a referral to an appropriate resource was offered to help him solve his problem. When Mr. H. expressed interest in the night-hospitalization plan, this interest was discussed and encouraged as he seemed to have a great need for job and financial stability. Through further consultation with the psychiatrist, it was felt that the patient had a homosexual problem, as shown by the abuse he accepted from Mrs. H. Because of this, it was felt that it would be well for Mr.H.

to be in an organized group, consisting mainly of men, as this would be a good outlet for him. As a result, arrangements were made with the medical director to extend Mr. H.'s in-patient stay so that plans could be worked out for possible night hospitalization. In the meantime, Mrs. H. was contacted and her attitude toward the patient was tentatively confirmed by her own admission of lack of interest in the marriage and association with other men. Arrangements were then made with patient concerning employment and transfer to the night-hospitalization plan on an out-patient basis.

Subsequently Mr. H. became stabilized in that he found employment and was able to be self-sustaining with night hospitalization for varying periods of time. Mrs. H. was seen several times and admitted to the caseworker her continuous infidelity to the patient. Although the patient relapsed several times and did not follow up on a divorce action, he made some progress in that he became more accepting of the situation, and was able to continue in treatment for a period of six months. Mr. H. terminated his stay at the hospital at this time against the advice of the staff. He felt that he was able to function independently and did not accept out-patient treatment.

Interpretation

Mr. H. presented a long history of inadequate and dependent behavior with the use of alcohol for the purpose of coping with situations which he was unable to meet, the principal one of these being marriage. He showed little capacity for self-direction. This was especially apparent in his shifting of the responsibility for a decision concerning a divorce action. The problem seemed to be noted in the early relationships with his parents and was intensified by his relationship with his wife. The patient showed inability to hold his wife on a sexual level

and an apparent lack of interest in the children. The complicating factor of a wife whose motivations in marriage seemed to have been neurotic from the beginning, probably stemming from deep-seated needs of early origin accentuated the problem. Mrs. H. had a strong need to dominate Mr. H. and often was the creator of crises in the home, causing Mr. H. to go on another drinking bout.

Mr. H. was able to participate for a limited period of time in the treatment plan recommended for him. However, due to the lack of the unusual capacity for change required to rise above his situation, the results were not lasting.

Case II

Background Information - Mrs. A. is a 35-year old housewife. She is the second wife of a once-divorced man who is twenty-three years older than she. They have been married for four years, and there have been no children by this marriage. Mr. A. has a son, 20, who lives at college and has little contact with the family. Mrs. A.'s maternal grandmother is residing in the home on a temporary basis.

Mrs. A. was an only child. Both her parents had been the only children and her maternal grandmother was also an only child. Her mother was described as having a violent temper, as did the patient, and was hated by Mrs. A. Although the patient learned to "swallow" her temper, her mother often abused Mrs. A. for something totally unrelated to her. Her mother had a nervous breakdown when Mrs. A. was twelve and tried to commit suicide at that time and on several succeeding occasions. The most recent of these was when Mrs. A., at twenty, broke her engagement to a man whom her mother wanted her to marry. Her mother was a heavy drinker and drank heavily at the time of that incident.

Mrs. A.'s father was described as a peacemaker. He gave Mrs. A. attention and affection, but never protected her from her mother's blows, which she resented. Although her father continually tried to excuse her mother's actions, Mrs. A. felt much closer to her father than her mother.

Mrs. A. was a person who had drank heavily on occasion after a build up of tension due to periods of unhappiness or frustration. However, after her marriage to a man more than twenty years her senior, her periods of heavy drinking increased.

Mrs. A. said that her parents always had given her everything that a child could want in the way of material things. She progressed satisfactorily in school and had an active social life. She went into nurses' training but failed during her probation period and then did secretarial work. She had always had a tendency to go with boys several years older than herself. She had a second engagement to the only man she really loved who was killed in the service in World War II.

She started drinking shortly before her marriage. At times of unhappiness or frustration, she would drink for several days. Between times, she would drink socially on occasion without any problem. However, since her marriage her drinking has increased though she feels that she has some control as the periods are not extended. She has attributed this to the fact that, because of the difference in ages, there is a lack of mutual interests with her husband. There have been some financial difficulties because of the payment of alimony to Mr. A.'s first wife, and they had to live out of the state until his final divorce decree. Also, Mr. A. travels and his absence makes her lonely, and although she longed for the companionship of a child, she had not become pregnant. She, therefore, was not convinced that she had a real alcoholic problem but blamed the marital situation.

Mr. A. was an intelligent, sincere, unemotional man of fifty-seven. He was raised in a small, close-knit, happy, but unemotional family setting. Both of his parents came from England, and his father ran a machine shop. Contrary to Mrs. A.'s home environment, everybody in his family respected everybody else, and problems were always discussed in a very

unemotional way. He claimed to have had an uneventful but happy childhood, being fairly close to both parents. He worked his way through college and became a traveling salesman for a chemical company. He described his first wife as being a neurotic, sickly person, really not suited for marriage. Because of his traveling, he grew away from both his wife and son, and finally she secured a divorce under which he pays alimony. He was aware that Mrs. A. drank to some extent before marriage but thought that this would cease when patient was away from her family. He did not know how to handle her drinking, especially in his absence, getting terribly upset, and sometimes not behaving in a very rational way. He expressed the need to try to be more demonstrative, understanding, and involved in Mrs. A.'s affairs when he was at home.

Patient was referred to social service for out-patient treatment by a private physician. This doctor had been called in by Mr. A. at the time of the patient's last drinking episode. With the support of the caseworker, Mrs. A. was able to make plans for transfer to one of the consultant psychiatrists for therapy on an out-patient basis for her personality difficulty. During the exploration period, the worker accepted the patient's resistance to the recognition of the severity of her drinking problem. Through sympathetic understanding of the patient's unhappy family relationships, the worker was able to reduce some anxiety in this area, so that she was able to enter more intensive therapy of her own volition. Although the worker accepted the mutuality of the problem, she was careful to keep the individual relationships with the patient and husband on a separate basis. Through the development of the casework relationship, the worker was able to build up enough positive transference to allow the patient some limited insight into the dynamics of the inter-relationship of husband and father. This helped open the way for the more intensive therapy to come. The patient saw the caseworker on a weekly basis for one month and continued with the therapist for a two-month period. At the end of that time, though beginning to show some insight and having had no relapses, she interrupted her appointments with the psychiatrist by a vacation and did not return to the hospital. Though Mr. A. returned for one interview, he could offer no specific

reason for his wife's behavior and discontinued his contact because of her lack of interest.

Interpretation

Mrs. A. presented a history of the use of alcohol in order to overcome tension built up during periods of unhappiness and frustration. Although these periods were brief and occasional before her marriage, they increased in intensity after marriage. Again, the problem seemed to be rooted in the early child-parent relationships and intensified by the relationship with the spouse.

Mrs. A. was the only child of a rejecting, abusive, and drinking mother whom the patient admittedly hated. She felt hostile and guilty toward this female figure, for whose attempts at suicide she was blamed, and with whom she could not identify. Therefore, she turned to the male figure, who, although attentive and affectionate, did not protect her from her mother's abuse.

It was noted that Mrs. A.'s relationships with the opposite sex were always with older men. She had two unfortunate romances, one with a man she rejected over her mother's strenuous objections, and another whom she lost in service. She finally married a much older man. He was a person who treated her much as her father did, not taking sides with her against her mother, and so reinforced the feelings of a lonely little girl. She then had the recurring periods of unhappiness and frustration which she resolved by drinking.

With the support of the caseworker, Mrs. A. was able to enter into psychotherapy but was unable to maintain contact over a sufficient period to resolve her problem.

Case III

Background Information - Mrs. P. was the attractive 27-year old wife of a patient who took the Conditioned Response Treatment. She was in the fourth year of her marriage and had two children, a girl, seven months, and a boy, two years of age.

Mrs. P. was an only child. There was not much information available on her early life. Her father was a heavy drinker, and she was not very close to him. Her mother was a rather unemotional person, and she never felt free to bring her normal troubles of growing up to her. She had a few male friends when younger and knew Mr. P. only a short time before marriage.

Mrs. P. was a young woman who, after marriage, had become involved in the problem of a drinking husband. His drinking bouts had become progressively worse so that at times she experienced loss of her pride and feelings of terror toward her husband, due to the fact that Mr. P. would appear in front of company in the home and pass out drunk. The neighbors would talk about him, and she would have to control herself to keep from screaming at them. On one occasion, Mr. P. brandished a gun and threatened to shoot the entire family. Mrs. P. has had to carry on the household in spite of these problems. She has received little understanding from either her or her husband's family. She tried to assume a blase attitude toward the situation, stating that things were not actually so bad. She felt that there was little need to discuss it, and that she could handle Mr. P. as she did a child. She described Mr. P. as otherwise being a good provider and businessman, though she complained that he neglected his business to cater to his mother, to whom he was very much attached.

Mr. P. was an alert appearing young man of thirty-one. He described himself as having had a very peculiar childhood. His father was a heavy drinker and formerly a successful businessman. However, due to his continuous drinking, he gradually lost his business and finally attempted suicide. It was "a blessing to all of us" when father died. Mr. P. used to be the one who, at ten or twelve years of age, would quiet his father and protect his brothers from him. The patient's paternal grandmother, though good to the children, covered up for the father and hated the mother. The patient's mother was described as having had a "rough life," with little opportunity to be close to the children. Mr. P. had intended to marry a girl he had known for many years, but on his return from the service found her to be promiscuous. This was a big blow to him and still bothers him. The patient attended college and began to drink heavily. After college, he started his own coal firm and did well in business. He married Mrs. P. at that time and stated that it was the smartest thing he ever did. He expressed a sincere desire to undergo treatment and change his pattern of living with a thorough realization of his misdeeds.

After Mr. P. was referred to the hospital by one of the local clinics, Mrs. P. was referred to the social service department. She was referred by the medical director for casework treatment for support and clarification of her role as related to her husband's rehabilitation at the outset of his Conditioned Response Treatment. The caseworker attempted through sympathy, warmth, and understanding to have Mrs. P. become more involved in her husband's rather difficult rehabilitation plans. An attempt was made to deal with Mrs. P.'s obvious hostility toward the hospital and to explore her feelings regarding this. It was realized that Mrs. P. had feelings of inferiority, compensated by feelings of superiority brought about by her husband's dependence during periods of drinking. The caseworker attempted to deal with Mrs. P.'s feelings of inferiority to determine if they had developed primarily from the marriage experience or were more deep-seated than this. It was hoped that in this manner she might accept the fact that Mr. P. had become an irresponsible partner because

> of his own predeveloped needs, rather than because of his wife's inadequacies. Then, Mrs. P. would have been freer to co-operate in her husband's treatment and in a subsequent change in his behavior.
>
> However, because of Mrs. P.'s deep-seated, neurotic, emotional pathology, little progress was made in getting her to become emotionally involved in the treatment plan. Although Mrs. P. was able to sustain her husband for a period of six weeks while he remained in the hospital, no plan could be developed to have her continue with casework or psychotherapy.

Interpretation

Mrs. P. had little in the way of emotional warmth as a child and, as a result, seemed to be able to express little emotion concerning her problems.

After a rather barren childhood, involving a drinking father and a rather cold, unemotional mother, she became involved with Mr. P., already a heavy drinker. She appeared very protective toward him in an unemotional way and was unable to release any of her feelings concerning him. She had built up this defense of resistance to her feelings, in order to withstand the large amount of inner conflict and turmoil stirred up as a result of her husband's drinking and hospitalization.

Mrs. P. showed marked feelings of insecurity and ambivalence concerning her husband's condition. As a result, she was not able to allow herself to become emotionally involved in the casework relationship which was focused on helping her to accept and support her husband in treatment for his alcoholism.

Although Mr. P. continued his contact with the medical director after his hospitalization, Mrs. P. did not become involved enough to continue treatment after that time.

CHAPTER VI

SUMMARY AND CONCLUSIONS

This project was undertaken to study the role of the caseworker with the alcoholic at the Washingtonian Hospital. Related to this were the following considerations: 1.) the major areas in which the caseworker functions, 2.) other types of help beside direct contact with the patient, 3.) the caseworker's function with the alcoholic in conjunction with other members of the agency team.

Chapter I was an introduction to this study.

Chapter II presented a history of the hospital, a history of the social service department, current services and a summary of the treatments offered.

Chapter III presented a three-part discussion of casework with the alcoholic, including a definition of alcoholism as a disease, a picture of the alcoholic personality and a presentation of areas in casework with the alcoholic.

Chapter IV presented eight tables dealing with statistics of special significance in relation to the alcoholic.

Chapter V presented three case studies of an in-patient, an out-patient and a relative of a patient at the Washingtonian Hospital.

The majority of the patients studied were male. They ranged from thirty-one through fifty-one years of age, the largest number being in their forties. They had all passed through the preliminary stages of alcoholism to the crucial phase, and, like many alcoholics, did not seek treatment until their illness was well advanced.

Just over half of the patients studied were referred through a source within the hospital, the others having been referred through community resources; hospitals, social agencies and professional persons. The majority of these patients were referred for the purpose of working out a rehabilitation plan, and this seemed to be the predominant area in which the patients themselves asked for help. It was noted that the temporary-care patients were the ones needing help from the caseworker in adjustment to the hospital. Half of the patients studied were in-patients. Of the remaining ten, six were out-patients, and four were persons transferred from in-patient to out-patient classification during contact.

The problem most often presented to the caseworker was not excessive drinking itself, but marital discord. This disharmony with the spouse was thought to be caused by, aggravated by, or met by the excessive drinking. There is here an indication of resistance, the reluctance of the alcoholic to accept by admission his condition, as only two of the twenty patients actually presented the problem of compulsive dependence on

alcohol. The other problems as presented were divided among: disrupted family relationships, nervous anxiety, reason for drinking and treatment under duress.

The caseworker helped nine or almost half of the patients with rehabilitation plans. Eight patients were helped in the area of family relationships. This reinforces the theory that work with relatives is of prime importance and should be one of the major concerns of the out-patient section of the social service department of the hospital.

The importance of the team-work approach was demonstrated in that the caseworker consulted with one or more members of the agency team in regard to fourteen of the twenty patients studied. Including the caseworker, two members of the team were involved with eleven patients and three members with three patients.

Not to be neglected are the eight relatives of patients--an integral part of the study, though included as a separate group. Of the eight relatives seen by the caseworker in the out-patient department, six were spouses of patients and two were parents of patients. It is of interest that four spouses of patients presented the same predominant problems of marital discord or disrupted family relationships to the caseworker as did the patient. Though, in general their contacts with social service and the caseworker were brief, the contribution of the relatives to the rehabilitation of the alcoholic patient was a valuable one.

It can be seen from the foregoing that the caseworker has an increasingly important role as part of the team approach in the rehabilitation of the alcoholic patient at the Washingtonian Hospital.

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APPENDIX

Schedule

I. Identifying Data
   - A. Age
   - B. Sex
   - C. Marital Status

II. Date of Referral to Social Service

III. Source of Referral
   - A. Outside source
   - B. Medical director
   - C. Staff physician
   - D. Self
   - E. Selected by social service

IV. Reason for Referral

V. Person in Treatment
   - A. In-patient
   - B. Out-patient
   - C. Relative

VI. Presenting Problem

VII. Areas in which Caseworker Functioned

VIII. Contacts in Addition to Those with Patient

IX. Treatment
   - A. Basic
     1. Casework
     2. Psychotherapy
     3. Conditioned Response
   - B. Supplementary
     1. Night-hospitalization
     2. Drug therapy

X. Caseworker as a Member of the Agency Team
   - A. Caseworker and medical director
   - B. Caseworker and psychiatrist
   - C. Caseworker, medical director and psychiatrist
   - D. Caseworker only

XI. Casework Contact

A. Length of contact
B. Frequency of contact
C. Status at closing