
3.

**Approaches to Alcoholism
Treatment**

Approaches to Alcoholism Treatment

Given the diversity of etiological understandings of alcoholism and the populations affected, it is not surprising that there are diverse treatments. Described below are the treatment modalities, settings, and providers that comprise the present health care system for alcoholism. It is im-

portant to recognize that each of the system components to be described affects the others, that specific modes of treatment can be offered in multiple settings, and that treatment providers often use several modalities and settings as part of a treatment program.

TREATMENT MODALITIES

The major treatments for alcoholism can be organized into three major approaches, which parallel etiological perspectives: 1) medical, 2) psychological, and 3) sociocultural. In practice, treatments often overlap, with psychologically oriented treatments using medications as adjuncts and drug treatments being combined with psychological techniques. In fact, the approach used with alcoholics in most treatment settings is eclectic and multivariant, with several approaches being utilized at the same time.

Medical Approaches

The difficulty of delineating the basis of alcoholism treatments is clear in any attempt to identify medical approaches. Three types of medical treatment are described here, one having to do with detoxification and the others with the use of drugs. Additional treatments that could have been included because they are often delivered by physicians, such as chemical aversion therapy and psychotherapy, are discussed as psychological approaches. The classification is less important than the nature of the treatment.

Detoxification

In the context of the present report, detoxification is not an actual alcoholism treatment, because it is not designed to treat the underlying dependence on alcohol. However, medical intervention may be necessary to manage withdrawal from alcohol and may be necessary as the first step in a treatment program. Chronic alcohol intake re-

sults in cellular alterations to which the body adapts, and withdrawal reactions may include heightened sensitivity to sensory stimuli, hyperactivity of reflexes, muscular tension and tremor, over-alertness, anxiety, insomnia, and reduced seizure threshold. The withdrawal reaction, itself causes additional physical stress, and problems may be further complicated when withdrawal results from the need to recover from surgery or serious injury. The severity of symptoms depends on the intensity and duration of the patients' drinking problem (285).

A recommendation of hospitalization for detoxification is made for patients with severe withdrawal symptoms, medical or surgical complications, or other evidence of moderate to severe withdrawal such as a history of seizures during past withdrawals (285). Detoxification can also be handled on an outpatient basis or in a nonmedical setting (a detoxification center), although medical backup is required in the event of emergencies. Increasingly, efforts are being made to detoxify patients without hospitalization, although that is safe only if the patient has no complications and has available supervision.

Support services are often an important part of the treatment for withdrawal (207). The use of supportive services without pharmacological treatment (e.g., reassurance, reality orientation, and frequent monitoring of signs and symptoms) is known as social detoxification and has been found to be safe and effective for patients who are not experiencing severe reactions (142,314, 334).

Antianxiety medications are often prescribed during the detoxification process for managing symptoms such as disorientation, seizures, visual and auditory hallucinations, and delirium tremens. The usual drugs of choice for managing alcohol withdrawal are the benzodiazepine derivatives: chlordiazepoxide (Librium[®]), diazepam (Valium[®]), clorazepate (Tranxene[®]), and oxazepam (Serax[®]). Some physicians continue prescribing these tranquilizers after the detoxification period, but such use can sometimes lead to psychological dependence on the drugs and other side effects that inhibit recovery (108). The dosage and the length of use of antianxiety medications vary widely. Some experts see the drugs in later stages as a symbolic vehicle in clinician/patient interaction, where the act of giving and receiving is seen as more important than the actual pharmacologic action (232,271).

Mood-Altering Drugs

Antidepressant medications have a long history of use in the treatment of alcoholics. The logic of their use seems persuasive, since alcoholism and depression are often inseparable (114,186,304,305). Most commonly prescribed are the tricyclic antidepressants and lithium. However, the side effects associated with these drugs and the deleterious and, at times, fatal effects of ingesting these drugs along with alcohol make their use questionable (165,199). Furthermore, these medications treat the affective disorder associated with alcohol abuse, but not alcoholism itself.

Some physicians (generally, psychiatrists) prescribe major tranquilizers or antipsychotic medications for alcoholics who are severely agitated. Some prescribe these drugs only for people who are both alcoholic and psychotic. Alcohol has been considered a form of self-medication that has been used by schizophrenics to calm themselves. When these individuals stop drinking, they may become severely agitated (199). Many physicians are hesitant to prescribe these medications at all (165). The fact that many patients do not take their medications as prescribed is another negative factor (262,336).

Sensitizing Agents

Disulfiram (Antabuse[®]) is the most commonly used drug in alcoholism treatment. Antabuse[®] does not cure alcohol craving or dependence per se, but causes psychological effects such as respiratory difficulty, nausea, vomiting, and sweating when alcohol is ingested while the drug is active. The intensity of reactions depends both on drug dosage and amount of alcohol subsequently ingested—with large doses of Antabuse[®] and alcohol combined, reactions may be fatal. After taking Antabuse[®], the patient's desire to drink will be dulled by the thought of inevitably getting sick (165). One disadvantage is that a person can stop the Antabuse[®] regimen at any point and shortly thereafter (within 24 to 48 hours) be able to drink with impunity. For patients who are motivated to abstain, however, life is simplified by Antabuse[®], as there is only one decision a day—either to take the pill or not to take the pill. For this reason, Antabuse[®]-based treatment has been described as a method of “ego-reinforcement” (30).

Antabuse[®] is not recommended universally for alcoholics for several reasons. It cannot be given to patients with other serious medical disorders (165). For example, the use of Antabuse[®] with elderly alcoholics is often contraindicated because of the risk of cardiovascular problems (23). Furthermore, Antabuse[®] has been associated with suicide among users (303).

Psychological Treatments

The forms of psychological treatment vary widely and, as with medical treatment, are difficult to classify. Behavioral approaches, although based on only one of several important themes used to explain alcoholism, have been widely employed in recent years to treat alcoholics. Other psychological therapies (including nonbehavioral and the related systems approaches), while extensively employed generally, have been used less frequently to treat alcoholism specifically.

Behavioral Approaches

A large number of behavioral techniques to treat alcoholics have been developed over the last

30 years (cf. 208). Based on research that investigates how individuals learn and maintain habits, behavioral approaches are supported by an extensive basic research literature and substantial evidence of their effectiveness in treating other disorders (cf. 227). Often, behavioral treatments are used in conjunction with other psychological treatments as part of broad-spectrum treatment packages (15,172,301).

One type of behavioral technique used with alcoholics is referred to as blood-alcohol level discrimination training. Based on the assumption that alcoholics do not accurately process information about their level of intoxication, the procedure teaches alcoholics how to estimate correctly their blood-alcohol level (182). A related technique involves confronting alcoholics with videotapes of themselves when drunk so they can experience their drunken behavior as observers do. In both cases, it is assumed that alcoholics can be taught to manage their alcohol intake.

A second group of behavioral techniques is used to train alcoholics to relax. These techniques are based on a tension-reduction hypothesis and an assumption that alcohol is ingested to reduce stress. Training alcoholics to relax, by teaching them, with biofeedback, how to alternately tense and relax their various muscle groups is believed to help them develop nonharmful, substitute behavior (171). Techniques of visualization and imagery are also used in relaxation and desensitization training (345).

One assumption behaviorists make about alcoholics is that they have difficulty expressing their wants, needs, and frustrations. Various assertiveness training approaches are used to develop their skills in self-expression. Role-playing and behavioral rehearsing of problem situations are also used. For example, an alcoholic practices saying "no" when offered a drink or role plays walking away from the kind of domestic scene that usually precipitates a drinking binge (21,298).

Cognitively oriented behaviorists assume that if alcoholics understand the idiosyncratic thoughts, feelings, and behaviors that precede their own drinking, they can substitute alternative behavior for drinking. Thus, analyses of patterns of drinking and counseling about alternative behaviors

may also be part of the behaviorists' repertoire. Sobell and Sobell used such an approach as part of their Individualized Behavior Therapy for Alcoholics (296,300,301).

Chemical aversion therapy is perhaps the best known treatment associated with behavioral theory. Its goal is to facilitate abstinence by developing a conditioned aversion to the taste, sight, and smell of alcoholic beverages. This aversion is accomplished by injecting an alcoholic patient with an emetic substance such as emetine hydrochloride just before serving him or her an alcoholic drink. Nausea results in about 2 to 8 minutes. Often, additional drinks are given over a 30-minute period as the nausea continues, and the sequence of pairing nausea with alcohol is continued. In some inpatient settings, treatment may involve five such injections given every other day over a 10-day period (335). By the end of the series, the alcoholic is expected to have developed a negative association to the sight and smell of alcohol. The treatment is based on Pavlovian classical conditioning principles, and according to the theory, a person who receives such treatment will develop a long-term aversion to alcohol. In many cases, reconditioning sessions are offered to maintain the aversion.

The advantage of chemical aversion therapy is that it offers the potential of training alcoholics to abstain. There are disadvantages, as well. Because nausea is repeatedly induced, the technique is potentially hazardous and must be administered under medical supervision (16). Chemical aversion therapy is typically provided in a hospital setting, and with the need for multiple sessions, it is a costly form of treatment.

A type of cognitive aversion conditioning without the dangers of chemical aversion therapy is covert sensitization (57). Patients treated with covert sensitization are instructed to imagine that they are about to drink some alcoholic beverage, experience a sensation of nausea, and vomit. In this way, the target stimulus (alcohol) becomes associated with an aversive stimulus (vomiting). Feeling better becomes associated with leaving the scene where the urge to drink occurred (escape conditioning). The technique is called covert, because the stimuli are not present at conditioning

sessions. The word sensitization implies a gradual buildup of an avoidance response. Covert sensitization is often preceded by relaxation, desensitization, and assertiveness training to treat the anxiety component of the drinking behavior. Depression is thereby avoided because the patient is provided with a means of coping with his or her environment when sober.

Nonbehavioral Psychotherapies

Various nonbehavioral psychotherapies are also employed with alcoholics. Nonbehavioral psychotherapy can be delivered on a one-to-one basis, in families, or in groups. The length of individual therapy varies, ranging from short term, of 12 or fewer sessions, to long term, from 2 to 7 years. The kinds of approaches vary widely although the approaches all have the goal of aiding the alcoholic (or family members) to understand and deal with physical or psychological dependence on alcohol (227). Several forms of psychotherapy can be employed, and speciality therapies such as transactional analysis (115) and reality therapy (308) are also used.

Although there is some limited use of psychoanalytic therapy, most psychotherapists who treat alcoholics emphasize treating the contemporary life problems of patients. They feel that alcoholism, while perhaps rooted in early experiences, is maintained by present interactions. Therefore, they focus their therapeutic attention on what produces stress on the job, in family interactions, and on the role alcohol plays in the patient's life. They may discuss feelings, offer support, and facilitate problem-solving. In addition, they may use some of the behavioral techniques discussed above in the belief that behavior change as well as insight is important. In all kinds of psychotherapy, the relationship between therapist and client is itself a key factor in encouraging change (cf. 104).

Group therapy has received a good deal of attention recently as the treatment of choice for alcohol problems (cf. 26,83). Group therapy sessions are usually held once or twice a week on an outpatient basis or, more frequently, in inpatient settings. Therapists focus on the process of the group as a whole, but may also work individually with patients. The group members support

and challenge one another. The feedback from the group is supposed to be a powerful catalytic agent in helping the alcoholic change.

It is generally assumed that nonbehavioral psychotherapies are effective because they deal with the underlying problems of an alcoholic, rather than the symptoms. Nonetheless, all psychotherapies have been criticized as being difficult to use with alcoholics. Psychotherapy is especially difficult to employ if attempted while a patient is still drinking (60). A number of experts are pessimistic about the efficacy of psychotherapy for those who cannot maintain abstinence or reduced drinking during treatment (35,129,135). Other reviewers have argued that this negative impression is not well founded and that psychotherapy is necessary to deal with the underlying psychological causes of alcohol abuse, especially for heavy, habitual drinkers (18,95,199).

Systems Approaches

As noted previously, most systems approaches focus on family interactions, and in particular, on family communication patterns. It is assumed that the family has developed ways of interacting that accommodate, if not perpetuate, the alcoholic's drinking. If the negative family interactions are not treated, when the alcoholic stops drinking, the family may subtly exert tremendous pressure on him or her to resume drinking.

Family therapy is related to group therapy. In practice, family therapy can involve various psychotherapeutic techniques. In general, the goal of such therapies is more direct expression of wishes, needs, and feelings by family members. Families are taught how to talk more openly about their own family interactions and to become observers of their interactions. It is assumed that such discussions and the development of communication skills will aid the alcoholic member by reducing environmental stresses and providing support to control drinking urges.

Sociocultural Approaches

The essence of sociocultural approaches is the assumption that the successful treatment of alcoholics requires changing the social environment

within which such individuals function. Such approaches share the rationale of group and family psychotherapies about the need to change the alcoholic's environment. In practice, this often means removing the alcoholic individual temporarily from his or her home and placing that individual in a new setting, such as an alcohol treatment facility. Changing the environment may also mean creating a whole new culture for the alcoholic, such as that which Alcoholics Anonymous (AA) provides (351).

AA is a volunteer self-help organization, which, although not a formal treatment provider, is perhaps the major resource for alcoholics in this country and elsewhere (5, 173). It provides a new ideology for members by supporting abstinence from alcohol (351), a sense of belonging, and an involving set of activities. Founded in 1935 by two alcoholics (one of whom was a physician), AA takes an approach that directly confronts the denial typical of alcoholics. At AA meetings, each speaker announces, "I am an alcoholic." In addition, AA incorporates a spiritual approach; as part of the "twelve steps" of *recovery*, all members submit to a "higher power." Although the organization has religious origins (the second founder was a religionist), belief in God is not essential, and many agnostics belong. At meetings, members share personal narratives about the difficulties caused by alcoholism and the positive experiences of sobriety. Members typically attend at least one meeting a week; some attend daily. Help for AA members is available 24 hours a day, with fellow members willingly visiting the home of

anyone needing assistance. For those who join AA, the group provides a network of abstainers to replace the individual's old social system (128,156).

AA can also help change the family environment through parallel programs such as Al-Anon (for spouses of alcoholics), and Alateen (for the children of alcoholics). Using similar group support techniques, these related groups help family members cope with the problems created by the alcoholic family member and provide a supportive environment for sobriety. Although AA has often been regarded as the most effective form of help for an alcoholic (103,109) it has also been subject to criticism (173).

Combination of Treatment Modalities

Although a variety of treatment modalities have been described, it is important to note that alcoholics and alcohol abusers are rarely, if ever, treated with only one method. Thus, for example, hospitals that employ aversion conditioning may also use individual and group counseling and participation in AA as part of the treatment regimen. Psychodynamically oriented therapists may also use desensitization techniques and prescribe "Antabuse" or a mood-altering drug to encourage the alcoholic to remain in treatment. Treatment providers may refer indigent alcoholics to vocational training or those with severe psychopathology for psychiatric care. The important point is that, in practice, no single treatment is considered sufficient for treatment of alcoholism.

TREATMENT SETTINGS AND PROVIDERS

A major focus of research on treatment effectiveness is often on the setting within which treatment is provided. Recently, research has begun to assess characteristics of settings in an attempt to discover effective treatment programs and appropriate patient-setting matches (cf. 24,42,72,73). Differentiating between various settings, however, is often difficult. Below, the most common treatment settings for alcoholism and the providers who deliver alcoholism services are described (also, see table 2).

Inpatient Care

The distinguishing characteristic of inpatient care is overnight stay in a medical facility. * Inpatient settings include: 1) alcoholism detoxifica-

*This distinction follows the typology of Armor (13) and others. However, the National Institute on Alcohol Abuse and Alcoholism analyses characterize as inpatient any form of residential care (half-way and quarterway houses, small group homes, boarding houses, as well as hospitals) (cf. 218).

Table 2.—Characteristics of Treatment Settings

Setting	Treatment modalities	Patients ^a
Inpatient		
General hospitals Short-term detoxification units Rehabilitation stay (3 to 4 weeks)	Medical: frequently pharmacotherapy	Socially stable, fewer years of heavy drinking
State and private psychiatric hospitals	Individual and group psychotherapy, alcoholism education, AA, Antabuse [®]	Lower middle class, relatively socially and vocationally disabled Severe psychiatric condition or opportunity to interrupt drinking pattern or motivate a resistant patient
Free-standing alcoholism rehabilitation facilities	Nonmedical: lectures, nonpsychodynamic group counseling, AA, family sessions	Socially competent, middle class, working
Aversion-conditioning hospital	Strong medical orientation: detoxification, emetine or faradic conditioning, counseling, group therapy, education, hospital followup programs	Socially competent, upper class
Outpatient		
Private physicians' offices	Medical: Antabuse [®] maintenance, symptom management, involvement of spouse and family	Usually alcoholism is not primary complaint
Community mental health centers	Medical, psychological, social services	Broad spectrum of patients
Free-standing outpatient clinics	Medical, psychological, social services	Broad spectrum of patients
Day care	Varied	Broad spectrum of patients
intermediate		
Halfway houses, quarterway houses, recovery homes	Peer-group orientation; food, shelter, supportive services in nondrinking atmosphere	Recovering alcoholics: ambulatory and mentally competent who usually have no spouse or immediate family

^aPatient descriptors are only rough characterizations.

SOURCE: Office of Technology Assessment.

tion units and alcoholism rehabilitation units in general hospitals, 2) alcoholism treatment units in State and private psychiatric hospitals, and 3) free-standing alcoholism rehabilitation facilities.

Detoxification/Rehabilitation Units in General Hospitals

In addition to providing medical services to alcoholics not being treated primarily for their alcoholism (241), general hospitals have recently begun to provide services directly to alcoholics. This practice represents a change in the long tradition of hospitals refusing to serve anyone with a primary diagnosis of alcoholism.

Detoxification/rehabilitation units in general hospitals typically provide an initial detoxification and/or evaluation period, followed by a 3- to 4-week inpatient stay for rehabilitation. According to Diesenhuis (81), general hospitals stress evaluation of medical status and frequently use pharmacotherapy. They tend to admit alco-

holics who are socially stable and who have experienced fewer years of heavy drinking.

Third-party medical insurance coverage is typically provided for inpatient care in general hospitals; Medicare provides coverage for up to 3 weeks of combined detoxification and rehabilitation in an inpatient medical setting (130).

Alcoholism Treatment Units in State and Private Psychiatric Hospitals

Psychiatric hospitals also provide inpatient care, but, as Diesenhuis (81) notes, there may be more stigma associated with "psychiatric" care than with "medical" care. Alcoholism treatment programs in State mental hospitals, in particular, have in the past been underfunded, accorded low status, staffed by untrained personnel (52) and regarded as ineffective (184,203). Their patients have typically been lower middle class and relatively disabled, both socially and vocationally (241).

The characteristics of the State and private psychiatric hospital population may be changing, however, as reimbursement for alcoholism treatment becomes more widely available. Private mental hospitals provide treatment to a substantial number of patients who abuse alcohol, although alcoholism may not be the primary diagnosis. The Alcoholic Recovery Program at the Menninger Hospital in Kansas uses a multivariant program that addresses the psychological, biological, spiritual, and social aspects of alcoholism (105). The 6- to 8-week treatment program consists of educational lectures, recreational activities under the direction of a leisure therapist, family sessions, group sessions, and nutritional advice, as well as restricted access to alcohol. Although physical evaluations are made, medical treatment is not a major focus. The Menninger program follows AA philosophy but uses a treatment team of professionals and paraprofessionals (including psychiatrists, nurses, mental health technicians, psychologists, social workers, alcoholism counselors, and medical internists).

Moore's analysis of a survey of private psychiatric hospitals found that the mainstay of these programs was individual and group psychotherapy, alcoholism education, AA, and Antabuse" (202). Psychiatric hospitalization is believed to be indicated when a severe psychiatric condition exists, regardless of its relationship to a drinking problem. It is also indicated when an opportunity to interrupt a drinking pattern or motivate a resistant patient is needed (7,201).

Free-Standing Alcoholism Rehabilitation Facilities

Free-standing alcoholism rehabilitation units are often nonprofit organizations, affiliated with but not necessarily located in hospitals, that provide inpatient programs with a nonmedical orientation, although medical and psychiatric support is also available (241,309). In these facilities, a therapeutic milieu is created in which alcoholic patients take some responsibility for program planning, activities, and ongoing maintenance. AA meetings are usually part of the community life, and family sessions are often a part of the program. Treatment includes lectures, nonpsychodynamic group counseling, family sessions, and attendance at ~ meetings (241). Pattison (241) characterizes these

programs, of which the Hazelden Foundation in Minnesota is a prototype, as having a "sense of 'elan,' commitment, and surety of purpose." They typically serve a socially competent, middle-class working clientele in a treatment program that lasts from 3 to 6 weeks.

Another type of free-standing rehabilitation facility has been called an aversion-conditioning hospital (241,295). Such facilities are often proprietary and offer residential treatment from 10 to 14 days. Their programs tend to attract socially competent, upper-class clients, and according to Pattison have a strong medical as opposed to a psychological orientation (241). Treatment consists first of detoxification, followed by emetine (chemical) aversion conditioning (in some cases, the aversive stimulus is an electric shock rather than a drug). *Counseling*, along with various forms of group therapy and education, are also offered as part of the treatment program (295, 317). In most cases, hospitals provide followup and continuing programs. The Raleigh Hills and Schick-Shadel hospital systems are examples of facilities that include aversion conditioning as an important component of their inpatient treatment.

Outpatient Care

In addition to services provided on an inpatient basis, some alcoholism services are provided on an outpatient basis in nonmedically oriented residential facilities and in a variety of other settings. Like inpatient facilities, outpatient facilities vary in the extent of their medical orientation. The more medically oriented outpatient facilities include: 1) private physicians' offices, 2) community mental health centers, 3) some free-standing outpatient clinics, and 4) day care hospitalization programs. The less medically oriented include the remaining free-standing outpatient clinics.

Private Physicians' Offices

Alcoholics who consult private physicians usually do not present a primary complaint of alcoholism. Nonetheless, they reportedly comprise 10 percent of general physician and internist case loads (84), with 70 percent of physicians in private practice seeing at least 10 alcoholics per month (197). Although general physicians do not

typically refer patients to alcoholism treatment programs (perhaps because the patients they see are less dysfunctional), they may provide other services. Such physicians may manage a program of Antabuse® maintenance, treat acute intoxication and mild withdrawal symptoms, use the doctor-patient relationship to engage patients in a treatment program, and involve the spouse and family in helping the patient deal with the problem (239).

Community Mental Health Centers

Community mental health centers are institutions formerly operated under guidelines of the Community Mental Health Center Amendments Act of 1975 (Public Law 94-63) or under State or local legislation modeled after the act. Such centers provide a broad range of community-based mental health services and treat alcoholism as only one of many problems presented by patients.

For insurance reimbursement, Health Care Financing Administration guidelines distinguish between hospital- and nonhospital-based community mental health centers and free-standing outpatient clinics (see below).

Free-Standing Outpatient Clinics

As defined by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), free-standing outpatient clinics are facilities that “one would enter only to receive alcoholism services” (217). These clinics provide a multiplicity of medical, psychological, and social services to a broad spectrum of patients. Treatment services may consist of outpatient individual, group, family, or marriage counseling; drug therapies; and vocational, social, and recreational services.

Medicare coverage for free-standing outpatient clinic patients is provided for services such as drug therapy, psychotherapy, and patient education that are reasonable and necessary and provided incident to a physician’s professional service (130). Marital and family therapies are specifically excluded (131).

Day Care Hospitalization Programs

Day care is treatment provided by a facility in which the patient does not reside. In day care hos-

pitalization programs, patients participate in a treatment program, with or without medication, for usually 5 or more hours per day, 5 or more days per week. Some of these treatment facilities are especially geared to alcoholics, while others serve a more general psychiatric population (216).

Day hospitalization programs per se are not covered by Medicare, although individual services provided in these programs maybe covered under outpatient guidelines. Meals, transportation, and recreational and social activities are not covered.

Intermediate Care

For this study, residential programs that provide primarily rehabilitation services to patients are considered here to be intermediate care facilities (13). Many of the patients of such programs have formerly been treated in hospitals. Such facilities include halfway houses, quarterway houses, and recovery homes. Typically, intermediate care facilities are community-based and peer group-oriented residences. They attempt to provide food, shelter, and supportive services in a nondrinking atmosphere. Residents in these programs are considered recovering alcoholics. They are ambulatory and mentally competent. Typically, they are without spouse or immediate family. The facility seems to provide psychological support and help with problems such as reentry to the work force.

Other Settings

Alcoholism treatment services are provided to varying degrees by correctional facilities, the military, driving while intoxicated programs, business and industry, and the so-called skid-row system of agencies (344). Various Federal and local government agencies support alcoholism treatment programs in correctional and military facilities, but the contribution of these programs to alcoholism treatment, as well as the contribution of employee assistance programs, is relatively small. Most such programs serve only as referral sources to the kinds of programs discussed previously and do not provide direct treatment.

Utilization

Estimating the use of treatment settings is made difficult by the multiple sources of data and by the tendency of patients to seek and receive treatment in multiple settings, even over the course of relatively short time periods. Until recently, when authority for alcoholism treatment programs was given to States with Federal assistance through block grants, each NIAAA-funded treatment center and each project were required to collect and report data on treatment utilization.

In 1980, 460 NIAAA-funded projects reported serving almost 250,000 people (218). The vast majority (83 percent) of patients in NIAAA projects received outpatient treatment, sometimes in conjunction with inpatient treatment. Of the patients who received 24-hour residential care (some of these patients also receive outpatient care), 3 percent were hospital inpatients and 23 percent were in other facilities. The most common inpatient treatment was detoxification, either social (41 percent) or medical (31 percent). The most common outpatient service was individual counseling (50 percent), followed by group counseling (21 percent) and crisis intervention (11 percent). Approximately one-quarter of the patients received followup or aftercare.

Estimates of the number of people receiving treatment for alcoholism in other than NIAAA-funded projects during 1976 and 1977 have been made by Vischi and colleagues (322). According to their data (see table 3), the largest population is served by AA programs. As noted above, however, data such as theirs are problematic, because some patients may receive treatment through multiple sources (this is especially so for those participating in AA programs). Furthermore, to the extent that alcoholic patients are treated under other diagnoses, these figures underestimate the problem of alcoholism. Not known is the number of alcoholics who receive no treatment at all; estimates of that number are as high as 85 percent of the total population of alcoholics (216).

Treatment Providers

Another major issue in the treatment of alcoholism concerns what kind of staff would be most effective, and, more particularly, what degree of

Table 3.—Estimated Treatment Utilization

	Population served
NIAAA-funded projects	197,000a
Other than NIAAA-funded projects:	
Short-stay hospitals	476,000
State and county mental hospitals. . .	111,000
Private mental hospitals.	11,000
Drug abuse facilities.	17,000
Mental health facilities.	286,000
Private physicians' offices	423,000
Community mental health centers . . .	113,000
Outpatient psychiatric clinics	53,000
Halfway houses	36,000
Veterans Administration.	133,000
Department of Defense	52,000
Department of Transportation (DWI). .	28,000
Indian Health Service	27,000
Alcoholics Anonymous.	671,000
Total.	2,634,000

^aThe NIAAA data are for 1980, and the other data are for 1977.

SOURCE: T. R. Vischi, K. R. Jones, E. L. Shank, et al., *The Alcohol, Drug Abuse, and Mental Health Data Book* (Rockville, Md.: Alcohol, Drug Abuse, and Mental Health Administration, 1980); and H. Diesenhaus, "Current Trends in Treatment Programming for Problem Drinkers and Alcoholics," in *Prevention, Intervention, and Treatment: Concerns and Models*, Alcohol and Health Monograph No. 3 (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, Alcohol, Drug Abuse, and Mental Health Administration, 1982).

staff professionalization is required for treatment effectiveness. Prior to the entry of the psychology and psychiatry professionals in the 1970's, roles within the alcohol treatment work force were not distinct. Most treatment took place in nonmedical settings where alcoholism counselors served as primary therapists, administrators, support staff, advocates, and outreach workers. The entrance of professionally trained personnel diminished the role of alcoholism counselors. Physicians, psychiatrists, psychologists, and social workers took on supervisory roles.

According to figures compiled by the National Drug and Alcoholism Treatment Utilization Survey (cited by 54), the three largest general categories of workers in alcoholism treatment programs are administrative and support staff, counselors, and nurses. Further, counselors without professional degrees comprise the largest single category (17 percent) of direct service workers in "alcohol only" programs. Alcoholism counselors (degree unspecified) comprise 37 percent of the project staff in NIAAA-funded treatment centers (100). Although alcoholism counselors dominate the field, their distribution varies greatly by treatment setting. Halfway houses and free-standing clinics employ proportionately more counselors

without professional degrees than do community mental health centers. Hospital programs rely primarily on medical staff (54).

Alcoholism counselors have objected to the over-professionalization of the treatment process, claiming that the “functional difference between them and professionals is unclear because both perform many of the same functions in the treatment process, ” although professionals get paid

more (54). In addition, from the view of counselors who are themselves recovering alcoholics, professionalization actually threatens the potential success of alcoholism services, the key ingredient of which is self-help. There is little empirical evidence, however, to settle the issue of the relative success rate of the various occupational groups in the treatment of alcoholics.

CONCLUSIONS

The treatments used for alcoholism are diverse, including treatments based on medical and psychotherapeutic approaches, as well as treatments based on various other approaches, such as self-help programs based on the AA model. Most treatment programs combine a variety of techniques. Adding to the complex number of treatments is the fact that the settings where treatment is delivered differ from one another on a number of key dimensions, including outpatient versus inpatient treatments, staffing patterns, and the kinds of populations who choose or are chosen for the setting. Moreover, alcohol abuse is present in various population groups, although it may manifest

itself differently and require different forms of treatment.

In comparing reviews and studies of alcohol treatment programs, this complexity of etiology, treatment, settings, and patients must be kept in mind. Many studies focus on a single aspect of treatment or explore a particular hypothesis, making comparisons between studies extremely difficult. General statements must be offered with great caution. The methodological issues underlying evaluation of treatment programs are reviewed in the next chapter,