

**COMPARISON OF PRIMARY TREATMENT
AND RELAPSE PREVENTION TREATMENT
FOR THE CHRONIC RELAPSE-PRONE
PERSON ADDICTED TO ALCOHOL**

by

John A. Prosser

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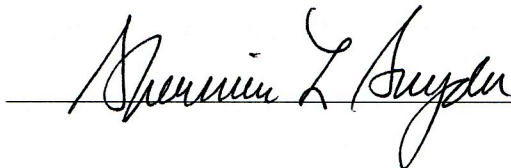
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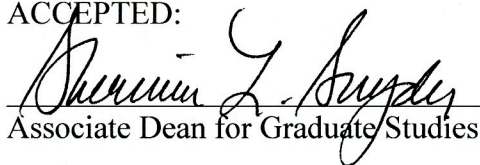
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ACCEPTED:



Associate Dean for Graduate Studies

ABSTRACT

The purpose of this study was to determine if two separate treatment methodologies should be used in a 28-day inpatient treatment facility for the disease of alcoholism and other chemical addictions. This study attempted to answer the following research questions: (1) Would a separate 28-day inpatient treatment program developed specifically for the chronic relapse-prone patient be more effective for their recovery or; (2) Placing the chronic relapse-prone patient in a standard 28-day inpatient primary treatment program that focuses on the basics of addiction and how to build an effective recovery program? The research, screening, selection and tracking of the identified 54 chronic relapse-prone patients that consented to this study, was initiated at a private inpatient treatment facility for the recovery of chemical addictions located in the southwestern United States. This study utilized 54 patients whose profile fit this researcher's criteria of the "chronic relapse-prone alcoholic/addict". The patients were randomly and evenly divided to form Group A and Group B. The 27 Group A patients entered the standard 28-day inpatient primary treatment program and the 27 Group B patients entered the program designed specifically for the chronic relapse-prone alcoholic/addict. The start and end date for the inpatient treatment and the resulting tracking period was the same for both the control groups. The 52-week monitored survey

ended March 1, 1997. The results of the study were based on the number of patients from each control group that remained totally abstinent for the entire 52-week period.

Although not significant, the findings indicate that the patients' rate of sobriety in Group B was higher than the rate of sobriety for Group A. The concept of implementing a separate treatment methodology targeted at the chronic relapse-prone patient appears worthy of further empirical research.

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CHAPTER 1

THE PROBLEM

Introduction

Research shows that relapse to alcohol and other mood altering substances is a common event among alcoholics and addicts. Many chemically dependent patients experience several abstinence/relapse episodes following inpatient treatment. Studies show that the ability to resist relapse increases as the overall period of abstinence from alcohol and other drugs also increases (Gorski & Miller, 1986).

Although studies seem to indicate that relapse is part of the recovery process for many patients, other studies of lifelong recovery/relapse patterns appear to indicate that patients are not without hope (Knott, 1986).

According to Vallant (1973) approximately one-third of the alcoholic patients released from primary inpatient treatment achieved permanent abstinence through their first attempt at recovery. Another one-third have a period of brief relapse episodes that eventually result in long-term abstinence. An additional one-third have chronic relapses that result in eventual death or insanity from their addiction (p.237).

Gorski (1994) maintains that his research evidence shows that chemically dependent people are difficult to treat, but they are not impossible to treat. With proper treatment, as many as two-thirds of chemically dependent patients can and do recover.

This leaves one-third that fall into the category of chronic relapse patients.

The above research indicates that approximately one-third of the recovering population are classified as chronic relapse patients, with little or no hope for long-term abstinence. In an effort to address that need, this study focused on the inpatient treatment portion of recovery. The objective of this study was to determine which treatment program would be the most effective for the chronic relapse-prone patient: (1) A traditional 28-day inpatient primary treatment program that focuses on the basics of addiction, rehabilitation and lifestyle changes or; (2) a 28-day inpatient treatment program that is designed specifically for the chronic relapse patient who understands the basics of addiction and is unable to maintain abstinence in spite of the previous primary treatment and attending AA or NA Meetings on a regular basis.

Development of the Problem

Alcoholism and drug addiction is a condition in which a person develops biopsychosocial dependence on any mood altering substance. An addiction causes a person to use alcohol or drugs for short-term gratification. The addiction creates long-term pain and discomfort. An addiction is accompanied by obsession, compulsion, and loss of control. When not using, the person who suffers an addiction thinks about, plans, and looks forward to using drugs or alcohol again. This is the obsession. Using interferes with living; there is a compulsion or overwhelming urge to use again in spite of long-term painful consequences. The alcoholic or addict uses the drug to relieve the pain created by

using the drug. Thus, continued use of the chemical leads to continued use of the chemical. This is addiction (Alcoholics Anonymous, 1958).

Understanding the nature and characteristics of addictive disease can help the addicted person avoid relapse. Many people fail to recover not for the lack of trying, but because of their limited understanding. The knowledge about the way addiction affects their physical bodies, their behavior, and their thought processes can provide a valuable tool for recovery. By replacing old behavior and beliefs with the new behavior and facts, people with addictive disease can avoid the destructive pattern of chronic relapse (Grant, 1992).

The abnormal reaction to the use of mood altering chemicals occurs because the brain and body of the addicted person respond differently to the use of drugs, than those of non-addicted people. Addicted people tend to have a deficiency in the brain chemicals that make them feel good and relieve the pain (Blum & Trachtenberg, 1987). This deficiency causes a free-floating compulsion that can be medicated by different mood altering drugs.

A free-floating compulsion is the irrational urge, thought or need to do something for no specific reason. The identification of those irrational thoughts or urges can prevent relapse by replacing them with rational thoughts and behaviors. The chronic relapse-prone patient's use of alcohol and drugs is like using an anesthetic. They don't hurt while they are using, but once they stop the pain comes back. This concept appears to escape the chronic relapse-prone patient. This issue needs to be addressed in a relapse prevention

program.

The chronic relapse-prone alcoholic/addict stage of addiction is marked by deterioration of the physical, psychological, behavioral, social, and spiritual. All body systems can be affected at this stage. The brain, the liver, the heart, and the digestive system are often damaged (Milam & Ketchum 1981).

Many chronic relapse-prone alcoholics/addicts mistakenly believe that recovery is abstinence from alcohol and drug use, and that relapse is the use of alcohol and drugs (Crewe, 1980). This leads chemically dependent patients to believe that anytime they abstain from the drug of their choice they are in recovery, and anytime they return to alcohol and drug use they are in relapse. As a result of this misconception, chronic relapse-prone persons come to believe that not using alcohol and drugs is their primary objective in recovery.

Recovery is not abstinence from alcohol and drug use. Abstinence is only a prerequisite for recovery (Maxwell, 1984). This researcher maintains the actual recovery process is lifelong and subject to relapse. Recovery can only be maintained by recognizing the lifelong need for a strong maintenance plan consisting of a daily program of ongoing recovery and personal growth.

The error made by the alcoholic/addict is that not using alcohol and drugs does not guarantee that they will be in control of themselves and automatically recover. Not using drugs and alcohol will break the addiction cycle and stop episodes of loss of control caused by intoxication. But, when the alcoholic/drug based symptoms are interrupted by

abstinence, they are replaced by sobriety based symptoms. These sobriety-based symptoms can be so severe, that they cause the relapse-prone alcoholic/addict to lose control of their judgement and behavior even when sober (Pickens, Hatsukami, and Spicer, 1985).

Need for the Study

Gorski & Miller (1988) state: “In our research we have talked with hundreds of alcoholics who have worked hard at AA and treatment, but still failed to stay sober. It is important that we remember that there are some people who are sicker than others are. These people experience severe and disabling symptoms when they attempt sobriety. They may have coexisting health problems or an illness that leaves them in a state of chronic pain. They may have serious mental or emotional problems that interfere with their sobriety. They need something more than primary treatment over and over again. This only produces the “professional patient,” who learns how to go through the motions of primary treatment but does nothing to bring about long-term sobriety for the relapse-prone patient” (p.17).

Determining the size of the chemically dependent chronic relapse-prone population is necessary for assessing the value or worth of the study. The scope of the alcohol problem is brought into focus with the following survey. The U.S. Department of Health Services, in a 1990 study of alcoholic beverages sold in the United States, summarized the following five-part findings based on the populations listed in Table 1:

Table 1
U.S. Department of Health Services
Alcohol Usage Statistics

18-year-old and over	196,235,460
Under 18-years-old	<u>69,048,323</u>
Total Population	265,283,783

A. Abstinence:

1. Thirty-three percent of the adult population abstain from alcoholic beverages, or consume immeasurable amounts. 2,100,000 are abstinent in AA (The AA Member, 1997).
2. Approximate population: 64,760,000.

B. Adult Population:

1. Sixty-seven percent of the adult population are consumers of alcoholic beverages.
2. Approximate population: 131,480,000.

C. Light Users:

1. Forty-six-point-three percent of the adult population that consumes alcoholic beverages are classified as light users. They consume less than four drinks per month and represents less than ten percent of the total alcoholic beverages sold.
2. Approximate population: 60,875,000.

D. Moderate Users:

1. Forty-point-three percent of the adult population that consume alcoholic beverages are classified as moderate users. They consume less than fourteen drinks per month, and represent approximately twenty-six percent of the total alcoholic beverages sold.
2. Approximate population: 52,987,000.

E. Heavy Users:

1. Thirteen-point-four percent of the adult population that consumes alcoholic beverages are classified as heavy users. They are daily drinkers and are considered alcoholics not in recovery. They represent approximately sixty-four percent of the total alcoholic beverages sold.
 2. Approximate population: 17,618,000.
- (Source: U.S. Department of Health Services, 1990)

In a separate study, it was estimated that 9.6 percent of men, and 3.2 percent of women in the United States will become alcohol dependent at some time in their lives

(Grant, 1992). The 12.8 percent of the adult population that consumes alcohol, equates to approximately 16,900,000 daily drinkers considered alcoholic not in recovery.

When averaging the figure 17,618,000 heavy drinkers (United States Department of Health and Service [U.S.D.H.S.], 1990) with 16,900,000 heavy drinkers (Grant, 1992), it is reasonable to assume that there are over 17,000,000 adults in the United States considered alcoholics not in recovery. Applying the previously mentioned thirty-three percent figure, which represents the chronic relapse-prone alcoholic/addict population in the United States, to the heavy drinker population, 17,000,000, suggests a potential patient need of approximately 5,600,000 chronic relapse-prone clients.

According to a 1991 survey of treatment facilities for alcoholics and their patients, almost 600,000 were treated in 8,928 facilities in the United States (U.S. Department of Health and Services [U.S.D.H.S.], 1993). Of these patients, twelve percent were admitted to inpatient programs, and eighty-eight percent were treated as outpatients.

The 1991 survey of treatment settings for alcoholic/addicts were delivered in two general settings—inpatient and outpatient (U.S.D.H.S., 1993). Inpatient settings mostly consisted of short-term 28-day residential programs. They offer intensive primary care treatment that focuses on the disease model of alcoholism and on the 12-Step or Alcoholics Anonymous (AA) Philosophy and practices. The treatment facilities were used mostly for the early phases of recovery and detoxification with group meetings and individual counseling twice daily along with evening homework assignments. There is very little or no relapse prevention therapy offered.

Outpatient settings provide more long-term maintenance, generally 12-weeks in duration, utilizing a three-hour block of group therapy offered once or twice a week. Individual counseling is limited and varies from two to four one-hour sessions during the 12-week treatment period. The outpatient program offers primary care treatment that focuses on the disease model of alcoholism and on the 12-Step or Alcoholic Anonymous (AA) Philosophy and practices. The primary thrust of outpatient treatment facilities was used mostly for early phases of recovery and non-acute detoxification. There is generally three to six hours of clinical time devoted to relapse prevention therapy, over the 12-week period of outpatient treatment.

However, it is important to note, that neither the inpatient or outpatient settings in this 1991 survey of 8,928 treatment facilities in the United States (U.S.D.H.S., 1993), offered a separate treatment program developed specifically for the chronic relapse-prone alcoholic/addict patient.

Drug use is also common among adults. Many adults have experimented with mood altering drugs other than alcohol, and have developed serious problems with drug addiction. There is a variance in the reported figures of pure drug addict, due to the dual-addiction problem that is, the alcoholic or addict that may be addicted to both drugs. For this reason and for the purpose of this study, the drug-addicted population is included in the heavy user category for alcoholics.

Calculating the national percentage to Arizona heavy user population shows a patient need of approximately 7,000 chronic relapse-prone alcoholics/addicts that could

benefit from a 28-day inpatient or residential treatment program.

As of June 1997, Arizona had no inpatient or residential treatment program targeted exclusively at the chronic relapse-prone population (Board of Behavioral Health, June 1997).

Purpose of the Study

The purpose of the study was to compare the effectiveness of a 28-day inpatient relapse prevention program and a primary 28-day inpatient treatment program for the chronic relapse-prone patient.

Research Question

This study attempted to answer the following research question: would a separate 28-day inpatient treatment program developed specifically for the chronic relapse-prone patient be more effective than placing the chronic relapse-prone patient in a standard 28-day inpatient primary treatment program that focuses on the basics of addiction and how to build an effective recovery program? In this study, effectiveness was defined by how many patients are sober at the end of the 52-week period.

Definition of Terms

AA Meetings	There are basically two types of AA Meetings: open meetings and closed meetings. An open meeting is simply a meeting that is open to any member of the public who chooses to attend. Family members, friends, and interested community members attend to get an idea of what AA fellowship is all about. The closed meetings, on the other hand, are restricted to attendance by admitted alcoholics only. AA states that the only requirement for membership is the desire to stop drinking. Any person who has the desire to stop drinking is welcome at any closed AA Meeting.
Abstinence	The state of being free from the use of alcohol or other mood altering substances. Abstinence is the absence of any mood altering chemical substance in the body.
Addiction	The physical and/or psychological dependence on alcohol or other mood altering drugs or chemicals, that is marked by frequent and heavy use, growing tolerance, inability to abstain without discomfort, continued use despite negative consequences. (Gorski, 1994).
Alcohol and Drug Dependence	A primary psychiatric disorder characterized by a cluster of recognizable symptoms, including alcohol and drug tolerance (i.e. needing more alcohol or drug to become intoxicated); physical withdrawal; loss of control over drinking; and continued use of alcohol and drugs despite social, medical, family or occupational problems (American Psychiatric Association [APA], 1994).
Alcoholic	A person suffering from alcoholism. (Webster's Dictionary, 1991).
Alcoholics Anonymous	A fellowship of men and women who share their experience, strength and hope with each other, that they may solve their common problem and help others to recover from alcoholism. (Also known as AA) (The AA Member, 1997, p.3).

Alcoholism	The abnormal reaction to the use of alcohol or mood altering substances. A chronic biopsychosocial disease characterized by preoccupation with alcohol, loss of control over consumption, and craving for the drug alcohol. The alcoholic drinks heavily, often getting intoxicated when he or she does not intend to. The alcoholic suffers a decreased ability to function socially and vocationally.
Biopsychosocial	The identification and resolution of the biological (physical), psychological (mental and emotional), and social (relationship and situations) problems that have been caused by chemical dependency which will lead to relapse if they are not dealt with. (Wallace 1989, p.325).
Blackouts	A “blackout” is when a person has been drinking and there are hours or days the person cannot remember. (Is AA for You?, 1997, p.3).
Chronic Relapse-prone alcoholic/addict	The reoccurring tendency to frequently fall back into the disease of addiction after apparent recovery.
Compulsion, Obsession, Craving	A strong or overwhelming emotional urge to do something. Compulsion often has a target such as use of alcohol or drugs. Compulsions to use are accompanied by obsession, (the out-of-control thinking about using) and craving, (the physical tissue hunger for the drug). (Three talks to Medical Societies by Bill W., Co-founder of Alcoholics Anonymous, 1958, p.21).
Sobriety	Living a meaningful and comfortable life without the need for alcohol or other mood altering drugs. It is living a lifestyle that promotes continued physical, psychological, social and spiritual health. (Goodwin 1980, p.101).

CHAPTER 2

LITERATURE REVIEW

Introduction

This chapter reviews literature related to alcohol and drug addiction treatment services, their setting and treatment programs relevant to the chronic relapse-prone chemically dependent population.

An overview of the chronic relapse-prone alcoholics/addicts is followed by a description of chronic relapse, overviews of inpatient and outpatient treatment programs, self-help programs and relapse prevention, concluding with a summary of the researcher's findings.

Chronic Relapse

The chronic, relapsing nature of alcohol and drug problems has long been recognized (Litman et al., 1977, 1984). However, it is only in recent years that research attention has begun to focus on factors affecting the process of relapse (Wilson, 1980; Gorski, 1985), and on the development of "relapse prevention" treatment strategies that may be particularly effective in reducing the probability and severity of relapse to alcohol or drugs (Marlatt and Gordon, 1985).

Relapse, by definition, involves a failure to maintain behavior change, rather than

failure to initiate change (Gottheil, 1982). Social learning theory approaches, and specifically Bandura theory of self-efficacy, hold that the most powerful procedures for inducing behavior change may not be the most effective techniques for producing generalization and maintenance of treatment effects (Bandura, 1977, 1978, 1986). That is, a treatment strategy may be highly effective in initiating a change in a patient's drinking behavior but ineffective at maintaining that change over time and avoiding relapses.

According to Royce (1989), attempting to treat the high-risk relapse-prone patient in the same setting as patients in early phases of recovery is counter productive for both patients. Typically, however, treatment for both patients is completed in 12-week outpatient or 28-day inpatient facility whose programs are mostly based on the disease model of alcoholism with very little emphasis targeted at relapse prevention (Gorski & Miller, 1986).

Patients who believe in the disease model of alcoholism or have a strong adherence to the philosophy of Alcoholics Anonymous (AA) are still likely to be suitable candidates for relapse prevention training; it is only necessary that they accept the value of learning to prevent relapse by dealing more effectively with high-risk drinking or drug use situations (Maxwell, 1984).

In terms of Maddux and Desmond (1981) research, they report the patient's outcome expectancy in treatment is total abstinence, the question, they continue, is the treatment setting and program presented. Their research suggests that patients who have clearly defined high risk areas of relapse may benefit more from a specialized relapse

prevention treatment program than do patients whose drinking and drug use is more generalized across situations.

Research indicates that many patients, even when motivated to follow their aftercare treatment plan are unable to maintain abstinence, “this population requires treatment in a specialized relapse prevention program” (Vallant, 1983, p.31).

Relapse to alcohol/drug use is a continuing problem for approximately thirty-four percent of the alcoholic population (Vallant, 1973, p.238).

Recovery from alcohol and other drug dependencies is considered a process rather than an event. An acknowledgment of this process, the American Medical Association (1990), has established criteria for recovery that are based on three years of abstinence from the drug of choice, with no abuse of other mood altering substances. Some researchers recommend that the criteria for recovery be based on five years of abstinence (Pejerot, 1975). Knowing that relapse may frequently and rapidly occur after primary treatment, members of Alcoholics Anonymous refer to themselves as “recovering alcoholics”. In studies combining a total of 499 treated alcoholics, only eighteen percent remained abstinent during the six months following primary inpatient treatment (Gottheil, 1982).

Relapse also may occur frequently and rapidly following primary inpatient treatment for dependency on other drugs. A study conducted by Maddux and Desmond (1981) showed that seventy percent, or 1,157 of 1,653 patients treated for drug dependency over a period of five years, were followed by less than one month of

abstinence. Eighty-seven percent of the balance, or 496 patients, were followed by less than six months of abstinence. A total of 65 patients, or four percent, remained abstinent for a period of three years or more without incident of relapse. Another study conducted by Simpson, Joe, and Bracy (1982), found that fifty-six percent to seventy-seven percent of opioid addicts in different treatment groups resumed opioid use within one year after completion of a thirty to ninety day inpatient primary treatment program.

The chronic relapse patient recognizes that they are dependent on alcohol or other drugs, that they need to maintain abstinence to recover, and that they need to maintain an ongoing recovery program if they are to remain abstinent. Such ongoing efforts usually mean either patient involvement with a 12-Step Program such as AA or NA, or other protracted efforts at psychological or physical rehabilitation. However, despite their efforts, these individuals develop systems of dysfunction that eventually lead them back to alcohol or other drug dependencies (Royce, 1989).

The patients chronically prone to relapse typically get stuck somewhere midstream in recovery. A “stuck point” is a recovery task that is perceived as insurmountable to the individual relapse-prone alcoholic/addict. It can occur during any period of recovery, resulting in failure to complete all the recovery tasks. The eventual consequence is relapse to alcohol or other drugs (Gorski, 1985).

Gorski and Miller (1986) postulate that generally a “stuck point” is caused either by lack of skill or confidence in the relapse-prone alcoholic’s ability to complete a recovery task. Other problems occur when a recovering person encounters a problem—

whether physical, psychological, or social—that interferes with the relapse-prone addict’s ability to use their recovery supports. Eventually, the stress will cause a deterioration in functioning that will result in relapse.

Inpatient/Outpatient Treatment

Alcohol and illicit or prescription drug withdrawal can be a potentially life-threatening medical problem requiring medical care; however, fewer than ten percent of alcohol-dependent patients are at risk for severe withdrawal symptoms. The challenge for withdrawal management is to identify those patients who need pharmacological support and intensive medical care in an inpatient setting (American Medical Association, 1990).

Alcohol-sensitizing medications are used to discourage the relapse-prone patient and patients in early stages of recovery from drinking during their rehabilitation program. When combined with alcohol, these drugs produce unpleasant effects, including facial flushing, nausea, vomiting, and increased blood pressure and heart rate (Institute of Medicine [IOM], 1990). In a comprehensive well-controlled study of the effectiveness of sensitizing drugs, Royce (1989) reported that the medications did not improve abstinence rates, the length of time to relapse, or psychosocial functioning of the chronic relapse patient.

Residential 28-day treatment programs traditionally have been considered the foundation of the early recovery period. These programs are mostly based on the disease model of alcoholism and on the 12-Step or Alcoholics Anonymous (AA) philosophy and

practices. Abstinence from alcohol and other drugs is the primary treatment goal in these programs (U.S.D.H.S., 1993).

According to the U.S.D.H.S. (1991) survey, inpatient or residential settings provide intensive, highly structured treatment, such as group therapy and alcoholism education, for several hours daily. Issues covered in alcoholism education include health consequences, course of the disease, effects on the family, and other relevant topics. In addition to these group activities, patients work individually with a counselor to develop and implement a treatment plan that defines the treatment goals and to receive personalized therapy for special problems or needs.

Walsh et al. (1991) explains the essential element of residential programs appears to be milieu treatment, that is, living with a large number of alcoholic/addict patients who have had similar experiences and problems and who can offer insight and advice on the recovery process. Professional staff is available during treatment's early stages to manage medical problems and to conduct a psychosocial evaluation to guide the treatment process. Grant (1992) reports that towards the end of the inpatient's stay, treatment for the alcoholic often involves the patient's family. Spouse, significant other or other family member may be asked to join the treatment process.

The majority of alcohol and drug patients are treated on an outpatient basis. In 1991, eighty-eight percent of the clients who sought treatment for alcohol problems were treated in outpatient facilities (U.S.D.H.S., 1993). These facilities offered detoxification services (to about 3,200 clients), intensive outpatient care (to about 52,000 patients), and

regular outpatient services (to about 641,400 clients).

Fink (1985) reports that originally intensive outpatient programs were modeled after psychiatric day treatment programs, which emerged in the 1970's as alternatives to inpatient hospitalization. The intensive outpatient programs, according to Fink, vary considerably in the amount of time that patients are treated, ranging from 5 hours per day, 7 days per week, to 3 hours per day, several days per week. Longabaugh (1983) research demonstrated that treatment costs were much lower in intensive outpatient than in inpatient treatment for the alcoholic/addict. However, intensive outpatient primarily treats the dual diagnosed patient and is given way to the more conventional "regular" outpatient care that typically treats patients whose primary diagnosis is alcohol or drug dependence.

The U.S.D.H.S. (1993) survey of regular or primary outpatient alcoholism services is used as primary treatment or as extended after care following completion of an inpatient program. These types of outpatient services usually include weekly group therapy sessions, regular individual counseling sessions with an alcohol/drug counselor, participation in AA meetings, and family therapy, when appropriate. The outpatient program offers primary care treatment, that focuses on the disease model of alcoholism and on the 12-Step or Alcoholics Anonymous (AA) philosophy and practices. The primary thrusts of outpatient treatment facilities were used mostly for early phases of recovery. There is generally three to six hours of clinical time devoted to relapse prevention therapy over the 12-week period or outpatient treatment.

Self-Help Programs and Relapse Prevention

Since the 1940's, community-based self-help programs have grown considerably. They are now widely available and offer an important intervention resource for people with alcohol problems. The best known and most frequently used self-help program is Alcoholics Anonymous (AA) (Cross, 1990). The Alcoholic Anonymous Member (1997) reports that AA groups are self-governed and independent of formal alcoholism treatment facilities. Meetings are conducted by recovering alcoholics without regard to formal counseling, training and experience. The 1997 report further explains that critical elements of the AA program include fellowship meetings with members expected to attend 90 meetings in 90 days when they first enter the program during the early recovery period; a sponsor system, in which newly recovering alcoholics are linked to an established member for assistance and advice; and the 12-Step Philosophy. This philosophy spells out a series of activities or steps that the alcoholic should achieve in the recovery process. A study by Vallant (1983) found AA participation to be the only significant predictor of length of sobriety with no specific treatment or intervention plan for the AA member that chronically relapses.

Gorski (1994) maintains that relapse during the early recovery process can be triggered by a variety of intrapersonal and interpersonal factors. Intrapersonal cues include stress, depression, and levels of alcohol craving and withdrawal. Interpersonal factors include the negative life events and daily inconveniences that an individual experiences in early recovery. Gorski continues relapse prevention strategies have been

developed to teach alcoholics in early recovery, how to cope effectively with potential relapse triggers after treatment.

According to a 1991 survey of 8,928 inpatient and outpatient treatment facilities in the United States, no facilities offered a separate treatment program developed specifically for the chronic relapse-prone alcoholic/addict patient.

Institute of Medicine (1990) review of marital and family therapy in alcoholism treatment facilities has supported the importance of involving family members in the early treatment process. The review found that a single session of alcohol and drug dependence counseling, for family and couples, improved drinking status and marital satisfaction to the same extent as eight sessions of couples therapy.

Miller (1992) explains that educational counseling for family, spouse or significant other is imperative for stable recovery outcome benefits and should be included in all treatment plans for the chronic relapse patient.

Summary

According to the literature reviewed in this chapter, the treatment of alcohol and drug dependence has benefited from a variety of scientific and clinical advancements in the last fifteen years. There is growing evidence for the effectiveness of outpatient settings for the delivery of treatment services for alcoholics and the chemically dependent in all stages of recovery.

Research on the chronic relapse-prone individual continues to highlight the unique

problems, treatment needs and numerical size of this population. However, the literature also indicates that the treatment focus is mostly aimed at the early phases of addiction recovery for the alcohol and chemically dependent patient. There appears to be very few or no treatment programs targeted specifically at the chronic relapse-prone chemically dependent population.

CHAPTER 3

METHODOLOGY

Introduction

The purpose of the study was to compare the effectiveness of a 28-day inpatient relapse prevention program and a primary 28-day inpatient treatment program for the chronic relapse-prone patient. In this study, effectiveness is defined by how many patients are sober at the end of the 52-week period.

Research Design

A descriptive research design was utilized in this project. The central focus of descriptive research is to examine facts about people, their opinions and attitudes. Its purpose is to draw attention to the degree two events are related, and to systematically describe the facts of a given population. Identification of the problem or justification of current conditions is then followed by the project or product evaluation. Comparison of experience between groups with similar problems to assist in future planning and decision-making (Merriam and Simpson, 1995, p. 61). The specific form of descriptive research that was used in this study, was casual/comparative research. According to Merriam and Simpson (1995), the casual/comparative design has many characteristics of the experimental method.

The central focus of this study was to examine facts concerning the method of inpatient treatment for the chronic relapse-prone alcoholic/addict.

Sample and Population

Participants were recruited in March 1996 from a pool of patients attending a 28-day inpatient alcohol and chemical dependency treatment facility located in Arizona. A total of 76 patients volunteered to be included in the study. Each individual was screened by this researcher and 54 of the 76 volunteers met the following six point criteria and were chosen as participants: (1) DSM-IV reporting primary diagnosis of alcohol or substance dependence with no history of psychosis or organic impairment, (2) permanent address and phone number, (3) qualify as a chronic relapse-prone patient as determined by participant's score on three-part screening questionnaire, (4) over the age of 21 years, (5) volunteer, and (6) agreed to 48 weekly follow-up interviews with this researcher in one of the following ways: face-to-face, telephone, postal, or patient designated collateral for the purpose of assessing length of abstinence.

A screening questionnaire designed by this researcher was used to identify the chronic relapse-prone patient. The participants that scored less than the required criteria in any one, or all three parts of the questionnaire, would not be classified as a chronic relapse-prone alcoholic/addict, and therefore, would not qualify for this study.

Instrumentation

The content of the screening questionnaire is based upon the professional experience of the researcher in providing treatment services to chemically dependent individuals from 1980 to the present, plus current research related to the chronic relapse-prone alcoholic/addict.

The screening questionnaire was designed by this researcher to identify the chronic relapse-prone patient. The 12-page questionnaire starts with initial intake form and consists of open-end questions relating to the participant's personal data, identifying information, treatment and family history. The remaining portion of the questionnaire consists of 50 questions divided into three categories: addiction knowledge, addiction stage, and treatment stage ending with scoring rational, summary and two treatment methodologies used in the research project. A copy of the questionnaire is contained in Appendix A.

Patient requirement for entry into Control Group "A" and "B" was based on the following scoring and rational:

Part I - Addiction Knowledge: To qualify as a Chronic Relapse-prone Patient, the participant must answer "yes" to all 6 questions.

Rational: The Chronic Relapse-prone Patient has already learned the basic about addiction and recovery, but has not been able to stay in recovery using the recovery skills they have learned in primary treatment. They need to focus primarily on learning how to prevent relapse, by learning to identify relapse signs and set up a plan to intervene, before they relapse again.

Part II - Addiction Stage: To qualify as a chronic relapse-prone patient, the participant must answer yes to four or more of the questions numbered 1 through

9, and answered “yes” to 9 or more of the questions numbered 10 through 24.

Rational: The Relapse Prevention Program is designed for the relapse patient who have recognized and accepted their addiction, and made a firm decision to stay abstinent. This means the chronic relapse-prone patient must understand the symptoms of their addiction and can apply this information to themselves.

Part III - Treatment Stage: To qualify as a Chronic Relapse-prone Patient, the participant’s total score must range from 64 to 82 on rational. Relapse Prevention Therapy is designed to help the Chronic Relapse-prone Patient understand the relapse process, and set up a recovery program that allows for the identification of the signs that lead to relapse. Chronic Relapse-prone Patients need to review basic recovery skills, and then develop an individualized relapse prevention plan that will allow them to maintain abstinence.

In summary, a participant that scored less than the required criteria in all and any one, or all three parts of the questionnaire, would not be classified as a Chronic Relapse-prone Patient, and therefore would not qualify for this study.

Procedure

Prior to participation in the study, each patient who met the inclusion criteria was fully advised of the purpose of the study. While each participant volunteered for the 52-week research project, each patient was responsible for the 28-day inpatient treatment fees. This study utilized 54 patients whose profile fit this researcher’s criteria of the “chronic relapse-prone alcoholic/addict”. The patients were randomly and evenly divided to form Group A and Group B. The 27 Group A patients entered the standard 28-day inpatient primary treatment program and the 27 Group B patients entered the program designed specifically for the chronic relapse-prone alcoholic/addict.

The patients were randomly and evenly divided to form the primary treatment

group (A) and the relapse prevention treatment group (B). The 27 Group A patients entered the standard 28-day inpatient primary treatment program and the 27 Group B patients entered the program designed specifically for the chronic relapse-prone alcoholic/addict. The start and end date for the inpatient treatment and the resulting tracking period was the same for both control groups. The 52-week monitored survey ended March 1, 1997.

Data was collected and assessed at weekly intervals over a 52-week period from March 3, 1996 and ended March 1, 1997. The four-week inpatient treatment began March 3, 1996 and ended March 30, 1996. Outpatient weekly follow-up began March 31, 1996 and ended March 1, 1997.

The weekly interviews were conducted by this researcher the day following completion of each week. Alcohol consumption or drug use behavior was assessed in terms of the previous 7 consecutive days of total abstinence, Saturday to Sunday. If the week involved no chemical use it was classified as a week of abstinence and added to the patients total weeks completed. If the patient relapsed during the previous 7 days, their abstinence weeks were totaled and added to the total patient list that completed or relapsed during that week.

The following treatment methodologies were used for the primary and relapse treatment programs:

Primary Treatment: 28-day Inpatient Program.

1. Patient Profile for Entry into Primary Treatment Program.

- A. Other people are telling them that they have a problem, and that they need treatment. They are willing and able to stop using alcohol or drugs, but do not understand what addiction is and do not know what they need to do to build a recovery program that will keep them in recovery.

2. Primary Treatment Program Defined.

- A. Primary treatment methods assist individuals to unravel the many issues that contribute to their addiction. In doing so, they will examine many different issues paramount for any recovering alcoholic or addict.

Among these are:

1. Dynamics of denial
2. Biopsychosocial aspects of addiction
3. Understanding the disease of addiction
4. Family of origin issues
5. Anger/Resentment issues and management
6. Interest/Interpersonal relationship issues
7. Communication skills training
8. Guilt and shame issues
9. Other emotion-based, trust, and honesty issues
10. Other themes are self-awareness, assertiveness training, addictive personality factors, and Post-traumatic Stress Disorder counseling. Those are all coupled with family and couple counseling.

3. Primary Treatment Broken down by Item and Number of Hours.

<u>Primary Treatment</u>	<u>Hours</u>
Large/Small Groups	122
One-on-one Counseling	6
Reading/Writing	68
Therapeutic Duties	8
Recreation	<u>12</u>
*Total Hours	216

*That equates to 54 hours per week, based on seven-day week.

Relapse Treatment: 28-day Inpatient Program.

1. Patient profile for entry into the Relapse Prevention Program.
 - A. Chronic Relapse-prone Patients stopped using alcohol and drugs before, knows what addiction is, and tried to use the recovery tools that were taught in primary treatment. But when trying to stay sober, they experience problems that cause them to relapse.
2. Relapse Prevention Program Defined.
 - A. The Relapse Prevention Program focuses on teaching the patient how to identify and manage the common relapse signs that lead from stable recovery to relapse, and how to individualize a recovery program that can identify and manage relapse signs as they experience them. They also receive family and couples counseling.
3. Relapse Treatment Broken Down by Item and Number of Hours.

<u>Relapse Treatment</u>	<u>Hours</u>
Small Groups	148
One-on-one Counseling	8
Homework	56
Therapeutic Duties	0
Recreation	<u>8</u>
*Total Hours	220

*That equates to 55 hours per week, based on seven-day week.

CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Participant Demographics

The study utilized 54 patients whose profile fit this researcher's criteria of the "chronic relapse-prone alcoholic/addict." The 54 participants included 40 males and 14 females with an age range from 26 to 59. Education level ranged from less than 11 years to post graduate level. The mean age of the participants was 38.8. Table 2 presents the demographics for all participants.

Table 2
Total Sample Demographics

Ethnicity

	<u>Frequency</u>	<u>Percent</u>
Caucasian	29	54
African American.....	11	20
Hispanic	9	17
Native American	5	9
	<u>54</u>	<u>100</u>

Addiction Status

	<u>Frequency</u>	<u>Percent</u>
Drugs only	24	44
Alcohol and drugs	15	28
Alcohol only.....	15	28
	<u>54</u>	<u>100</u>

Educational Level

	<u>Frequency</u>	<u>Percent</u>
DO.....	1	2
Ph.D.	1	2
Master's Degree	7	13
Bachelor's Degree.....	11	20
High School Diploma	23	43
11 year or less	11	20
	<u>54</u>	<u>100</u>

The 27 participants in Group A included 18 males and 9 females with an age range from 29 to 58. Education level ranged from less than 11 years to post-graduate level. The mean age of Group A participants was 38.9. Table 3 presents the demographics for Group A.

Table 3
Group A Demographics

Ethnicity

	<u>Frequency</u>	<u>Percent</u>
Caucasian	15	56
African American.....	5	18
Hispanic	4	15
Native American	3	11
	<u>27</u>	<u>100</u>

Addiction Status

	<u>Frequency</u>	<u>Percent</u>
Drugs only.....	13	48
Alcohol and drugs	8	30
Alcohol only.....	6	28
	<u>27</u>	<u>100</u>

Educational Level

	Frequency	Percent
DO.....	1	4
Ph.D.	1	4
Master's Degree	2	7
Bachelor's Degree.....	5	19
High School Diploma	12	44
11 year or less	6	22
	27	100

The 27 participants in Group B included 22 males and 5 females with an age range from 26 to 59. Education level ranged from less than 11 years to post-graduate level. The mean age of Group B participants was 38.6. Table 4 presents the demographics for Group B.

Table 4
Group B Demographics

Ethnicity

	Frequency	Percent
Caucasian	14	52
African American.....	6	22
Hispanic	5	19
Native American	2	7
	27	100

Addiction

	Frequency	Percent
Drugs only.....	11	41
Alcohol and drugs.....	7	26
Alcohol only.....	9	33
	27	100

Educational Level

	<u>Frequency</u>	<u>Percent</u>
DO.....	-	-
Ph.D.	-	-
Master's Degree	5	19
Bachelor's Degree.....	6	22
High School Diploma	11	40
11 year or less	<u>5</u>	<u>19</u>
	27	100

Findings

The results of the study were based on the number of patients from each control group that remained totally abstinent for the entire 52-week period. These findings are illustrated in Table 5.

Table 5
Abstinence Data Distribution

1) Group A – Primary Treatment Program

<u>Gender</u>	<u>Total Patients</u>	<u>Abstinent 52 Weeks</u>	<u>Percent Abstinent</u>	<u>Number Relapsed</u>	<u>Percent Relapsed</u>
Male	18	1	5.6%	17	94.4%
Female	<u>9</u>	<u>2</u>	<u>22.2%</u>	<u>7</u>	<u>77.8%</u>
Total	27	3	11.0%	24	89.0%

2) Group B – Relapse Prevention Program

<u>Gender</u>	<u>Total Patients</u>	<u>Abstinent 52 Weeks</u>	<u>Percent Abstinent</u>	<u>Number Relapsed</u>	<u>Percent Relapsed</u>
Male	22	7	32.0%	15	68.0%
Female	<u>5</u>	<u>1</u>	<u>20.0%</u>	<u>4</u>	<u>80.0%</u>
Total	27	8	30.0%	29	70.0%

3) Group A/ Group B Comparison

<u>Gender</u>	<u>Group A</u>		<u>Group B</u>		<u>Variance +/-</u>
	<u>Abstinent 52 Weeks</u>	<u>Percent Abstinent</u>	<u>Abstinent 52 Weeks</u>	<u>Percent Abstinent</u>	
Male	1	4%	7	26%	+ 6
Female	<u>2</u>	<u>7%</u>	<u>1</u>	<u>4%</u>	<u>- 1</u>
Total	3	11%	8	30%	+ 5 (+19%)

Although not significant ($z = -1.69$, $p = .09$), the findings indicate that the patient's rate of sobriety in Group B was higher with thirty percent compared to the eleven percent for Group A.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to compare the effectiveness of a 28-day inpatient relapse prevention program and a primary 28-day inpatient treatment program for the chronic relapse-prone patient.

In this study, the researcher designed and administered a separate 28-day inpatient relapse prevention treatment program for the 27 identified chronic relapse-prone alcoholic/addicts that volunteered as subject for this project. Data on abstinence form this group was compared to data from a group of patients who participated in a 28-day inpatient primary treatment program. Although not significant, the findings showed a higher rate of abstinence for the relapse-prevention treatment group.

Conclusions

The findings support the use of a 28-day inpatient relapse prevention treatment program specifically targeted at the chronic relapse-prone population. The treatment strategies of this program are primarily based on identifying and managing the client's personal high-risk relapse warning signs for alcohol or drug-related situations. The purpose of relapse prevention treatment is to effect a rise in confidence and awareness

across all areas of perceived drinking risk. The evidence from this study has provided a promising direction in the treatment of severely dependent alcoholic/addicts.

The abstinence rate of thirty percent for the relapse prevention treatment group compared favorably with other investigations. For example, Miller (1992) reported that eighteen percent of subjects had abstained for a six-month period, then fell to two percent at twelve-month period. A similar figure of nineteen percent was reported by Gottheil (1982) at six-month follow up, the twelve-month reported outcome was less than five percent.

The impact of the relapse prevention treatment program is particularly relevant given the generally poor treatment outcomes reported with subjects, such as those in this study, who have high levels of alcohol and drug consumption, dependence and related problems.

Due to financial problems associated with late stage addictions, many participants from both treatment groups returned to environments where unemployment levels were high and remained unemployed. Many lived in poor quality housing, had poor significant relationship, where limited recreational opportunities ran parallel with readily available alcohol and where heavy drinking and drug use was the norm within substantial segments of the population. It is hypothesized that the poor quality environment to which the subjects returned eroded treatment effects.

High relapse rates remain the most common outcome in the treatment of problem drug use. The relapse prevention treatment program designed specifically for the

identified chronic relapse-prone patient in the current study did have impact, at least in the short term. Those 27 clients exposed to this newly developed treatment program compared favorable to other treatment studies with problem drinkers, including those patients in Group A or this study.

The 52-week comparative study clearly favors a separate program for treating the chronic relapse-prone patient and is worthy of further research.

Evidence from this study shows that 24 of the 27 chronic relapse-prone patients in Group B, primary treatment program, relapsed during the fifty-two week test period. These patients all reported in general, that they became so dysfunctional in recovery that return to active use seemed like their only option. They were in so much mental, physical and emotional pain that they came to believe that they only had three choices left: (1) drug and alcohol use to medicate or kill the pain; (2) suicide, or (3) insanity. Given these options the alcohol and drug use seemed like the best choice.

These 27 chronic relapse-prone patients in Group A had not learned how to interrupt old behavior patterns and do something different. They had not learned that relapse is a process that can be changed. They had not learned about sobriety-based symptoms and how to manage them. They had not learned how to identify their own personal relapse signs and to recognize when they were moving away from recovery and towards a relapse episode.

Recovery is not an event but a process. Recovery is improved through accurate and helpful information. As addicted persons increase their knowledge about addictive

disease and the addiction cycle, they increase their chances for quality recovery and reduce the risk of relapse. The chronic relapse-prone population needs to learn what their personal relapse signs are and modify their behavior in appropriate ways.

By identifying their personal relapse signs and practicing positive outlets and replace addictive thinking with healthy thinking, the relapse patient moves away from illness towards help. Through a planned recovery program, people with addictive disease learn relapse prevention skills. They take concrete steps away from their old behaviors toward balanced living. As a result, an accurate understanding of the addictive disease process, is one of the most powerful tools for relapse prevention, and needs to be addressed in a specialized program for inpatient treatment of the chronic relapse-prone patient.

Recommendations

Given the short-term impact of the treatment program, a number of future investigations are indicated. The first is to assess the impact of individual components of the aftercare treatment plan. The second is to investigate the potential of environmental manipulations in developing durable treatment effects. Third, this study has focused on the effects of the inpatient treatment program alone. Other studies will need the role of aftercare one-on-one, couples and family counseling during the first year of sobriety.

Aftercare counseling following discharge from inpatient treatment utilizing performance based strategies that enhance skills and confidence expectation may hold promise in improving treatment outcome. Observation over the 52-week period suggest

that attention should extend beyond the clinic to the broad environment in which hazardous and harmful alcohol and drug use develops and is maintained.

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APPENDIX A

SCREENING QUESTIONNAIRE

Initial Intake Form (Clinical)

Name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Telephone: _____ Work: _____
 Therapist Name: _____ Date: _____

Identifying Information

Age: _____ Date of Birth: ____ / ____ / ____ Place: _____
 Sex: Male _____ Female _____ Height: _____ ft., _____ in. Weight _____ lbs.
 Race: white _____ black _____ Asian _____ Hispanic _____ other _____
 If Married, Spouse's Name: _____ Age: _____
 Occupation: _____ Employer: _____
 Occupation (Spouse): _____ Employer: _____
 Referral Source: Self: _____ Other: _____
 Name of Referral Source: _____
 Address of Referral Source: _____

Treatment History (General)

Are you currently taking any medication? _____ Yes _____ No
 If yes, name(s) of the medication(s): _____
 Dosage of medication(s): _____
 Provider of medication(s): _____
 Have you received previous psychiatric/psychological treatment? _____ Yes _____ No
 If yes, name of provider: _____

Date(s) of service: _____ Location: _____

Reason(s) for termination of treatment: _____

Presenting problem or condition (current): _____

Presenting factors (contributors): _____

Symptoms (describe): _____

Acute: _____ Chronic: _____

Family History (General)

Father's Name: _____ Age: _____ Living _____ Deceased _____

Occupation: _____ full-time _____ part-time _____

Mother's Name: _____ Age: _____ Living _____ Deceased _____

Occupation: _____ full-time _____ part-time _____

Screening Form

Three part screening process used to identify the chronic relapse-prone patient for entry into group "A" or "B".

Part One: Addiction Knowledge

Circle your answer to the following questions:

1. Do you understand what alcoholism/addiction is?
Yes No
2. Do you believe that you are addicted to alcohol?
Yes No
3. Do you believe that you need to totally abstain from alcohol or drugs in order to recover?
Yes No
4. Have you been able to totally abstain from using alcohol/drugs for a period of 12 weeks?
Yes No
5. Did you try to use AA/NA/CA to help you abstain?
Yes No
6. Did your cravings and urges diminish to the point that you felt comfortable not using alcohol or drugs?
Yes No

Part Two: Addiction Stage

Read each of the questions and circle the appropriate answer.

1. Do you use alcohol more than twice a week?

Yes No

2. On the days when you use alcohol, do you usually have three drinks or more?

Yes No

3. Do you get intoxicated on alcohol or drugs more than four times a year?

Yes No

4. Have you ever felt that you should cut down on your drinking?

Yes No

5. Have other people ever criticized your drinking, or been annoyed by it?

Yes No

6. Have you ever felt guilty about your drinking?

Yes No

7. Have you ever done things while you were using alcohol or drugs that made you feel guilty or ashamed?

Yes No

8. Have you ever used alcohol or drugs upon awakening to get started, or to stop shaking?

Yes No

9. Have you ever thought that you might have a problem with your drinking?

Yes No

10. Has drinking caused trouble at home?

Yes No

11. Have you ever used alcohol or drugs in larger quantities than you intended to?

Yes No

12. Have you ever used alcohol or drugs for longer periods of time than you intended?

Yes No

13. Have you ever had a desire to cut down or control your use of alcohol or drugs?

Yes No

14. Have you ever tried to cut down or control your drug or alcohol use?

Yes No

15. Have you ever failed to meet a major life responsibility because you were intoxicated, hungover, or in withdrawal from alcohol or drugs?

Yes No

16. Have you ever had any physical, mental, or social problems that were caused by your alcohol or drug use?

Yes No

17. Have you continued to use alcohol or drugs, even though you knew they were causing physical, mental, or social problems?

Yes No

18. Did your tolerance increase after you started to use alcohol or drugs?

Yes No

19. Do you ever get physically uncomfortable or sick the day after using alcohol?

Yes No

20. Have you ever missed days of work or school due to your alcohol or drug use?

Yes No

21. Do you have blackouts? (A blackout is when you have been drinking, and there are hours, or days, which you cannot remember.)

Yes No

22. Have you ever felt that your quality of life would be better if you did not use alcohol or drugs?

Yes No

23. Have you ever decided to stop drinking for a week or so, and found yourself drinking in a couple of days?

Yes No

24. Do you tell yourself you can stop drinking anytime you want to, even though you keep getting drunk when you don't mean to?

Yes No

Part Three: Treatment Stage

Read each of the questions and circle the most appropriate answer. A number appears after each answer on the questionnaire. For each answer selected, write the number assigned to it in the space provided in front of the question.

- ___ 1. How many times have you made serious attempts to stay sober?

One (1)	Three (3)	Five (5)
Two (2)	Four (4)	More than 5 (6)
- ___ 2. What is the longest period of time you have been able to stay sober?

Twelve weeks or more (4)	Four weeks (2)
Six weeks (3)	Fewer than four weeks (1)
- ___ 3. How many times have you been admitted for detoxification from alcohol?

None (0)	Three (3)	More than 5 (6)
One (1)	Four (4)	
Two (2)	Five (5)	
- ___ 4. How many times have you been admitted to an inpatient treatment program for alcohol or drug addiction?

None (0)	Three (3)	More than 5 (6)
One (1)	Four (4)	
Two (2)	Five (5)	
- ___ 5. How many times have you been admitted to an outpatient treatment program for alcohol or drug dependence?

None (0)	Three (3)	More than 5 (6)
One (1)	Four (4)	
Two (2)	Five (5)	
- ___ 6. What is the longest time period that you have been continuously involved in an outpatient program for alcohol or drug dependence?

Sixteen weeks or more (4)	One to four weeks (1)
Nine to twelve weeks (3)	I never attended an outpatient program (0)
Five to eight weeks (2)	
- ___ 7. When you were involved in an outpatient program, how many group therapy sessions did you attend in an average month?

Ten or more a month (4)	Fewer than two a month (1)
Six to nine a month (3)	I never attended an outpatient program (0)
Two to five a month (2)	

- ___ 8. When you were involved in an outpatient program, how many individual therapy sessions did you attend in an average month?
- | | |
|-------------------------|--|
| Ten or more a month (4) | Fewer than two a month (1) |
| Six to nine a month (3) | I never attended an outpatient program (0) |
| Two to five a month (2) | |
- ___ 9. When you were actively involved in recovery, how many group AA/NA/CA meetings did you attend during an average week?
- | | |
|--------------------------|--|
| Three or more a week (4) | One a week (2) |
| Two a week (3) | I never attended a self-help group meeting (0) |
| One a week (2) | |
- ___ 10. When you are actively involved in your recovery, how often did you do a 10-Step inventory outside of your group meetings, or therapy?
- | | |
|--------------------------------|-----------------------------|
| Seven or more times a week (3) | One or two times a week (1) |
| Three to six times a week (2) | Less than once a week (0) |
- ___ 11. How often did you read recovery-orientated literature i.e., AA Big Book, or AA Twelve by Twelve, or listened to recovery-orientated tapes or speakers?
- | | |
|--------------------------------|-----------------------------|
| Seven or more times a week (3) | One or two times a week (1) |
| Three to six times a week (2) | Less than once a week (0) |
- ___ 12. Did you have a Sponsor?
- | | |
|---------|--------|
| Yes (4) | No (0) |
|---------|--------|
- ___ 13. Did you have a home group?
- | | |
|---------|--------|
| Yes (4) | No (0) |
|---------|--------|
- ___ 14. How often did you talk to your AA/NA/CA Sponsor outside of the meetings?
- | | |
|--------------------------------|----------------------------|
| Seven or more times a week (4) | Less than once a week (1) |
| Three to six times a week (3) | Did not have a Sponsor (0) |
| One to two times a week (2) | |
- ___ 15. Choose the statement that most accurately describes your experience with the fourth and fifth steps of AA:
- | |
|---|
| I completed a written fourth and talked about it with my Sponsor. (3) |
| I completed a written fourth step but did not talk about it with my Sponsor. (2) |
| I did a fourth step in my mind, but never wrote it down or talked to anyone about it. (1) |
| I never did a fourth or fifth step. (0) |

___ 16. How long after you stopped going to AA/NA/CA meetings, did you return to alcohol or drug use?

I was actively attending meetings when I started using again. (5)

Less than a week after I stopped. (4)

Between one and three weeks after I stopped. (3)

Between four and seven weeks after I stopped. (2)

Eight or more weeks after I stopped. (1)

___ 17. Choose the statement that best describes your understanding of the basic information about alcohol and drug dependency.

I can explain it clearly without help. (3)

I can explain it clearly to others with help. (2)

I understand it, but I can't explain it. (1)

I don't understand it. (0)

___ 18. Choose the statement that best describes how strongly you believe you're suffering from drug and alcohol dependence.

Totally convinced. (3)

Harshly convinced. (1)

Mostly convinced. (2)

Not convinced. (0)

___ 19. In the past have you experienced periods of pain or trouble functioning when you were sober?

Yes, and it caused me to use in spite of my honest desire to stop. (3)

Yes, and it caused me to feel a compulsion to use in spite of my honest desire not to drink or use. (2)

Yes, and it cause me to think about using, but not to feel a compulsion to use. I didn't use. (1)

I never experienced periods of pain or difficulty functioning. (0)

___ 20. When you have been sober, did you experience any progressive problems that caused you to think about using for relief?

Yes, and it caused me to use in spite of my honest desire not to. (3)

Yes, and it caused me to feel a compulsion to use, in spite of my honest desire not to, but I didn't use. (2)

Yes, and it caused me to think about using, but not to feel a compulsion to use. I didn't use. (1)

I never experienced progressive problems. (0)

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