THE ALCOHOLIC CLIENT AND THE REHABILITATION COUNSELOR

STEPHEN M. MARSON

ABSTRACT

This paper reviews some of the issues that face alcoholics: cerebral dysfunction, family, drugs, the environment, abstinence, and employment. The literature is filled with information on problems and treatment of alcoholic individuals, however, most of this literature does not address itself to rehabilitation personnel. The intent of this paper is to present data to rehabilitation workers in a meaningful way. Counseling combined with skillful knowledge of alcoholism and community resources should enhance the alcoholic's lifestyle and increase independence and gainful employment.

In contrast to the past in which rehabilitation workers dealt predominantly with physical disabilities, the problem of alcoholism and its treatment are currently demanding more attention. Statistically, alcoholic clients are being referred for vocational rehabilitation services with greater frequency based on data provided by The Office of Human Development (Washington, D.C.). However, the successful closure rate for alcoholic clients is relatively low. This data does not necessarily indicate that the clientele were unassisted by the Rehabilitation Services Administration. There are many variables to consider, such as high unemployment rate. For example, in 1974, the unemployment rate was 9.9 percent. The following year it jumped to 13.9 percent (U.S. Bureau of Census). Other variables include inflation, changes in closure requirements, and the stigma of alcoholism. Tringo (1970) shows us that alcoholic clients are of the least preferred groups of the rehabilitation worker case load. This same stigma often inhibits employers from hiring alcoholic individuals.

Recent developments in the area of alcoholism research can provide insight into better vocational services for alcoholics. The literature (Armor et al. 1976; Goldfried, 1969; Marson, 1976, Mindlin, 1959) consistently confirms the validity of certain prognostic indicators. This paper will describe how rehabilitation workers can utilize knowledge of some of these variables for the best interest of their clients. Six related variables will be discussed: cerebral dysfunctions, the family of the alcoholic client, drugs, the environment, abstinence, and employment. Although drugs and abstinence are not key variables, they will be discussed within this paper because of abuses by some clients.

Cerebral Dysfunctions

While facing initial counseling issues, an assessment of cerebral functioning is useful. Such an assessment needs to include a comprehensive evaluation of the client's mental deterioration in order to determine vocational potential. "Clinical neuropsychologists provide the behavioral measurement appraisal needed for some of the problems of diagnosis, progress evaluation, or planning that neurological patients present" (Lezak, 1976, p. 11). Obtaining the services of a neuropsychologist is helpful for defining realistic vocational goals for the alcoholic client.

After being detoxified, the alcoholic client usually performed poorly on tests of intellectual functioning (Page & Linden, 1974; Marson, 1976). However, significant improvement was noted following one week of abstinence (Page & Linden, 1974). Some of the brain damage introduced by alcohol is acute and reversible, while sometimes, the damage is chronic and irreversible. Research has suggested that "both peripheral and central nervous system recovery in alcoholics is possible with prolonged abstinence from alcohol" (Long & McLachlan, 1974, p. 1228). However, Parker et al. (1974, p. 824) suggested that "chronic impairment of abstract ability due to alcohol" may occur. Sometimes, the client who sustains extensive brain damage must follow a vocational goal less demanding than his former occupation.

Older alcoholics usually took longer to stabilize mental functioning as compared to younger alcoholics. They also tended to exhibit significantly more brain damage than younger groups (Cermak & Ryback, 1976). However, both groups did equally well in treatment (Marson, 1976).

Empirical evidence indicated that the general intelligence of alcoholics is on the same level of the general population, supporting the assumption that alcoholism does not usually lead to a general intellectual impairment (Bergman & Agen, 1974). Marson (1976) exhibited the Shipley Institute of Living Scale I.Q. estimates of 158 alcoholics. The mean for this group was 102.5 with a standard deviation of 11. These scores approximated population norms.

There are three key points to remember in terms of brain damage and the alcoholic client. First, not all alcoholics will sustain brain damage. Marshman
reported that 24% of her alcoholic sample "did not show signs of cerebral dysfunction on psychometric testing." This group has the highest employment potential and, as a result, untested conclusions about cerebral dysfunctions should never be embraced as a tool for rehabilitation. The functioning of abstract thinking varies greatly in alcoholic samples. As in all types of disabilities, the alcoholic client should be perceived as an individual. While some clients exhibit severe damage, others may show either partial or no damage.

Second, monitoring cerebral dysfunction is needed for clients who do exhibit damage especially older clients. Damage was significantly reversible in most cases if the client maintained abstinence (Long & McLachlan, 1974; Page & Linden, 1974). A client's ability to think abstractly may increase in the matter of a week. If this phenomenon occurs, some authors have suggested postponement of an intensive rehabilitation program until the client has stabilized (Page & Linden, 1974; Marson, 1976).

Third, clients in general and particularly alcoholic clients, ask questions about the extent of brain damage. Alcoholics, being people with fears, aspirations, hopes, and dreams, usually find interpretations of cerebral testing meaningless. In times such as these, the client needs the essential qualities of the counselor (acceptance, understanding, sincerity) in expressing his feelings about himself, his disease, and his future—particularly his future in a world filled with alcohol. Clients who have sustained substantial cerebral damage are less likely to understand facts about their organic problems.

The Family of the Alcoholic Client

In recent years, literature in the field of rehabilitation has placed emphasis on the client's family (Shellhase & Shellhase, 1972; Thompson & Clifford, 1972; Christopherson, 1962; Spencer & Mitchell, 1971). When a client is disabled, he needs the emotional support of a significant other (usually family) to accept his disability and to facilitate his adjustment to the rehabilitation plan. Many experts believe that a family's awareness of the client's crisis will help the client adjust more adequately to his new lifestyle. In the area of alcoholic rehabilitation, Berenson (1976, p. 184) has identified family therapy as "the most notable current advance in the area of psychotherapy for alcoholism."

In Janzen's (1977) review of the literature on family treatment of alcoholism, several key points are presented:

1. There is a positive correlation between stable marriage and success in treatment (Auger et al., 1973; Smith, 1976).

2. Involvement of spouse is useful when the client lacks motivation (Berman, 1968).

3. Conjoint therapy produces better results than individual therapy (Burton & Kaplan, 1968).

4. In a six-month follow up, clients without family treatment had a significantly greater relapse rate compared to clients with family treatment (Cadogen, 1973).

Later, Janzen (1977, p. 122) points out that, "Improved social stability of the alcoholic and the family, increased employment and financial stability, fewer scrapes with law enforcement agencies, improved marital communications, and better care for children have been reported" as consequences of family treatment.

In some cases, the process of alcoholism severely disrupts normal family patterns. Some families will exhibit communication breakdown and apathy toward the successful recovery of the alcoholic member. At times, family members sabotage the patient's treatment. "Hospitalized patients often got worse after visits from family members, as though family interaction had a direct bearing on symptoms; other family members got worse as the patient got better, as though the sickness in one of its members were essential to the family's way of operating" (Meeks & Kelly, 1970, p. 399).

Whether the family is supportive or destructive to the rehabilitation plan, the literature encourages the rehabilitation counselor to be cognizant of the family attitude. Cohen and Krause (1971, p. 15) write "all professional helping disciplines must make a united effort to solve the problem of alcoholism and to serve not only the victims of this disabling disease but also their families."

Drugs and Alcohol

Drug use of any kind is particularly dangerous for the alcoholic client. One of the favorite drugs of the alcoholic is diazepam (Valium), which has proven to be quite dangerous when taken in combination with alcohol. "Deaths have resulted from this combination (valium and alcohol)—usually attributed to depressed cardiac functioning, vasomotor collapse, and respiratory failure" (Coleman & Evans, 1976, p. 18). Mood-changing chemicals have been found sufficiently dangerous to warrant a caution to the family physician of the alcoholic client. For example, a staff of seven physicians of the alcoholic unit at St. Anthony Hospital in Columbus, Ohio sends a letter to the discharged patient's doctor. Included in this letter are the following points:

1. Complete and permanent avoidance of alcohol and any of its forms.

2. Avoid completely the use of all tranquilizers such as librium, valium, or meprobamate and bar-
biturates, hypnotic medications, or stimulating
drugs.

3. Mood-affecting drugs will tend to reactivate
the client's drug dependency and to precipitate
a new round of acute alcoholism.

The Physician's Desk Reference (1976, pp. 1307-
1308) points out that “drug addicts or alcoholics
should be under careful surveillance when receiving
diazepam or psychotrophic agents because of the
predisposition of such patients to habituation and
dependence.” In a recent national survey, Jones &
Helrich (1972) discovered that over 90% of
physicians questioned treat their alcoholic patients
through the use of medications. In acute conditions
of alcoholism, 46% of the physicians prescribed
valium, while in chronic conditions, 47.5% of the
physicians used this drug. When clients are using
such mood-changing chemicals, the rehabilitation
counselor is well-advised to monitor drug abuse.
When abuse of drugs is noted, it is appropriate to
confront the client. Clients are usually receptive to
such confrontation if the counselor has rapport with
them. In most cases, this problem can be solved by
having a member of the client's family give him
his drugs as the prescription orders. Most attending
physicians want to have knowledge of drug abuse
problems of their patients.

The Environment

Ludwig (1972) pointed out that psychological
stress was the primary reason for alcoholic relapse.
In light of this factor, the rehabilitation counselor
usually will receive the alcoholic referral after ex-
tensive treatment. At this point, the client returns
to his old environment with the same psychological
and sociological stresses. Such stresses reach their
peak immediately following the individual's discharge
from the treatment facility. The client should be
encouraged to utilize all community resources that
would facilitate promotion of “quality sobriety.”

The environment plays an important role in
maintaining sobriety. In general, clients should be
encouraged to assimilate into an environment con-
ducive to abstinence particularly toward the begin-
ing of their remission. Oftentimes, clients will have
strong ties with “drinking buddies.” Demanding the
client give up old friends poses relationships and
ethical problems. One can suggest, however, that
clients make new friends. To avoid going to jail,
judges, probation and parole officers often insist that
clients attend A.A. meetings in order to establish new
peer relations. Armor et al. (1976, p. 98) pointed
out that “A.A. achieves a substantial positive effect;
if other treatment is not available.”

Other community resources that encourage the
alcoholic to abstain should be utilized. Pittman &
Tate (1972) pointed out that clients involved in
aftercare services following inpatient treatment func-
tioned significantly better than clients not receiving
aftercare services. Pokorny et al. (1973, p. 442) also
advocated aftercare services for alcoholics. They have
shown that “the overall outcome in a program of
60-day inpatient care followed by weekly out-patient
supportive group therapy visits equaled the results
of a 90-day hospital program without follow-up
support. This alteration not only substantially reduces
hospitalization costs but reduces also the negative
influence of prolonged hospitalization on many pa-
tients.” If a client has been discharged from a
treatment facility, he/she should be encouraged to
use the facility's aftercare services. Keller (1974)
supports “third-party coverage” for such services.

Abstinence

The traditional goal of the alcoholic client has
been total abstinence. However, this goal has recently
been questioned (Pattison, 1976; Davies, 1962). These
authors pointed out that some alcoholics can return
to “normal drinking.”

Alcoholics Anonymous adheres strictly to the goal
of total abstinence. Many see the nonabstinent goal
as a rationalization to return to alcohol use. The
research related to social drinking for the alcoholic
has often been misinterpreted. Clients are unaware
of the strong controls involved in establishing em-
pirical data. Thus, after the alcoholic gains thrust
with his rehabilitation counselor, he may attempt to
justify the nonabstinent goal. At this point, it would
be wise for the rehabilitation counselor to point out
the implications of changing goals. In most cases,
encouraging the alcoholic to become a “social drink-
er” is like encouraging an infant to play with a box
of razor blades. In some cases, patients have died as
a result of a first drink.

Pattison (1976, p. 925) pointed out that “abstinence
may be an inappropriate goal for patients with
moderate or minimal degrees of alcoholism problems.”
One must question the whole concept of the non-
abstinence goal. If alcohol can be described as a
“moderate or minimal” problem, then the client
should have no problem maintaining abstinence.
Blume (1977) provides an interesting analogy in
support of the “abstinent goal,” when she notes that
people often “cheat” in their dieting. By requiring
a 1000-calories diet, many people will cheat with a
1300-calories. If the physician requires a 1300-calorie
diet, dieters are likely to take 1700-calories. Striving
for the ideal of total abstinence is a useful tool.

Pattison (1976), however, clearly pointed out that
some truly diagnosed alcoholics can return to “social
drinking.” Nevertheless, Armor et al. (1976, p. vi)
have stated, “We have no evidence whatsoever, nor
is there any method present, that enables us to identify those alcoholics who might safely return to drinking and those who cannot.” At the present time, total abstinence must remain the rehabilitation goal. No practitioner has the right to encourage or suggest that his client can return to “normal, social drinking.” This is particularly true of the client who has suffered severe physical problems as a result of drinking and those who cannot.” At the present time, total abstinence must remain the rehabilitation goal. No practitioner has the right to encourage or suggest that his client can return to “normal, social drinking.” This is particularly true of the client who has suffered severe physical problems as a result of drinking and those who cannot.”

**Implications for Jobs Placement**

As with other disabilities there is substantial employment discrimination against the alcoholic person. In many cases, employers have discharged alcoholics even if their problem was controlled and they caused no production problems. Fortunately, most employers do not discharge their personnel if the problem is controlled. Businesses have an investment in their employees and, as a result, the alcoholic client may be referred to the rehabilitation counselor for intensive counseling and follow-up. In some cases, the client may return to his former job without requiring extra training. However, extra guidance (vocational or otherwise) is needed.

Apart from those who return to their former jobs, there are other clients who have no job prospects and no skills. This population is the most challenging with which to work. Daily supportive contact is suggested with intensive utilization of all resources available.

Employment is an extremely important aspect of the alcoholic’s rehabilitation. Gainful full-time work will help to provide the alcoholic person with feelings of independence and self-esteem. In a practical sense, full-time employment can eliminate an alcoholic’s preoccupation with thoughts and dreams about drinking. In providing placement services for alcoholics, the rehabilitation counselor might note some areas to avoid. For example, it is usually considered inappropriate to place an alcoholic client in alcohol-related occupations, such as a tavern worker or a brewery laborer. Hardy & Cull (1971) pointed out that alcoholic persons have a greater job preference for social service and clerical than mechanical occupations. After examining the verbal intelligence and vocational preferences of their sample, Hardy & Cull reported that the alcoholic sample was less suitable for social service and clerical than the nonalcoholic sample. It is of some importance to note that in this project the alcoholic sample was being treated in an inpatient rehabilitation facility. The results imply that it may have been too early to administer testing. At any rate, job placement should be directed in areas which are in congruence with the client’s cerebral impairment. A frustrating job placement for a client may eventually induce him to drink.

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**BIOGRAPHICAL SKETCH**

Steve Marson, M. S. W., is presently on faculty of the Sociology Department at Pembroke State University in North Carolina. Previous professional experience includes employment as a Case Manager with Vita Treatment Center, Inc., the Methadone Maintenance Program; the Alcoholic Rehabilitation Unit of St. Anthony Hospital; and the Bureau of Vocational Rehabilitation, all in Columbus, Ohio.