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This Issue in Brief

Systems Therapy: A Multimodality for Addictions Counseling.—Chemical dependency is a growing problem which has increased at least tenfold over the past decade. Until recent years the phenomenon was not recognized as a disease, but rather a mental health problem, and current therapies still tend to address mental health aspects rather than the disease of chemical dependency. Alcohol, although a drug, is still considered to cause separate and distinct problems from other drugs. Author John D. Whalen maintains, however, that alcoholism and drug abuse can be treated as one common problem with a set of exhibiting symptomologies. This article describes Systems Therapy, a therapeutic approach developed by the author.

Assessment of Drug and Alcohol Problems: A Probation Model.—Authors Billy D. Haddock and Dan Richard Beto highlight the increased emphasis on assessment methods in drug and alcohol treatment programs and describe the assessment model used in a Texas probation department. Major theories of substance abuse and dependence are discussed as they relate to assessment. The objectives, components, and general functioning of the assessment model are described. A counselor/consultant is used in the assessment process to offer greater diagnostic specificity and make individualized treatment recommendations. According to the authors, the assessment process facilitates a harmonious relationship between probation officers and therapists, thus promoting continuity of care and quality services.

Drug Offenses and the Probations System: A 17-Year Followup of Probationer Status.—Authors Gordon A. Martin, Jr. and David C. Lewis provide the current status of 78 of 84 probationers previously studied in 1970. Of the original group, 14.1 percent are deceased and 18 percent have had constant problems with the law. Sixty eight percent have had varying degrees of success, with one-third essentially free of all criminal involvement. The study indicates that younger probationers who used heroin and barbiturates were the population at greatest long–term risk and merit the longest periods of probation

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and most intense supervision. For them, marijuana did not serve as a "gateway" drug, though alcohol may have. The authors note that the original group of probationers was supervised by a probation officer who was a specialist in drug offenders. While his probation load was sizeable, it was manageable. For probation to fulfill its crucial mandate—the authors conclude—more resources must be made available to it, and caseloads must be manageable.

All-or-Nothing Thinking and Alcoholism: A Cognitive Approach.—Self-destructive all-or-nothing thinking is both a correlate of alcoholic drinking and a likely area for cognitive intervention. Author Katherine van Wormer contends that it is not the alcoholic's personality but the alcoholic's thinking that is the source of the drinking. Specific cognitive strategies are offered—strategies that should be effective both in recovery from alcoholism as well as in its prevention.

Lower Court Treatment of Jail and Prison Overcrowding Cases: A Second Look.—In 1979 and 1981, the United States Supreme Court issued opinions in which it ruled that double-bunking of prison and jail cells designed for single occupancy was not unconstitutional *per se*. It also indicated that lower courts should demonstrate greater restraint in "second guessing" the decisions of correctional administrators. In 1983, *Federal Probation* published an article in which author Jack E. Call concluded that many lower courts were still quite willing to find overcrowded conditions of confinement unconstitutional. In this followup article, Call finds that after 4 more years of lower court decisions in overcrowding cases, this earlier conclusion is still valid.

Rewarding Convicted Offenders.—Offenders can be rewarded by deescalating punishments in response to behavior one wishes to encourage. This practice has distinguished origins, has been subjected to a variety of criticisms, but is regaining ascendance. In his review of the controversy, author Hans Toch suggests that defensible reward systems for offenders can be instituted and can enhance the rationality, humaneness, and effectiveness of corrections.

Current Perspectives in the Prisoner Self-Help Movement.—Prison rehabilitation programs are usually designed to correct yesterday's problems in order to build a better tomorrow for criminal offenders. Yet the struggle for personal survival in prison often diverts inmates' attention away from these "official" treatment policies and toward more informal organizations as a means of coping with the immediate "pains of imprisonment." Prisoner self-help groups promise to bridge the gap between immediate personal survival and official mandates for correctional treatment. Drawing on historical and interview data, author Mark S. Hamm offers a typology that endeavors to explain the promise explicit in prisoner self-help organizations.

Consequences of the Habitual Offender Act on the Costs of Operating Alabama's Prisons.—Habitual offender acts have been adopted by 43 states and are under consideration in the legislatures of others. According to authors Robert Sigler and Concetta Culliver, these acts have been adopted with relatively little evaluation of the costs involved in the implementation of this legislation. The data reported here indicate that one area of costs—costs to departments of corrections—will be prohibitive. The authors suggest that the funds needed to implement the habitual offender acts could be better used to develop and test community-based programs designed to divert offenders from a life of crime.

Evaluating Privatized Correctional Institutions: Obstacles to Effective Assessment.—Institutional populations in the American correctional system have increased dramatically during the last decade. This increase has produced serious concern about both overcrowding and the economic costs of imprisonment. One proposed solution to the current dilemma involves the engagement of the private sector in the correctional process. Although it is apparent that there are a number of potential benefits to be obtained from private sector participation in the administration of punishment, a variety of potential hazards have also been identified. In this article, author Alexis M. Durham III considers some of the hazards associated with the evaluation of privately operated correctional institutions. The discussion identifies some of these potential obstacles to effective evaluation and concludes that although evaluation impediments may well be surmountable, the costs of dealing with these problems may offset the economic advantages otherwise gained from private sector involvement.

Negotiating Justice in the Juvenile System: A Comparison of Adult Plea Bargaining and Juvenile Intake.—Plea bargaining and its concomitant problems have been of little concern to those who study the juvenile justice system. We hear little or nothing of "plea bargaining" for juveniles. However, in this article, author Joyce Dougherty argues that the juvenile system itself is based on the very same system of "negotiated justice" that lies at the

heart of adult plea bargaining. By placing society's interest in "caring for its young" (translated into the doctrine of parens patriae) over the individual rights of juveniles, the juvenile justice system has created a situation where the determination of a child's "treatability" has become more important than the determination of his or her guilt or innocence. The author compares adult plea bargaining and juvenile intake in an effort to illustrate how, despite all theoretically good intentions, the "justice" in the juvenile system is no better than the "negotiated justice" that is the end result of adult plea bargaining.

All-or-Nothing Thinking and Alcoholism: A Cognitive Approach

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"I Quit!"
"Forget It!"
"When I drink it's to the point of oblivion. Otherwise why drink at all?"

It is a fact much cited in the literature that alcoholics tend to have been reared in families of alcoholics and teetotalers alike (Peele, 1987). It is a fact not much cited in the literature but known by alcoholism counselors that all-or-nothing thinking is characteristic of alcoholic clients. These two seemingly unrelated pieces of information may, in fact, be united by a common theme—an extremeness in thought and behavior. And this common theme may have important implications in the treatment of alcoholism and in its prevention.

"Stinking thinking" is the term used by Alcoholics Anonymous (AA) members to characterize the type of irrational mindset with which they are so very familiar. Alcoholism counselors find that, because of the addict's inclination toward emotions and behaviors of excess, treatment for the disease must necessarily be a lengthy process. Stopping the drinking is "not the half of it."

Today, observers needlessly debate the point—is alcoholism a moral or a physical defect? What has apparently not occurred to writers in the press or attorneys-at-law caught up in the debate is that the moral side may indeed by a physical ramification. The contention of this article, consistent with the latest compelling scientific research, is that there is no either/or in alcoholism, that the alcoholic thinking and the alcoholic drinking stem from the same indistinguishable psychoneurological source. The tendency to be addictive and addictive thinking are one and the same.

Although all the scientific proof is yet forthcoming, recent research clearly points in the direction of some sort of cognitive-perceptual deficit in alcoholics, a deficit which manifests itself in early childhood long before the onset of problem drinking. Hyperactivity, poor impulse control, and antisocial conduct are cited as precursors of alcoholism in several neurologically-based studies (Goodwin, 1976; Gorenstein, 1987; von Knorring et al.). Gorenstein (1987) speculates that alcoholism, hyperactivity, and antisocial behavior may be somehow derived from the same predisposing factor. He presents empirical data to substantiate the hypothesis. Depression, similarly, has been widely cited as antecedent to drug abuse, a finding consistent with the "self medication" explanation of alcohol use (Deyken et al., 1987; Royce, 1981).

The cognitive component in alcoholism is an integral part of the disease itself. At the heart of the problem of alcoholism (and of drug abuse and bulimea) are underlying thinking and belief disturbances conducive to self-defeating behavior. Self-defeating thinking, in short, leads to self-defeating behavior. The thinking shapes the course of the drinking: The thinking determines the when, where, why, how much.

If I wanted to explore the relationship between a certain cognitive style and drinking behavior, I would first briefly review some of the pertinent, highly empirical research being done on alcoholism and the brain. Then I would want to examine all-or-nothing thinking in some depth, giving attention to its many ramifications. And then I would want to look at other cultures to explore the relationship between alcoholic thinking and alcoholic drinking and follow this with a penetrating look at the AA philosophy and thought control. Finally, and above all, I would want to study treatment implications and strategies for prevention. These, then, will be the basic tasks for this article.

Research Findings

Twin studies, adoption studies, brain chemistry studies—these all suggest a strong biochemical/hereditary component in alcoholism. Twin studies indicate a likelihood that if one of a set of identical twins is alcoholic, the other is likely to be alcoholic also; the congruence in fraternal twins is consistently less (Begleiter, 1984). Carefully documented studies from Denmark indicate that the biological children of alcoholics are more likely to have alcohol problems, even though reared in non-alcoholic homes, than are the children of non-alcoholics (Goodwin, 1976). Evidence of EEG anomalies in children at

statistical risk for alcoholism is suggestive of an early neuropsychological impairment (Begleiter et al., 1984). Gorenstein (1987) gave to 44 male alcoholic patients, 18 antisocial subjects, and 18 college students various neuropsychological assessment batteries. Findings were as follows: cognitive-perceptual deficit was present among both the alcoholic and antisocial subjects, the degree of anomaly was in proportion to degree of loss of control over alcohol in terms of quantity consumed. The absence of an age difference is consistent with the possibility that prefrontal-type deficits in alcoholics predate their abusive drinking. The author hypothesizes a connection between cognitive abnormalities and the inability to curb drinking.

More significant for cognitive implications than the high incidence of alcoholism among those biologically predisposed to alcoholism is the consistent finding that not all those biologically inclined to have alcoholism problems have addiction problems. Where one identical twin is alcoholic, for instance, why sometimes is the other one not alcoholic? Why do some in a family drink addictively and others do not? What is the key to the insulating factor in prevention of alcoholism? Researchers would want to look to the cognitive realm for answers.

All-or-Nothing Thinking

You must be first or last, best or worst. Make an A in a course or drop it or get an F. Extremes in all things are the name of the game. "What's the point of drinking," laughed one of my alcoholic clients, "if you're not going to get completely, 100 percent drunk?" Worse yet, the entire group of DWI (drinking with intoxication) offenders nodded their heads in agreement.

Definition

The all-or-nothing thrust ("Give me liberty or give me death") involves an extremeness in word and deed. It is a caricature of the American obsession with being number one, "Whatever you do, be the best at it." Related to perfectionism, the all-or-nothing (or black and white or dichotomous) syndrome is broader than perfectionism because it tells what you will have if you are less than perfect—nothing.

The all-or-nothing perspective is a split into either-or: Either I am the greatest or I might as well quit. Note the extreme elements in the following alcoholic client statements:

> I'll stay in jail until my time is served. No probation for me. When I get out I want to be completely free. Otherwise forget it!
>
> I expect to get an A in any course that I take. Otherwise I'll drop it. Or just plain fail.
>
> I never tolerate any dirt in the kitchen. I say if you're going to clean it up, make it spotless.
>
> When I drink it's not to get high. It's to get rolling-on-the-floor drunk. Or else why drink at all?
>
> What do you mean I haven't completed my hours (of court mandated therapy)? Just send me to jail then!
>
> I said to my daughter, "Either you mind me, or get out of this house."

Because of the lack of compromise here, such pronouncements are a prescription for failure. It is easy to understand the degree of problematic behavior that would accompany such an outlook. Rigid, uncompromising, the all-or-nothing person sets a trap for himself/herself before a particular task is even under way. Burns' study of "the perfectionist's script for self defeat" is relevant here:

> Reaching for the stars, perfectionists may end up clutching at air. Studies show that these compulsives are especially given to troubled relationships and mood disorders. They may even achieve less than others. (1980:34)

Dangers of All or Nothingness

Engrained in the near-hysteria of the all-or-nothing framework is a mandate to "end it all" or escape. The destructiveness that ensues is immortalized in ancient and modern drama and recorded in the daily obituary column. Depending on an individual's tendency to internalize or externalize pain, the means to end it all may range from merely quitting a job or running away to the ugly extremes of suicide or murder. A pattern of escape from difficult situations is an early clue of possible untimely death. The seeming desire to bury oneself in substance abuse is just another avenue of escape into nothingness. Whatever the form the escape mode takes, the danger to the self and others is obvious.

Polarized Thinking and Alcoholism

Research on the thought processes of substance abusers indicates that such individuals are plagued with dysfunctional thinking patterns and that these dysfunctions precede the use of mood altering substances (Begleiter et al., 1984; Deykin et al., 1987; Gorenstein et al., 1987). Alcoholism, as conceptualized by Brown (1985) is "primarily a behavioral and cognitive disorder maintained by a faulty core belief." Alcoholic thinking, to Brown, makes the drinking reasonable and secondary to cognitive considerations. Numerous other studies describe the peculiar kind of logic that precipitates alcoholic behavior (Brown, 1985; McCourt and Glantz, 1980; Snyder, 1975). None of these, however, elaborates on the role of the all-or-nothing or dichotomous framework although several writers have observed its occurrence among alcoholics in treatment (Glantz,

1987; McCourt and Glantz, 1980). Significantly, writers on depression—a strong component in substance abuse—define the framework and its treatment in some detail (Beck, 1976; Burns, 1980; McCourt and Glantz, 1980).

Alcoholism, in common with other addictions, I believe to be a normal response to an abnormal way of framing reality. Absolutist patterns of thinking can lead to drinking in two fundamental ways: (1) the all-or-nothing attitude in itself mandates excess, and this can lead to addiction, and (2) the overreaction to life's cruelties can encourage drinking for "pain control." The thinking, in short, leads to the drinking. And the drinking doesn't do much for the thinking either, but this is another story.

A controversy exists concerning the putative "alcoholic personality." A certain response pattern on part of the MMPI (Minnesota Multiphasic Personality Inventory)—the McAndrews scale—is a fairly good indicator of alcoholism tendencies (Hoffmann et al.) Significantly, drinking is not mentioned *per se* in this scale. Some writers claim there is an alcoholic personality; others deny, just as emphatically, that such a reality exists.

Confusion centers on use of the broad-based term, *personality*. A narrower focus on characteristic alcoholic thought patterns would be more useful both in describing the unique attributes of the alcoholic and in shaping appropriate intervention strategies. Although personality characteristics of alcoholics are known to vary enormously, a certain similarity in thought mechanisms paves the way toward excess. For this reason, the newly recovering alcoholic gets hooked on marijuana, pain pills, sex, or religion. To eradicate one addiction seems to be to open the door to another. Significantly, 95 percent of alcoholics smoke; chain–smoking among alcoholics is commonplace. And, among the younger generation, polydrug use is the norm rather than the exception.

Alcoholic Drinking in Cultural Context

Why do some countries or cultural groups with the highest alcohol consumption rates have the lowest alcoholic rates, while those with the lowest consumption rates often have the highest rates of alcoholism? Why do some groups that perceive any kind of drinking as a sin have high alcoholic rates for those who do decide to drink? Why are there likely to be teetotalers and alcoholics both in the same family?

For the answers, cross-cultural data on alcoholism are informative if of some questionable reliability. Because of differences in international measurements, cross-cultural comparisons of alcoholism rates are difficult to make. Cross-cultural comparisons are confused by possible biological differences in susceptibilities to alcoholism. Orientals, for instance, who are physiologically very sensitive to alcohol ingestion and who tend to show a flushing response, have low alcoholism rates. Milam's hypothesis (1974) that the longer the period of time a people have been exposed to alcohol the lower the vulnerability to alcoholism can be used to explain in part the low rates of alcoholism among the Mediterranean peoples—Jews, Greeks, southern Italians, in contrast to high rates among Native Americans, Irish, Russians, Poles, North Americans.

Yet attitudes toward alcohol are also highly important in determining the course the drinking will take, whether it will be moderate or immoderate drinking. Jewish traditions, Greek and southern Italian culture show an appreciation for the use of wine as an integral part of mealtime and religious ritual. Drunkenness is neither condoned nor expected. Inhabitants of the northern latitudes, on the other hand, experience strong ambivalence toward drinking, and the tendency to go to extremes is engrained. Specific attitudes toward drinking are of the all-or-nothing, get drunk or abstain variety.

The Mormon religion forbids the consumption of any substances with mood altering properties. Mormons, accordingly, have a very low consumption rate but a very high alcoholism rate. When a Mormon drinks, apparently, he/she drinks addictively. Among these and other dry group members who drink, there is a higher than average rate of alcoholics and problem drinkers, notes Royce (1981). Apparently, the theme of immoderation in abstinence is repeated in drinking. The two opposite sides of the same coin, abstinence and alcohol abuse, actually have more in common with each other than with moderate drinking. They both derive from the same source—polarized thinking—and the same obsessive concern about the beverage, alcohol. As a young female alcoholic told me:

> My father always said to me, don't ever take that first drink. Once you take that first drink you will not be able to stop. And it will wreck your life . . . And it almost has.

AA Principles and Pitfalls

Principles

Alcoholics may cease to drink (often because of life–threatening health problems or under court order) and still think alcoholically. This is known in AA parlance as "the dry drunk." Membership in AA does a great deal to quell the "stinking thinking" of addiction. The principles have been widely used by

all self-help groups. A study of the techniques may provide a clue to their success.

The tendency to excess in the alcoholic is well recognized in the simplicity and practicality of AA's oft-repeated themes:

> "Easy does it."
> "One day at a time."
> "Make things simple."

Each meeting begins with the aptly named serenity prayer: "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference." Many AA members carry copies of the prayer with them and refer to it often.

The success of AA can be attributed to its highly simple, universally appealing rhetoric that focuses on replacing unhealthy thoughts with healthy ones. When one member's thinking begins to sound irrational there is always an experienced member who will offer a slogan such as "Easy does it." Such slogans, however simplistic they may sound, are an attempt to replace harmful thoughts with helpful ones. They are an attack on destructive all-or-nothing thinking. In short, as Brown (1985) correctly notes, the new language of AA begins to provide its own form of cognitive control.

Pitfalls

And yet AA members themselves are apt to be authoritarian (Canter, 1966). Three related tenets of the AA belief system are all absolutist in nature: (1) the only way to recovery is through total abstinence, (2) only through active and continual AA involvement can recovery occur, and (3) effective counselors must themselves be recovering alcoholics of the AA school.

One of Brown's clients, Sally, sums up the popular thinking as follows:

> AA is all or nothing. You're either sober or you might as well drink (1985:p.144)

Unlike Brown, the author of the text, I am struck by the dichotomous thinking reflected in these words. Such thinking, which undoubtedly has its functional side in maintaining sobriety, if often reinforced by the profession of alcoholism counselors who tend to be of the AA school. My co-therapist once berated a resistant group of clients with the following words:

> Either you're an alcoholic or you're not. Tell me, can you be a little bit pregnant?

Alcoholism counselors are a singularly dedicated and knowledgeable lot. When they err, however, they err in the direction of rigidity.

The inclination to excess clearly does not depart with the cessation of the drinking: One alcoholism counselor, for instance, displayed his motto with *four* "Easy Does It" stickers on his car. Many AA members, nevertheless, successfully utilize humor as an antidote to the tendency to overdo, to overreact. Fortunately, the rapid professionalization of the field is underway, and a revolutionary examination of the occupation's basic premises is evident.

Cognitive Treatment

The cognitive-behavioral approach is founded on the principle that a person's emotional and behavioral reactions are determined by his/her conceptualizing of reality. Alcohol abuse, according to this model, is associated with a multi-dimensional defect in thinking that constricts reality in a rigid, polarized fashion. Whether or not these distortions of reality originate in some underlying organic disorder, they may lead to a "what-the-heck," self-defeating drinking pattern. The heavy drinking, in turn, further distorts the thinking. An intensive treatment program utilizing cognitive theory and techniques can offer a powerful mechanism for change. Intervention in the cognitive realm is relatively easy to do, non-threatening and conducive to short-term, demonstrable results.

Dysfunctional beliefs, cognitive distortions, and maladaptive behavior patterns receive the emphasis in cognitive therapy with alcoholics. Designated roles for the cognitive therapist are the roles of teacher, clarifier, coach. Didactic instead of dogmatic, the mode of cognitive-behavioral therapy is both egalitarian and empirical in nature. The client is taught the skills of testing and examining underlying assumptions and beliefs so that he/she can take responsibility for his/her own behavior and thoughts. A thorough grounding in maladaptive thinking processes including all-or-nothing characterizations is provided.

Glantz (1987:55) succinctly states the challenge facing the alcoholic worker:

> The maladaptive conceptualizations of the alcoholic have a crucial role, not only in the etiology of alcohol abuse but also in its maintenance and exacerbation; most relevant here, the maladaptive conceptualizations of the alcoholic are the primary target of the cognitive-behavioral psychotherapy.

From the earliest stages of treatment absolute sobriety is a must: to work with the mind and clarify thinking the thinking must not be muddied with intoxicants. Diagnosis of the alcoholic client's particular psychopathology is, as Glantz (1987) indicates, the logical starting point in applying cognitive

theory to practice. Specific attitudes and conceptualizations arise naturally through early therapy discussions of the client's interpersonal and personal problems for the client. That it is within the power of each patient to control thinking processes so as to shape feelings and behaviors is a basic theme of instruction.

To help the individual combat extreme elements in thought and to enjoy a more flexible and tolerant outlook, both individual and group therapy are recommended. Specific cognitive techniques are available from Beck et al. (1979) and Glantz (1987) to this end.

Consistent with the therapist's teacher role, homework assignments are given to enable the client to monitor his/her own behavior beyond the formal therapy hours. The keeping of a daily log of events and the thoughts they triggered and emotional reactions to the thoughts is a useful exercise. The counselor will review the results to show the client if and when the absolutist thinking occurs and ways in which his/her thinking may or may not be polarized.

Clients can be actively helped to replace unhealthy thought processes with healthy and productive ones by means of use of positive self-talk and cognitive restructuring. Positive self-talk is taught by the counselor's juxtaposition of the client's defeatist cognitions—e.g., "I might as well quit"—with more encouraging pronouncements—e.g., "I can do it; I've done it before!" The client is trained to use the word "Stop" when the old words appear, then to very deliberately substitute them with new formulations. Often the client was previously even unaware of the destructive nature of the thoughts that were going through his/her head or of their emotionally draining powers.

Cognitive restructuring is a related strategy for inculcating in the client cognitive techniques for coping with difficult situations in the future. By means of cognitive restructuring the counselor reframes life events in a more positive and realistic light: Thus a setback will be redefined in terms of a challenge rather than as "the beginning of the end" or an "evil omen." And the fact that a client doesn't achieve the "all" in the all-or-nothing framework will be reinterpreted in light of what has been achieved rather than in terms of what has been lost. The occasion of a relapse provides a typical illustration. Through cognitive reframing, the recovering alcoholic will be encouraged to view the relapse not as failure but as a normal process in recovery. A review of the client's progress will be undertaken.

The group setting, because of the power of collective feedback, is ideal for cognitive work. Clients can so easily see the fallacies in another's thinking and behavior patterns although not in their own. As clients contrast each other's frameworks and defenses they learn about their own frameworks and defenses. Once in a group a member was fulminating on and on about his myriad revenge plots. There seemed to be no way to get this overwrought man to see reason. Then a fellow alcoholic ex-logger confronted him: "I think you're a great guy. But sometimes you don't have too much up here" (knocking loudly on his own head). The group laughed in recognition, and the speaker then laughed too and acknowledged at once his bullheadedness.

For "setting the ball rolling" in a group, an exercise that is actually a list of masochistic thoughts is useful. Among items on the list are: "Count all your friends younger than yourself who are making more money"; "Review all the poor investments you have made over the years"; "Think of all the hurtful things your spouse has said to you." This exercise reveals in a paradoxical way the pain that can be aroused by certain lines of thought. Group members are generally willing to add their own masochistic favorites.

Results of cognitive therapy for depression disorders have been empirically substantiated. Used by itself or in conjunction with psychotropic medications, cognitive therapy has been shown to effectively alleviate depression. Thought control is therefore a reality; the mind can take conscious control over the body; the intellect can squash the emotions. The success of AA's simple (though not simplistic) sloganizing gives credence to the efficacy of the wonderful power of reason.

Prevention Implications

The power of thought control is in directing life toward moderation and away from the counterproductive extremes. The application of these techniques goes beyond mere alcoholism because alcoholism, remember, is but one manifestation of the excessive all-or-nothing disturbance. By identifying and reformulating the entrenched pattern, the counselor is able to offset many of the violent and harmful consequences of a certain line of reasoning. Additionally, work in this area is far less threatening to the average involuntary client than is work, say, in the area of values, morals, or prejudices. I have found it to be especially effective in working with the resistant alcoholic male client once some kind of rapport has been achieved.

Cognitive treatment of polarized thinking is relevant to a wide range of populations among which

are: (1) adult children of alcoholics who have been shown to have tendencies of perfectionism and addictions problems, (2) alcoholic families who ask, "How can we prevent our children from growing into alcoholics?" and who can benefit from clear guidelines on empowering children to control the course of their thoughts, (3) persons addicted to sex, love, gambling, etc. because they have as their starting point some kind of irrational notion to do with self-worth in an absolutist framework, (4) those who have attempted suicide which was probably out of the belief that complete escape was the better course, (5) criminals and ex-cons whose "crimes of passion" were their way of closing the door on a failed relationship and criminals who committed extreme acts to "get rich quick," and, finally, (6) persons suffering from anorexia and/or bulimea as opposite but related eating anomalies. What all these diverse situations have in common is a compulsion that seems to take over and obscure all sense of proportion. In helping victims of these disorders to think more clearly and find some balance, their many strange compulsions and behaviors can be offset. To treat the immediate symptoms of any one disorder is not enough; the same forces will simply spring up somewhere else. The primary focus is in thought processes, their patterns and content. There is perhaps more wisdom in my alcoholic client's simple thumping of his head than in many of the lengthy treatises of erudition.

Conclusion

A focus on prevention, not treatment, would be more productive in the long run. Prevention efforts, ideally, would begin during the school years. Instead of films showing the horror of drug abuse and the tragedy of suicide, focus on how a person can organize his/her thoughts for greater coping power against the cruelties of life. In literature and health classes a cognitive exploration of a play such as *Romeo and Juliet* could get the necessary points across dynamically. A de-emphasis on educational competition and perfectionism would also be in order.

The cognitive approach to alcoholic treatment has the advantages of offering a solution as well as an explanation. The more we learn of the applicability of the cognitive mode, the more we will be prepared with specific interventions.

To the extent that the cognitive approach to alcoholism is utilized, it is utilized sporadically, fitfully, and often inadvertently (as in the AA tradition). In alcoholism treatment circles, the disease model of alcoholism receives the overriding emphasis, often to the detriment of direct treatment approaches. Conversely, social workers and others who emphasize self–control and willpower often overlook the important physiological/biological components. That there is no contradiction in these basic truths of causation, that alcoholism is at once a disease—a hereditary disease—and a cognitive disorder is one of the basic contentions of this article.

The need for further research to demonstrate the efficacy of directing interventions along cognitive lines is not only indicated but urgent. Addictions problems take their toll every day even while the treatment industry flourishes. The need is for carefully controlled studies of cognitive work in prevention and treatment, of cognitive work with a wide range of ages and educational levels, short-term studies and longitudinal studies alike. Refinement of certain conceptual modes such as the all-or-nothing dichotomy would be both exciting and conducive of improved alcohol education and treatment programs.

References

Beck, A. T., Rush, J.A., Shaw, B.F., and Emeny, G. (1979). *Cognitive Theory of Depression.* New York: Guilford Press.

Begleiter, H., Porjesj, B., and Kissin, B. (1984). "Event-Related Brain Potentials in Boys at Risk for Alcoholism." *Science* 225:1493-1496.

Brown, S. (1985). *Treating the Alcoholic: A Developmental Model of Recovery.* New York: John Wiley and Sons.

Burns, D. D. (1980). "The Perfectionist's Script for Self-Defeat." *Psychology Today.* November:34-52.

Canter, F. M. (1966). "Personality Factors Related to Participants in Treatment of Hospitalized Male Alcoholics." *Journal of Clinical Psychology* 22:114-182.

Deykin, E. Y., Levy, J. C., Wells, V. (1987). "Adolescent Depression, Alcohol and Drug Abuse." *American Journal of Public Health* 77(2): 178-182.

Glantz, M. (1987). "Day Hospital Treatment of Alcoholics." In A. Freeman and V. Greenwood (eds), *Cognitive Therapy: Applications in Psychiatric and Medical Settings.* New York: Human Services Press, pp. 51-68.

Goodwin, D. W. (1976). *Is Alcoholism Hereditary?* New York: Oxford University Press.

Gorenstein, E. E. (1987). "Cognitive-Perceptual Deficit in an Alcoholism Spectrum Disorder." *Journal of Studies on Alcohol* 48(4):310-318.

Hoffman, H., Rodney, G. L., and Kammeier, M. L. (1974). *Quarterly Journal of Studies on Alcohol* 35:490-498.

McCourt, W. and Glantz, M. (1980). "Cognitive Behavior Therapy in Groups for Alcoholics." *Journal of Studies on Alcohol* 48 (6):523-527.

Milam, J. R. (1974). *The Emergent Comprehensive Concept of Alcoholism.* Kirkland, WA: Alcenas.

Peele, S. (1987). "The Limitations of Control-of-Supply Models for Explaining and Preventing Alcoholism and Drug Addiction." *Journal of Studies on Alcohol* 48(1):61-76.

Royce, J. E. (1981). *Alcohol Problems and Alcoholism.* New York: The Free Press.

Snyder, V. (1975). Cognitive Approaches in the Treatment of Alcoholism. *Social Casework* 56(10):480-485.

von Knorring, L., von Knorring, A. L., Smigan, L., Lindberg, V., and Edholm, M. (1987). "Personality Traits in Subtypes of Alcoholics." *Journal of Studies on Alcohol* 41(3):338-346.