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This Issue in Brief

Restitution As Innovation or Unfilled Promise?—Author Burt Galaway discusses what we have learned about restitution since the establishment of the Minnesota Restitution Center in 1972 and in light of the early theory and work of Stephen Schafer. Noting that restitution meets both retributive and utilitarian goals for punishment, the author finds considerable public and victim support for restitution, including using restitution in place of more restrictive penalties. He cautions, however, that we must clarify the difference between restitution and community service sentencing and discusses challenges which exist for future restitution programming.

Parole and the Public: A Look at Attitudes in California.—Describing recent events in California, Author Walter L. Barkdull stresses the need for parole authorities to develop community support for the concept of parole. Public attitudes hostile to parole have been crystalized by the release of several notorious offenders at the end of determinate sentences. Community groups have discovered the power of organized action to thwart the state's ability to locate facilities and place parolees. Resulting court decisions have provided both the public and parole authorities with new rights, while legislation has imposed severe operating limitations.

Long-Term Inmates: Special Needs and Management Considerations.—Society's response to crime has contributed to a number of trends which have resulted in longer terms of incarceration for convicted felons. Determinant sentencing, modifications in parole eligibility criteria, enhanced sentences for repeat offenders, and longer terms for violent offenders have resulted in an increase in time served and a subsequent increase in the proportion of long-term inmates in state facilities. The incarceration of greater numbers of long-term inmates brings a number of programmatic and management concerns to correctional administrators which must be addressed. Using data on Kentucky inmates incarcerated as "persistent felony offenders," authors Deborah G. Wilson and Gennaro F. Vito identify the programmatic and management needs of long-term inmates and delineate some possible strategies to address this "special needs" group.

The Use of Counsel Substitutes: Prison Discipline in Texas.—Although prison discipline has changed significantly through internally and externally initiated reforms, it remains a critical aspect

CONTENTS

Identifying the Alcoholic: A Practical Guide for the Probation Officer

By Edward M. Read
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The probation officer occupies a unique position within society. It is virtually impossible to work within the system and *not* confront an absolute plethora of substance abuse related problems. This is the reality, and it comes with the turf. And make no mistake about it, alcoholism *is* substance abuse. Alcoholism is also drug abuse. If we study one, we also study the other, however easy this is to overlook.

We are charged with the responsibility of protecting the community (supervision) and assisting the courts in arriving at appropriate sentences for convicted offenders (presentence investigation reports). Since often the *majority* of our cases present alcohol and other drug problems it behooves us to become more than just a little "familiar" with this condition. We must become close to "expert."

Having previously advanced some thoughts on working with the alcoholic on probation supervision (Read, 1987), the author now wishes to concentrate on a more comprehensive description of alcoholism and how we might *ourselves* safely make a professional, valid, and expeditious diagnosis. Identifying the problem is a critical first step (Shaffer and Kauffman, 1985). Knowing what to look for, becoming comfortable with the interview process, and then making a confident assessment are sorely needed supervision skills.

But why must we face the truth about alcoholism and take this problem so seriously? What are the facts? Is alcoholism a disease? Are there telltale signs? Can we as probation officers learn how to make accurate and reliable assessments? By what means? And from this, what can we learn about addiction in general? These are but a few of the questions we hope to address here. Theory will remain largely absent. We will stay with the facts, with behavior, and with practical suggestions for use in the assessment process.

Facing the Facts

The conspiracy of silence rages on. As professionals within the community, we are still far too uncomfortable working with the typical alcoholic or person who drinks too much. It is easier to talk about or "staff" the heroin or cocaine addict. Identifying out is much less difficult; it is not hard to feel different or "better than." Not so with the alcohol "addict," as Milkman and Sunderwirth (1987) prefer to call the alcoholic so as not to make a distinction from other drug addicts. This unconscious avoidance is much more an issue with the less glaringly alcoholic client, but it does operate at some level within most of us.

Our resistance is present because most of us also drink beverage alcohol. We may even drink too much on occasion—perhaps on too many occasions. Our families or people close to us have surely been touched by alcoholism in one form or other. This can make us sensitive and much less willing to talk about the problem—yes, even with our own clients on supervision. Physicians are still coming under attack for having a similar problem (Helzer and Pryzbeck, 1988). This damaging silence must be broken.

Why? Because as Bill Wilson, co-founder of Alcoholics Anonymous, so aptly put it, alcohol is "cunning, baffling, and powerful" (1984). This we *do* know about alcohol and its unfortunate victims, the addicts. One need only glance at the statistics to be convinced. Alcoholism is currently ranked in the United States as the number two killer behind cancer. Were it not for the conspiracy of silence, it would probably be number one; so many deaths which are actually alcohol–related are not recorded as such. Families would rather not risk disclosure.

The average city policy officer spends half of his time with alcohol-related offenses. Nearly half of the men and women in prison are alcoholic or at least heavy drinkers. Alcohol is involved in 60 percent of the reported cases of child abuse and in the majority of domestic violence incidents. Forty-one percent of assaults, 39 percent of rapes, 64 percent of homicides, and at least 80 percent of suicides are attributable to alcohol (Goodwin, 1988; Milam and Ketchum, 1981). Alcohol is now even being implicated as a contributory factor in the contraction of AIDS (Siegel, 1988).

The facts do not stop here. Between 20 and 30 percent of male psychiatric admissions are alcoholic.

About 25 percent of the men admitted to general hospital wards for medical treatment have alcohol-related problems. Industry loses billions of dollars a year due to work inefficiency related to alcoholism. Alcoholics are about three times more likely to experience divorce than non-alcoholics. There are an estimated 15,000 deaths a year from alcohol-related traffic accidents. Studies are indicating that most of the drinking drivers are not just social drinkers coming home from a Christmas party but serious problem drinkers, alcoholic by most definitions. Thirteen percent of the American adult population is alcoholic.

And finally, on the more positive side, nearly half of the American adult population cannot even be classified as "regular" drinkers; thirty-two percent are abstainers and 15 percent are "infrequent," meaning at least once per year but less than once a month (Finn and O'Gorman, 1981). It may be surprising to some of us that so many people choose not to drink at all, and those that do, do so infrequently.

Disease Concept vs. Willful Misconduct: Does it Matter?

Unfortunately, we simply do *not* yet know what causes alcoholism. Herbert Fingarette (1988) delivers a stunning indictment of past and present alcohol research efforts. He writes, "Despite decades of imminent breakthroughs, the current dominant consensus among researchers is that no single explanation, however complex, has ever been scientifically established as the cause of alcoholism." But does it really matter? Does it matter to us as probation officers? The etiology of addiction may remain clouded in mystery. Our addicted clients will not. They are there in full force, and we must work with them on a daily basis.

Nor does it matter that the controversy between "disease" and "willful misconduct" labors on with no clear end in sight. Dr. Fingarette feels we can "give up the search for an explanation of the disease that does not exist" (1988). This is a bit simplistic, perhaps even annoyingly glib. But be that as it may, by far the majority of experts in the field of alcoholism continue to refer to it as a disease. Goodwin (1988) writes convincingly, ". . . the evidence that alcoholism can properly be called a disease is just as strong for alcoholism as it is for many medical conditions universally regarded as diseases." If we can begin to understand this addiction, we will be much better equipped to work with other drug addictions. In the end we might even begin to see ourselves having an impact within the community.

Toward a Diagnostic Hallmark

Because this is a disease so sorely misunderstood, it should be no surprise that definitions often fall short of providing any real diagnostic help. They are either too general and non-specific or far too detailed and cumbersome.

Anderson (1976) provides a good example of the more elaborate approach. He writes,

> Alcoholism can best be defined descriptively as a behavioral disorder, one in which certain chronic and progressive phenomena take place in certain rather well-defined stages. Although there are many commonly used descriptive definitions of alcoholism, they all share certain elements: excessive drinking, exaggerated dependency on alcohol, preoccupation with drinking, surreptitious drinking, loss of control over the amount consumed or the time of drinking, a progressive loss of control, and the obvious fact that even though the alcoholic has been in trouble on numerous occasions over drinking he still continues to drink.

Whitfield (1985) disentangles but leaves us with nothing more than,

> Alcoholism or other chemical dependency can be defined most simply as recurring "trouble", problems or difficulties associated with drinking alcohol or using other drugs.

The trouble finding a proper definition of alcoholism becomes painfully obvious in the literature. At least Rogers and McMillan (1988) admit as much and attempt to explain why this might be so. Alcoholism is "selective"; most drinkers do not become alcoholic. A definition must account for this fact. Alcoholism does not happen overnight; symptoms can appear and them disappear, thereby confusing our definitional construct. The continuing debate over whether or not alcoholism is a disease only adds fuel to the fire.

However, in our review of the literature there is one incontrovertible and rarely neglected symptom about which there is no debate: *loss of control.* Anderson (1976) and others mention it (Ohlms, 1983). Whitfield (1985) makes an obvious inference. The American Psychiatric Association's diagnostic manual lists nine criteria, only three of which must be met for diagnosis. Loss of control is thematically represented throughout most of the specific criteria.

Establishing a definitional foundation is critical for both assessment as well as treatment. It becomes the beacon by which we can proffer further questions to substantiate an initial hypothesis or suspicion of alcoholism. Having read countless definitions we wish to propose the following as most representative of the crucial diagnostic criteria: *Alcoholism is a chronic (it endures or recurs) condition marked by one's progressive incapacity to control alcohol consumption despite psychological, spiritual, social, or physiological life disruptions.*

The key word of course is "control." The non-alcoholic heavy drinker will have the wherewithal to stop a self-destructive pattern of drinking in the face of compelling life circumstances such as marital problems, poor job performance, or liver malfunction. The alcoholic on the other hand will be unable to *sustain* control over time.

Loss of Control

Identified as alcoholism's diagnostic hallmark, loss of control must be considered in an appropriate contextual environment. Dr. Fingarette (1988), in his anathematizing and highly controversial book, *Heavy Drinking*, takes issue with the popular (and we might add out of context) notion that alcoholics cannot control their drinking. He writes,

> The public has been so indoctrinated by the idea of loss of control that few dare to seem naive by carefully observing alcoholic conduct and acknowledging that heavy drinkers often do moderate and limit their drinking. We may be close to people who have been labeled alcoholics, but we discount our observations of the times they show self-control because we have been told that alcoholics have no control. Or if we do recognize evidence of control, we decide the drinker in question cannot really be a true alcoholic. We then minimize or discount that person's drinking problems. . .

How true and yet so misleading. First, "heavy drinkers" can control and limit their drinking—they are simply not alcoholic. Second, the issue of control requires careful definitional refinement; it does not stand alone or apart from discussion and elaboration.

The initial concept is almost too simple. If the true alcoholic could control his drinking he would not be one. It's that simple. The trouble arises because, as Dr. Fingarette pointed out, alcoholics do exhibit periods of control throughout their drinking histories. This paradoxical problem, or "gross misunderstanding" as described by Keller (1972), has its genesis in the old Alcoholics Anonymous (AA) adage, "one drink away from a drunk."

Members of AA are usually quite sincere when they utter this phrase. But they do not mean it in the truest, most literal sense. As Keller (1972) writes,

> What is fascinating about that slogan is that nearly all the alcoholics I have known, including those who in all sincerity proclaim that slogan, have told me that, even during the course of the severest stage of their active alcoholism, they had a drink or two or three on many occasions and stopped without further drinking, until on some other occasion, days or weeks later, they did not stop.

Keller examines the history of this misinterpretation and comes up with an interesting historical note. E.M. Jellinek, the pioneer alcoholism researcher who first launched the disease concept during the 1940's, did not intend to create such tight parameters for the control concept. It was a mistake, literally "a momentary slip of the pen" (Keller, 1972).

So what is loss of control? Put most simply it is losing the ability to *predict* when and how much alcohol will be consumed on any particular occasion. This becomes a double-edged quandary. Sometimes the alcoholic will feel as if he has no control (or choice) over his decision to take or not to take a drink. Once started, the alcoholic cannot predict with absolute certainty whether or not the occasion will turn into a "bout," or remain within socially acceptable boundaries. Because of this facet of the disease, making a decision to quit drinking altogether or switching brands *and* not being able to do so consistently becomes a dangerous sign of alcoholism. Social drinkers do not find it necessary to exact much self-control.

Progressive Loss of Control

Long heralded as central to the understanding of addiction, the stages of progression become a significant tool in the assessment process. If we can identify the rudiments of these stages, we will be well on our way to an accurate diagnostic assessment. Alcoholism has a definite beginning, middle, and final stage.

We must train ourselves to *search for this progressive pattern*. When taking a drug history, we need to discipline ourselves to gather precise chronological data. It is simply not sufficient to rely on present drinking or drugging patterns. Start out with when the client first used alcohol and move through time to the present. Concentrate on reasons for use, the social context, types of alcoholic beverages, and general control issues. Isolate the circumstances when the client experienced "life disruptions," such as arrests which may have been drinking–related.

Researchers have uncovered valuable information detailing the stages of this disease (Milam and Ketcham, 1981). For some it is a painfully slow progression, taking decades. For others it is incredibly rapid, taking only months. This progressive pattern is not exclusive to alcoholism, Other drug addictions have similar developmental stages (Milkman and Sunderwirth, 1987).

The *early stage* is characterized by a growing physiological tolerance for the drug. A person may begin to notice he can hold his liquor better than others. He may even feel some associated pride. But then it will take increasing amounts to achieve the desired effect. There will be preoccupation with alcohol and related social circumstances or activities. Rarely will the early stage alcoholic be caught in

social situations without alcohol. It will be at the top of the shopping list. And unfortunately at this stage, there is little disapproval by significant others. Nor is the alcoholic experiencing much internal pain. Overt symptoms are absent and an unexpected drunk might be passed off as intended. Some evidence, albeit highly controversial, would point toward the possibility of helping the early stage alcoholic initiate controlled (more responsible) drinking habits (Nordstrom and Berglund, 1987).

The *middle stage* alcoholic manifests a slightly different set of behavior patterns with loss of control slowly becoming more apparent. Unfortunately, some of the telltale signs remain subtle and necessitate specific questioning on the part of the interviewer. Pre-drinking (having a few before a party, for example), gulping the first drink, and surreptitiously fortifying drinks exemplify the alcoholics' progressive preoccupation. Attempts to control should become evident; the alcoholic might try and switch to beer from whiskey or go "on the wagon" for a period of time to prove to himself and others he does not have a problem. Personally devised proscriptions against drinking in the car or drinking alone might surface. Guilt should begin to make an occasional appearance but the alcoholic will usually blame others or mistakenly identify the problem as depression or stress-induced.

Family relationships will be the first to suffer. This will be followed usually by legal problems, health complications, and financial turmoil. *Employment is often the last to go.* The interviewer must persevere through the alcoholic's denial system. He will maintain he could not possibly be an alcoholic given his job responsibilities and diligent work ethic. But talk to him about his wife, his children, or his friends vis a vis his drinking. Collateral contact with spouses, children, and others can be awfully illuminating.

Most, but certainly not all, middle stage alcoholics begin to experience "blackouts." This is a frightening episode involving whole chucks of time during which the person will appear to be functioning relatively normally but end up not remembering anything the next day. This should not be confused with "passing out." In essence it forms the quintessential example of loss of control. The alcoholic did not intend to drink to the point where he would have no recollection of how he drove himself home the night before. This is a symptom which clearly distinguishes alcoholics from non-alcoholics.

The final stage of the disease is obvious to even the most casual observer. *Late stage* alcoholism will include morning drinking, frequent over drinking of tolerance, prolonged binges, hospitalizations, suicide attempts, job loss, financial dependence, delusional thinking, and serious withdrawal symptoms.

Some Fiction on Addiction

Listed below are common statements we hear from our alcoholic clients as they unwittingly try and divert our attention from the problem. By avoiding a few very common pitfalls we can make the diagnostic process much simpler.

"I only had a few drinks and felt fine to drive." Obviously we need to ask some questions about the "few drinks." An actual number of "drinks" will tell us little. Beer contains varying amounts of alcohol (malt liquor can be almost twice as powerful as regular beer). He may have had 16– or 8–ounce beers. He may have had 12 percent wine or 20 percent wine. The situation is worse with mixed drinks. Their alcohol content varies anywhere from 80 to 120 proof. And how did the bartender pour? Was he generous or not? *Try and come up with a BAC (blood alcohol content level).* But then keep in mind that tolerance levels vary for individual drinkers. A BAC of .15 or above *with* no obvious signs of intoxication is usually a good sign of dangerous tolerance level. Unfortunately, police reports often fail to provide accurate data on "signs of intoxication." Ask your client—feeling "perfectly ok to drive" at .15 tells us something.

"I have a good paying and responsible position with the government. I work hard every day. I have a home, a wife, and two cars. I cannot possibly be alcoholic." This could be a hazardous assumption. By far the majority of functioning alcoholics fit just such a mold. They "appear" successful. Look for quality of life. Look for depression. Talk to family members about the person's *present* relationship with them.

"This was my first DWI and I was just unlucky enough to get caught. I do not have a problem with alcohol. I just drank a little too much on this particular night." Be cautious. Statistical studies tell us 50 percent of all first-time DWI offenders are problem drinkers or alcoholic. A second DWI reduces the chances to 80 percent. And the third is generally considered 100 percent diagnostic.

"I can control my drinking; I can handle my liquor. How could I be alcoholic?" Growing tolerance is characteristic of the first stage of the disease. Remember, social drinkers rarely find it necessary to "control" their consumption patterns.

"Look, I'm simply having a rough time. I was reared in a supportive non-alcoholic home. There is no way I could have a problem." Not neces-

sarily so. Yes, he could be experiencing significant stress, but he could also be alcoholic. The majority of alcoholics do *not* come from alcoholic homes. Being from an alcoholic home only increases your chances of developing the disease. Most people do not resort to using alcohol to relieve stress. Further questioning appears indicated.

"How could I be developing an alcohol problem? I have never gotten into any trouble over my drinking." It is very easy to buy into a statement like this. Besides, the alcoholic is usually an accomplished salesman. In addition to looking for deteriorating relationships as described above, ask the client if his life might be improved without alcohol. There are scores of people in recovery who self-diagnosed because they came to the conclusion they could not stop drinking on their own. All external facets of their lives were in order. It was living with themselves that became unbearably painful.

"I am not an alcoholic—I never drink alone or in the morning." Maybe so but this does not disqualify someone from being a victim of this disease. Many alcoholics never get to the point where they drink in the morning. Remember, this is a progressive disease. Just as many never end up drinking alone. It is what happens to the person when he drinks that is important. The loss of control factor needs to be unraveled.

Formal Test Instruments

Time constraints, high case loads, and a personal reluctance to formulate a diagnostic assessment often result in the probation officer feeling compelled to refer clients for outside "evaluation." We think it saves time. We think a "professional" opinion is always necessary. But perhaps we have been misled. It takes time and paperwork to administer a proper referral. The process detracts from valuable treatment time lost in the interim. Given a good test instrument, there is no reason the interested officer could not do this on his own.

One of the best known instruments used nationally is called the Court Procedures for Identifying Problem Drinkers (Mortimer-Filkins or HSRI Test, 1971). Many local probation offices have separate units exclusively for the administration of this test on their DWI population. It has shown good results but it lacks simplicity and requires significant interview time as well as officer input.

The Michigan Alcoholism Screening Test (MAST) is a much simpler but just as reliable test instrument for making alcohol assessments. It only takes approximately 15 minutes to administer. And contrary to what you might think, "self-report" data from alcoholic subjects is surprisingly reliable (Sobell et al., 1988). Here it is as reprinted from the *American Journal of Psychiatry* (Selzer, 1971)*:

Points		Question	Yes	No
2	1)	Do you feel you are a normal drinker?	( )	( )
2	2)	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening before?	( )	( )
1	3)	Does your wife (or parents) ever worry or complain about your drinking?	( )	( )
2	4)	Can you stop drinking without a struggle after one or two drinks?	( )	( )
1	5)	Do you ever feel bad about your drinking?	( )	( )
2	6)	Do friends or relatives think you are a normal drinker?	( )	( )
0	7)	Do you ever try to limit your drinking to certain times of the day or to certain places?	( )	( )
2	8)	Are you always able to stop drinking when you want to?	( )	( )
5	9)	Have you ever attended a meeting of AA?	( )	( )
1	10)	Have you gotten into fights when drinking?	( )	( )
2	11)	Has drinking ever created problems with you and your wife (or spouse)?	( )	( )
2	12)	Has your wife (or other family members) ever gone to anyone for help about your drinking?	( )	( )
2	13)	Have you ever lost friends or girlfriends/ boyfriends because of drinking?	( )	( )
2	14)	Have you ever gotten into trouble at work because of drinking?	( )	( )
2	15)	Have you ever lost a job because of drinking?	( )	( )
2	16)	Have you ever neglected your obligation , your family or your work for two or more days in a row because you were drinking?	( )	( )
1	17)	Do you ever drink before noon?	( )	( )
2	18)	Have you ever been told you have liver trouble? Cirrhosis?	( )	( )
2	19)	Have you ever had delirium tremens (DT's), severe shaking, heard voices or seen things that weren't there after heavy drinking?	( )	( )
5	20)	Have you ever gone to anyone for help about your drinking?	( )	( )
5	21)	Have you ever been in a hospital because of drinking?	( )	( )
2	22)	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?	( )	( )
2	23)	Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drinking had played a part?	( )	( )
2	24)	Have you ever been arrested, even for a few hours, because of drunk behavior?	( )	( )
2	25)	Have you ever been arrested for drunk driving or driving after drinking?	( )	( )

*The Michigan Alcoholism Screening Test is reprinted with the permission of Dr. Selzer.

Points are assigned as indicated for positive responses. A score of three points or less is considered non-alcoholic. A score of four points is suggestive of alcoholism and a score of five points or more is fairly strong evidence of alcoholism. We suggest you use this test instrument for those clients about whom you may have some doubt. It certainly need not be employed with every case.

Informal Assessment Tools

We will now introduce two informal (and much speedier) techniques for determining whether or not alcoholism intervention may be required. Perhaps they could be used prior to implementation of the MAST as means of making an initial hypothesis. Their use is not restricted to suspect alcoholics; other drug abusers may also be identified. Just change the wording.

First, we offer the **CAGE** questions, an acronym for **C**ontrol, **A**nger, **G**uilt, and **E**ye-opener:

1) *Have you ever attempted to Control your drinking?*
Ask about switching brands, vows to stop, resolutions to limit drinking during certain times, personal proscriptions against drinking in the car or alone, etc.

2) *Has anyone close to you ever expressed Anger about your drinking habits?*
Ask about wives' and husbands' opinions about the person's drinking. Have children ever expressed concern? Or a parent or lover?

3) *Have you ever felt Guilty about your drinking?*
Would his or her overall quality of life be improved without alcohol or without as much alcohol? Ever woken up and felt ashamed about the incidents of the night before?

4) *Have you ever taken an Eye-opener or morning drink to help you get started in the day?*

Answering "yes" to any one of these questions is a definite sign of problem drinking. Two or more positive responses is suggestive of alcoholism.

Second, and as an alternative assessment tool, we suggest the use of a short AA pamphlet entitled, "Is AA for You?" (1973). It poses a series of 12 "yes" or "no" questions designed to help the possible alcoholic reflect on his or her drinking practices. Four positive responses suggest the person "may be in trouble with alcohol." Copies of this pamphlet may be obtained by writing Alcoholics Anonymous World Services, Inc., Box 459, Grand Central Station, New York, NY 10163.

Take the time to experiment with these tools and discover the one which is most practical for you. If nothing else, read the MAST questions and study them. By becoming familiar with the instrument's intent, and remembering a few key questions, you may be surprised with your ability to make initial assessments. You will certainly have grasped the essence of alcohol addiction.

Conclusion

The conspiracy of silence surrounding alcoholism need not continue. As probation officers in the field, we have the option of choosing to play an integral role in the identification process. Perhaps we even have an obligation to assume this role. By facing the facts of the disease, accepting a definitional foundation, learning to identify progressive loss of control as a diagnostic hallmark, and utilizing simple test instruments, we could find ourselves on the brink of initiating a critical and lifesaving change process.

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