THE NURSE AND THE PROBLEM DRINKER:

A STUDY OF HELPING BEHAVIOUR

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A B S T R A C T

The purpose of this study is to examine aspects of the behaviour of nurses towards persons with alcohol-related problems. Similarities and differences in helpful and unhelpful behaviour as perceived by providers and by users of care are identified using the Behaviour Relating to Alcoholism Management (B.R.A.M.) Scale.

The research covers two phases. In Phase One 27 registered nurses and 12 members of Alcoholics Anonymous completed critical incident questionnaires which furnished a list of helpful behaviours and a list of unhelpful behaviours. These have been analysed and a set of descriptive statements prepared which constitutes the B.R.A.M. Scale. In Phase Two this has been administered to 67 registered nurses and 46 members of Alcoholics Anonymous, and the results assessed. The findings show that nurses and problem drinkers view the same behaviours as helpful. There is, however, a significant difference between the two groups in the types of behaviour they consider to be unhelpful. This finding has consequences for those who provide care for problem drinkers, and for teachers and students in education programmes for nurses.

P R E F A C E

From 1977 to 1979 the author of this thesis worked as a nurse therapist in an alcohol and drug addiction centre in an urban area in the North Island of New Zealand. Some people admitted for treatment to the centre were able to change their drinking habits. Others were not able to alter their drinking behaviour. It was not usually possible to predict which patients would be able to maintain sobriety on their return to the world outside the centre. It seemed that this discrepancy between those who could and those who could not achieve and maintain sobriety could perhaps be linked with the behaviour of the centre personnel, most of whom were nurses. The intuitive link, stated above, has been substantiated since the author left the centre and has been working as a district nurse in the extra mural services alcohol management team. This involves interacting with problem drinkers and those who provide their care. Interaction takes place in a variety of settings, including the local general hospitals.

One particular question recurrently addresses itself to the providers of services for problem drinkers. This question is

> Why do some problem drinkers change their behaviour while others do not?

Allied to this question are others. These are

- Is it something within the problem drinker?
- Is it a question of motivation?
- Is it something that is present or not present in the treatment service?

- Is it something to do with client-therapist interaction that contributes to this difference?
- Is there some helping behaviour by the nurse that encourages some problem drinkers to change?

The last question has evolved as a useful and exciting focus for this research, a study which utilizes the experience of nurses as well as the problem drinkers themselves in their roles of patient-as-consumer and first-line teachers.

Nurses are the professional health personnel who are most likely to be available to spend the greatest amount of time with the problem drinker in the hospital setting, as well as in other treatment agencies. Nurses are, therefore, in an ideal position to behave helpfully toward problem drinkers. To do this successfully requires therapeutic skills which include listening and paying attention to the patient or client, and the ability to "get alongside" people, as well as specific background knowledge of alcoholism as a modern health problem.

This thesis begins with an overview of problem drinking. The approach taken combines that of an academic exercise with reference to the media as evidence of interest which is both popular and official, and which strongly suggests a public health problem of some magnitude.

The literature review continues with an overview of the continuum that begins with alcohol the beverage and may end with alcohol the inducer of insanity. Such is the variety of definitions, causal theories and theories of treatment that the writer chooses a particular

framework within which to explore for possible answers to the question that becomes the proposition in this study.

A profile of the problem drinker is included as both a starting place and a meeting place - a human tapestry in which the threads, as they interweave, may allow some insight into the relationships which lead to theory building. The thread chosen as the focus of this study is that of helping behaviour and the therapeutic nurse-patient relationship.

The writer's approach is that of the "new" path to theory construction, that is, the discovery approach which is represented as a diagram in Figure 1.1. This means exploring psychosocial phenomena to allow another to discern something of the subjective universe of the experiencing person. It also means an idiographic study design in order to extract the substance and meaning from the phenomenological, personal world of the few. It is an alternative way of seeing to the traditional approach and "may not be totally explanatory, predictive, or directly testable". But it "permits nursing to return to the richness and complexities inherent in its social and scientific roots and goals". (Watson, 1981, P. 416).

The study, and the self-report instrument created in the process, is designed to discern a part of the experience of both nurse and problem drinker. The timeless essence of nursing may be something called caring. Through this study it is hoped that relationships may be discovered that will further explain this caring as a science.

A C K N O W L E D G E M E N T S

To have finally come to the stage of its being appropriate to record my thanks to the people who made possible the completion of this project is to experience very real joy.

True and lasting special appreciation goes to my supervisor, Miss Nancy J. Kinross, for her unflagging counselling, assisting, re-directing and encouraging.

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Special thanks go, too, to Mrs Val Webster whose assistance was far more valuable than that of her namesake dictionary.

The willing participation of those registered nurses and members of Alcoholics Anonymous who responded to the questionnaires made the project possible, and supplied the data base. My thanks to each one.

C. Jean Bramley

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30.10.81

G L O S S A R Y

A.A.	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. A.A. Preamble).
Addiction:	A state caused by periodic or chronic intoxication, produced by repeated consumption of alcohol. (Adapted from Cohen, 1976). For characteristics of addiction see Appendix A.
Al-Anon:	An organization, parallel to A.A., for the significant others of alcoholics.
Alcohol:	Ethyl alcohol (or ethanol).
Alcohol Withdrawal Syndrome:	A state of hyper-excitability representing a "rebound" phenomenon in the previously chronically depressed nervous tissue. (Estes and Heinemann, 1977).
Alcoholism:	Drinking which causes more harm than good to function and/or health and which later becomes compulsive. (Moon, 1979).
B.R.A.M. Scale:	Behaviour Relating to Alcoholism Management Scale. (Scale developed in the course of the research).
Counselling:	A professional problem-solving relationship. (Bailey et al, 1978).
Dependence:	Repeated use of alcohol (or any other chemical) for the satisfaction derived from it. (Adapted from Cohen, 1976). For characteristics of dependence see Appendix B.
Helping Behaviour:	Interaction, based on trust and effective communication, which facilitates a change in life-style. (defined for this study).
Motivation:	A desire to change sufficient to ensure action toward desired goals. (Moon, 1979).
Non-specialist Helper:	A helping professional, in this case a nurse, who has not specifically acquired skills for working with problem drinkers (defined for this study).

Nurse:	The nurse is a person who has completed a programme of basic nursing education and is qualified and authorized in her country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness and the care of the sick. (International Council of Nurses, 1965).
Problem Drinkers:	Alcoholics and others whose alcohol consumption is associated with problems. (Report of Task Force on Treatment Services for Alcoholics, 1978).
R.N.:	Registered Nurse.
Significant Other:	A meaningful other person (defined for this study).
Tolerance:	Ability of organism to become used to increasing amounts of alcohol upon repetitive exposure. (Adapted from Cohen, 1976).

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CHAPTER 1

INTRODUCTION

STATEMENT OF THE PROBLEM

After four years of working closely with problem drinkers, their families and friends, the author has become curious about the apparent differences between those drinkers who changed their behaviour and those who did not. One direction of inquiry has led into the study of treatment outcome and helping behaviour presented in this thesis.

AIM OF THE STUDY

The aim of this study is to elicit and examine incidents of behaviour in service settings which are seen as helpful and unhelpful by both the users and providers of treatment for problem drinkers. This leads to the construction of a behavioural scale which is used to examine the attitudes of both groups to individual behavioural items in the scale.

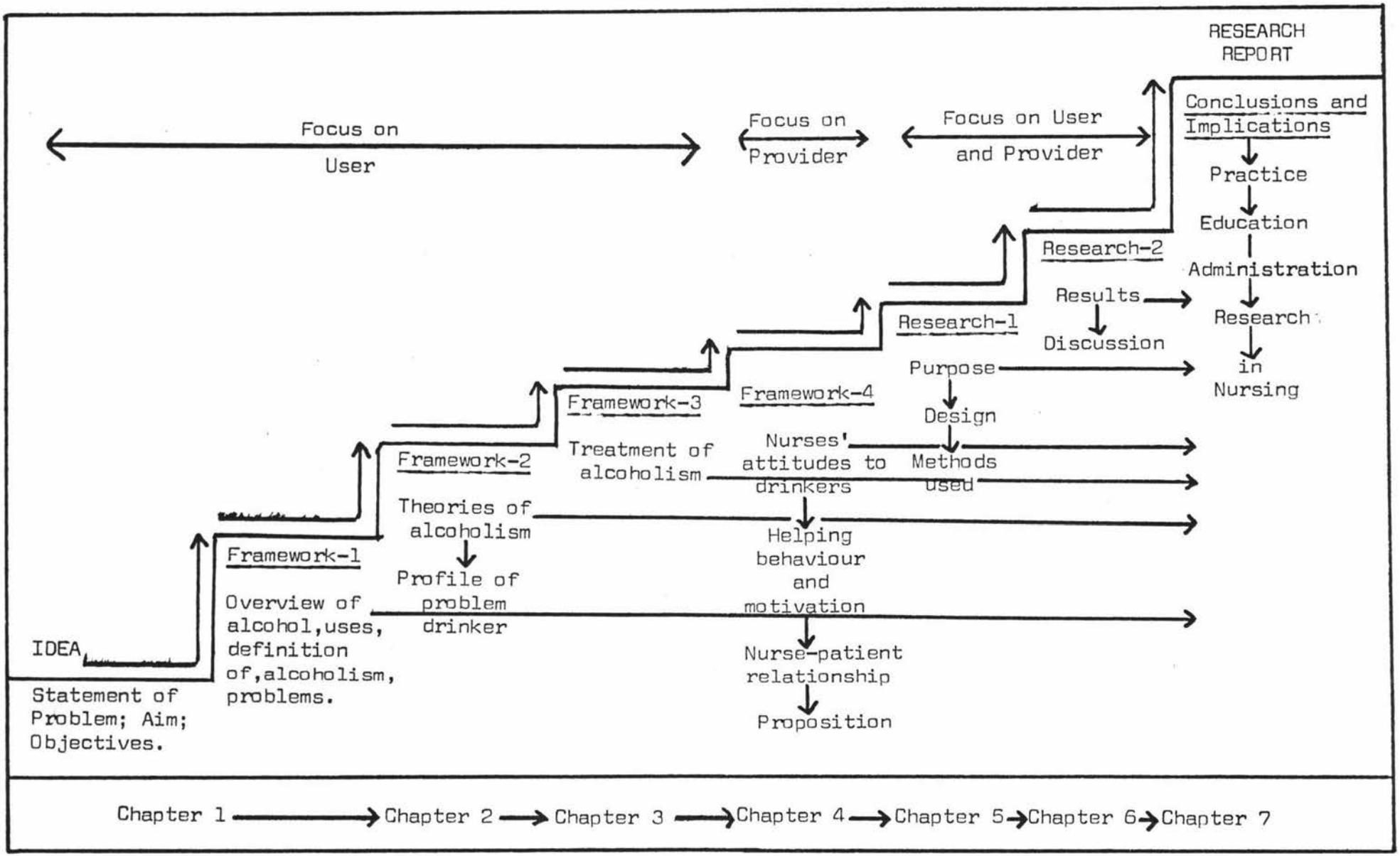

Figure 1.1: Plan of Thesis using Discovery Approach

OBJECTIVES

These are, as presented in Figure 1.1:

1. to review the relevant literature to obtain information about alcohol, alcoholism, and the behaviour of problem drinkers;

2. to develop a theoretical framework for the investigation of user and provider behaviour within the health services for problem drinkers;

3. to design a self-report instrument for obtaining perceptions of helpful and unhelpful behaviour towards problem drinkers;

4. to administer the instrument to providers and users of treatment for problem drinkers;

5. to present and discuss the results and their implications.

ALCOHOL AND ITS RELATED PROBLEMS: AN OVERVIEW

In this introductory chapter the characteristics of alcohol, the chemical, are presented. The personal experience of the author, and comment from the media, are then used as a backdrop for an extensive examination of definitions of alcoholism.

Alcohol has long been recognised both for its harmful and for its medicinal properties. For example, the Bible refers several times to the use of wine, usually advocating moderation. A negative

reference in Hosea states: "Whoredom and wine and new wine" (i.e. strong drink) "take away the heart." (Hosea 4 : 11, King James Version). Proverbs adds: "Wine is a mocker, strong drink is raging ; and whosoever is deceived thereby is not wise". (Proverbs 20 : 1, King James Version). Wine and beer were widely used as solvents in ancient Egypt. Today alcohol remains a socially approved and readily available means for feeling different. It is socially acceptable until problems occur, then disapproval, rejection, denial and indifference are expressed. Alcohol appears to have always been associated with problems of one sort or another.

Alcohol the Chemical

The alcohol referred to in this study is ethyl alcohol or ethanol. Its chemical elements are carbon, hydrogen and oxygen in simple combination to form a colourless liquid. Only ethyl alcohol has the well-known conventional effects and is safe to consume. It can be prepared easily from a variety of plants, is water-soluble, and is metabolized to provide energy at about ten grams per hour. The chemical formula is C_2H_5OH, i.e. two linked atoms of carbon have five hydrogen atoms attached to form the ethyl radical and the chemical molecule is completed by a hydroxyl (alcohol) group.

Ethyl alcohol results from fermentation by yeast of sugars that occur naturally in the plants. Although it provides calories and a rapid source of energy, the energy cannot be used efficiently because of the intoxicating and incoordinating effects of the alcohol. Such effects depend on the amount of alcohol taken and not on any other constituents of the particular beverage (the congeners). The chemical is absorbed into the bloodstream from the stomach and is gradually

destroyed by oxidation, mainly in the liver, finally being broken down into carbon dioxide and water. A small proportion (about 2%) escapes this process and is excreted in the breath and the urine.

The maximum rate at which the alcohol is oxidized is reached quickly, so that it takes far longer for someone who has been drinking heavily to return to normal than it does for one who has drunk moderately. Though apparently less incapable, those who drink slowly but continuously (i.e. keep "topped up") take as long to recover from drinking as those who absorb a similar quantity rapidly.

Personal impression

The author has gained the impression, through her association with problem drinkers in her field of work, and through her own life experiences, that the ready availability and social acceptability of alcohol promote its widespread use as a means of tension reduction. To check this out, the author approached two different groups of people at a treatment centre who agreed to report their reasons for drinking alcohol.

One group reported that they used alcohol:

> as a beverage, for medication, to feel good, to feel better, to lessen problems, for its taste, as a social lubricant, for relaxation, because it was forbidden at home, before being legally entitled to go in the pub, to prove manhood, to anaesthetize loneliness, as a mood-changer, as a tranquillizer in reaction to being upset, to cope with unwelcome feelings, for toasts at functions, on traditional occasions, to delay labour, as a vasodilator, as a sedative, as a cold cure, to sterilize objects, for industrial purposes, as a local application, to accompany food, as self-medication against fear, and to cope with differentness.

The other group reported that they used alcohol:

> for its sedative/anaesthetic effect, to get drunk, as fluid replacement, to encourage appetite, to prevent hangover/withdrawal symptoms, to be socially accepted, for its mood-changing effect, to cope with stress/long hours , to be accepted in peer group, as a stimulant, to avoid social intercourse, to prove manliness, to keep weight down, to cope with feelings such as loneliness, anger, fright and anxiety, through boredom, to relax, to escape from reality, through physical addiction/necessity, to quench thirst, from habit, for the taste, from a wish to be a connoisseur, and to facilitate being something one is not.

There is a marked concordance in these reported uses, which illustrate the variety of reasons for drinking, and the uses of alcohol. For further consideration of reasons for drinking the reader is referred to Appendix C, "Why Does an Alcoholic Drink?", an example from the literature.

Media Evidence

International Context

Within the last 30 years there has been a change of focus from considering alcohol-related problems as moral issues to their increasing visibility as a public health concern.

In the early 1970's in Canada, alcohol was identified as the most serious non-medical drug problem, and in the United States of America alcohol was then being considered a more significant problem than that of all other forms of drug abuse combined. It was reported in The Dominion of 25th June, 1980, that after cancer and heart disease alcoholism is the largest killer in the United States, which has at least 10,000,000 diagnosed alcoholics; in another edition it is

stated that in both North American countries medical societies have set up programmes for the detection and rehabilitation of impaired doctors, with special emphasis on alcoholism and drug addiction. (O'Hagan, 9/4/80).

Alcohol consumption throughout the world has increased (A.L.A.C. [1] Newsletter No. 14, December, 1980); in Britain consumption of wines and spirits has doubled in the last decade, and an estimated 300,000 - 500,000 people now have a serious drinking problem. (Hawke's Bay Herald Tribune 17/2/79; MacMillan, 1980). Later media evidence states that the number of people admitted to mental hospitals for alcoholism treatment has doubled for men and trebled for women, the highest increase involving people aged under 25 years (Hawke's Bay Herald Tribune, 11/6/80).

A recent report from Japan disclosed that the country now has an epidemic with more alcoholics than unemployed since their number rose sharply in the 1960's and 1970's. (Hawke's Bay Herald Tribune, 14/6/80). The same newspaper, on 25th August 1981 carried an item reporting a 12 per cent increase in alcohol consumption in Australia in the last ten years. Hewitt (1980) writes that in rapidly developing Papua New Guinea there is an increase in alcohol problems among young leaders pushed suddenly into top jobs.

The New Zealand Situation

The findings from Casswell's (1980) survey of drinking by New Zealanders suggest that the amount of alcohol now being consumed

1. Alcoholic Liquor Advisory Council

in New Zealand is causing problems. These are indicated by per capita consumption, the number of people seeking help for alcohol-related problems, and the involvement of alcohol in acts which bring people to the notice of various social agencies. Both Moon, in Hawke's Bay Herald Tribune, 12/2/79, and O'Hagan (1980) note that doctors themselves are worse victims of community prejudice with regard to alcoholism in that their alcohol-related problems are allowed by their colleagues to go much further than those of other people. The author of this thesis suggests that this is a symptom of the national situation.

Executives of the National Society on Alcoholism and Drug Dependence in New Zealand estimate that there are 50,000 - 60,000 alcoholics in the country with an at risk population in excess of 100,000 persons.

Such variations in estimating numbers of alcoholics highlight the difficulties in obtaining accurate data. It is, however, certain that alcoholism is now a major health problem in the country and employers know that 3 - 6 per cent of their work force is likely to be at some stage of alcoholism. Abuse and misuse of alcohol has recently been estimated to be costing $500 million a year in New Zealand, per capita consumption having risen 25 per cent in the last 10 years (Launder, 1981; Gair, 1981).

Alcohol as a Public Health Concern

Families often undergo material and emotional suffering long before a diagnosis is made, although it is slowly becoming less shameful to admit to having a drinking problem. Two distinct difficulties appear to be:

1. that the problem drinker tends not to look for help from his or her general practitioner, but from other agencies.

2. that many general practitioners do not know enough about early indications of alcoholism and are therefore only aware of chronic alcoholics with secondary complications.

> . . . many doctors have, until now, approached the alcoholic as an individual outcast with only nuisance value. It is hardly surprising that, if he seeks help, it is often from other agencies. (James, et al, 1972, P. 14).

Casswell's (1980) study found that a 9 per cent minority of heavy consumers among New Zealanders aged 14-65 years accounts for almost two-thirds of the total amount of alcohol drunk, but that self-reported drinking under-estimates by 37 per cent the amount actually consumed. The total alcohol taken, rather than the pattern of taking it, was found to be relative to associated health risks, and the changing role of women to suggest drinking habits and problems related approaching those of men.

In a social work survey the consumption of alcohol was found to be a substantial contributing factor in 16 per cent of the casework problems, and the major problem in one-third of that 16 per cent. Two groups in particular invited the notice of social work agencies: those aged 15 - 24 years, and those in their 40s. The kinds of alcohol-related ailments cited were depression, brain damage, tuberculosis, bronchitis, gastric disorders, "back trouble" and skin complaints, with a single report of a liver damage. (Morton, 1973).

A list of clinical manifestations of excessive alcohol consumption is included as Appendix D. (Delany, 1979).

In June 1980, North, reported in an Alcoholic Liquor Advisory Council Newsletter, stated

> Alcohol consumption has been increasing steadily in New Zealand over the last 20 years. Alcohol-related diseases and accidents account for about one-tenth of all hospital admissions in New Zealand and for half of the fatal motor accidents. The costs of alcohol-related diseases to our health services and thus to ourselves as taxpayers run into many millions of dollars each year in direct health expenditure. The indirect costs of increased alcohol consumption, in poor productivity, absenteeism, disruption of family life and disturbed adolescent behaviour far exceed the direct costs.
>
> Studies in several countries have shown that there is a direct relationship between the annual consumption per head of alcohol and the prevalence of alcoholism and alcohol-related diseases. (p. 4)

He warns of the likelihood of a consequent 5 per cent increase in alcohol consumption leading to further extra costs to the government, the insurance industry, and the taxpayer being linked with government's decision to allow liquor advertising on radio and television. North predicts that this one decision will cost the hospital services of New Zealand more than all the savings that have been achieved so painfully and slowly in recent cuts in hospital expenditure.

Batt reports finding a relationship between increased alcohol consumption and violent crime. (1974, 1980).

Other media evidence includes:

New Zealanders have been expressing concern about liquor abuse for more than 60 years. (Hawke's Bay Herald Tribune editorial 2/12/78).

There is mounting evidence that from 15 - 25 per cent of hospital beds are occupied by patients with alcohol-related problems (Burns, 1975, 1979; Hawke's Bay Herald Tribune, 11/6/80); that the cost of abuse is high in monetary terms (A.L.A.C. Newsletter, No. 13 September, 1980); and in public health terms (Burns, 1975; Crawford, 1976; O'Hagan, 1979). In 1975 Burns set out the criteria for judging whether a phenomenon is a public health and medical problem. (Appendix E).

DEFINITIONS OF ALCOHOLIC/ALCOHOLISM

Whiteside (1979) divides definitions into two complementary categories:

Structural physiological phenomena

The Addiction Research Foundation of Ontario Consumption Model offers one example in this category. Here, alcoholism is defined in terms of quantified standards.

An alcoholic can be defined as anyone who consumes more than 15 millilitres of absolute ethanol a day (115 - 120 grams) which is equivalent to:

12 - 14 ounces of spirits	(40% v/v Ethanol)
22 - 24 ounces of fortified wine	(20% v/v Ethanol)
36 - 40 ounces of unfortified wine	(12% v/v Ethanol)
100- 120 ounces of beer	(3 - 4% v/v Ethanol)

(Because of body size two-thirds of this amount may apply to women).

Whiteside uses the Edwards and Gross Syndrome Description, as another example of a structural definition which poses a continuum over a range of severity. It includes progressively compulsive behaviour, increasing central nervous system tolerance, increasing severity of withdrawal effects that are relieved by alcohol ingestion, and further relapse.

Functional psychosocial phenomena

A number of definitions come under this heading.

Bell (1970) defines alcoholism as:

> the placing of energy into alcohol instead of into one's family, one's friends, or one's vocation, focusing on the ability to function at life's tasks and covers every stage of an illness which affects individuals at all levels of society. (cited in Whiteside, 1979, P. 19).

Keller has offered a definition that has proved helpful in other research:

> Alcoholism is a chronic behavioural disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that interferes with the drinker's health or his social or economic functioning. (cited in Millsap, 1972, P. 124).

Davies (1977) defines alcoholism in terms of the intermittent or continual ingestion of alcohol which leads to dependency or harm or both. He adds that its presentation is sometimes medical, sometimes social, while sometimes it does not present at all, as it

consists simply of dependency, which, by definition, is harmless.

A sociologically oriented definition proposed by Trice is offered by Perry et al (1970) and sets out four facets of behaviour which distinguish the alcoholic from his fellow drinkers. First, his use of alcohol regularly deviates from the typical drinking standards of his particular social groups - home, job, neighbourhood. Second, his role performance in these groups is impaired. Third, his regular and excessive alcohol use results in physical and emotional damage. Fourth, even though he may know that his life is impaired by his drinking he shows an inability to stop drinking once he starts; thus he does not have conscious control of his use of alcohol.

The Alcoholism and Drug Addiction Act, 1966, No. 97 states:

> 'Alcoholic' means a person whose persistent and excessive indulgence in alcoholic liquor is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs.

The World Health Organization defines alcoholics as:

> those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning, or who show the prodromal signs of such developments. They therefore require treatment. (W.H.O., 1952).

The W.H.O. definition, although inviting debate, serves a purpose. A fundamental criticism levelled by Edwards (1977) is that it mixes up disability with dependence. It is quite possible for a person to have a degree of dependence on alcohol without any disruption to physical or mental health, or economic or social function. Conversely, a drinker may sustain disabilities in several areas of his life without abnormal dependence on alcohol.

A paraphrase of the W.H.O. definition is supplied by Moon (1979):

> Drinking .... which causes more harm than good to function and / or health and which later becomes compulsive.

This is represented in Figure 2.1:

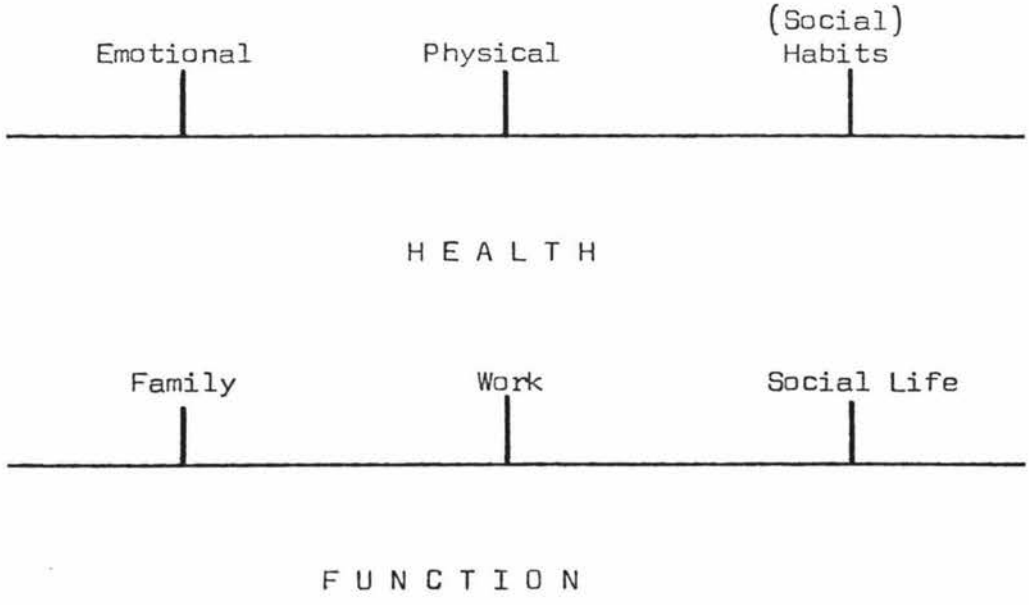

Figure 2.1: Areas of health and function in which alcohol causes harm. (Moon, 1979).

This allows more scope for therapists, including nurses, than the lengthy W.H.O. definition, which, as Spielman (1979) points out applies a diagnosis of a late stage of alcohol consumption which has been present for many years. For usually 5 - 15 years prior to the appearance of physical signs and marked socio-economic disruption excessive drinking has taken place. What may be called an ecological approach to a definition links well with O'Hagan's (1979) working hypothesis that "alcohol-induced ill-health is a disease" with all the ramifications of physical, emotional, spiritual and social aspects.

Moon's paraphrase of the W.H.O. definition is the one used in this study. It has all the advantages of being brief yet global in its scope. It conveys the concept of progression yet it has a potential for intervention. It is practical, easily understood and contains a combination of physical, psychological and social vectors. The other definitions described do not meet all these criteria.

S U M M A R Y

In this chapter, a range of definitions of alcoholism have been examined. The interest shown by the media is indicative of popular concern regarding the health and social implications of alcohol abuse.

CHAPTER 2

THEORIES OF ALCOHOLISM

The previous chapter relates the health and social implications of alcohol abuse to the interest evidenced by the media. This chapter provides a basis for designing the research project reported in this thesis. In this chapter theories of alcoholism are described and the behaviour of the problem drinker is discussed.

INTRODUCTION

Relevant Variables

A number of variables need to be considered in formulating theories of alcoholism. Culture is an important influence on drinking habits. Kessel and Walton (1975) state that Jews have a low rate of alcoholism. Explanations given are their lack of cultural taboos against the moderate use of alcoholic beverages. These play an integral part in ceremonial and social activities but there is strong disapproval of drinking to excess. By contrast, Casswell (1980) in her study of drinking in New Zealand cited in Chapter 1 (page 7)reports the existence of potentially hazardous drinkers among many dissimilar groups in New Zealand society. Drunkenness is tolerated behaviour.

The second variable is the quantity and frequency of the consumption of alcohol. In Scotland many public houses are frankly drinking shops where customers come for the one purpose. In such

generally one-sex settings the restraining influences of social conventions, such as the presence of women, are weakened and pathological drinking frequently occurs. The highest rates for alcoholism and alcohol-related diseases are found among those whose work brings them in contact with alcohol, and in Scotland the alcohol industry is a major one. (Kessel and Walton, 1975). In the comparison of Maori and non-Polynesian drinking-intensity within each occupational group there is a larger proportion of Maoris in the heavy consumer group. (Casswell, 1980).

The use of alcohol in relation to lifestyle constitutes another variable. Hodgson (1977) states that alcoholics relapse because they experience frustration or anger, or fail to resist social pressure to drink. That is, when these people are subjected to interpersonal stress they use alcohol as a coping mechanism. Or, expressed another way, their way of life gives expression to the prevailing cultural norms and system of social relationships. (Partanen, 1979).

> Our internal dispositions are also given expression by ways of life .... (P. 55)

Next there may be predisposing psychological problems. Alcohol may be taken as self-medication for feelings of depression. Here, the psychological state can operate as a trigger to initiate drinking (Chalmers and Wallace, 1978). Similarly, schizophrenia can be brought to notice by symptomatic alcoholism (Kessel and Walton, 1975).

Social conditions are a further variable, e.g. availability

and relative cost of alcohol. In 1976 a bottle of gin cost a worker on the average New Zealand wage $1\frac{3}{4}$ hours' work approximately. In 1971 it cost around 3 hours' work. (Crawford, 1976).

The last consideration is that of the presence or absence of physiological addiction. Hore (1977) uses the term alcoholism to embrace two groups of people. The first group are people with a drinking problem - those whose drinking causes social rather than medical problems. They may or may not be psychologically dependent on alcohol, therefore they do not inevitably become addicted. The other group are people who are alcohol addicts - those who are physically dependent to the extent of experiencing the alcohol withdrawal syndrome on cessation or reduction of intake.

A Plethora of Theories

For many years theories of alcoholism have been a concern of behavioural, biological and physical scientists and alcohol dependency has been characterized as biopathological, intra psychic, social, or involving all three causal systems. (Perry et al, 1970). Three major theoretical schools of thought have evolved. These are psychological, socio-cultural and biological. Epidemiological information has made possible both development and testing of theories, e.g. family history and twin data from populations in genetic formulations, and examination of the relationship between alcohol abuse and crime, referred to in the section on biological theories.

PSYCHOLOGICAL THEORIES

These involve the association between psychological factors and alcoholism.

Tension Reduction Theory

Alcohol in small quantities has the general effect of reducing tensions .... "inasmuch as problem drinkers tend to be more anxious and more depressed than most people, they drink in order to 'feel normal' " (Lindgren and Byrne, 1971, P. 416). Other studies show that while most of a group of alcoholics reported that drinking caused them to feel relaxed and pleasant, observations of their behaviour during drinking demonstrated them to be nervous, anxious and depressed.

It appears that tension reduction is not the most probable major factor in the onset or continuation of alcoholism.

Reinforcement Theories

Reinforcement theories are based on the premise that the drinking behaviour is rewarded or reinforced, with the reinforcing effects often being situation and time dependent. The taking in of alcohol is said to be learned behaviour.

A recent development is the "drinkwatchers" group which operates from the stance that alcoholism is a reversible behavioural disorder rather than an irreversible disease. "Drink watchers" is analagous to the "weight watchers" diet group. It offers courses

which train people to control their own drinking by monitoring it. If they drink to excess, people examine the precipitating causes. It is suggested that this may be more effective treatment for alcoholics than asking them to abstain. (Heather, 1980).

Behavioural methods on their own have not met with noticeable success and do not explain the whole problem.

Psychodynamic Theories

The assumption here is that individuals proceed through stages of specific psychosocial development. Alcohol use is attributed to the frustration, lack of fulfilment, or over-gratification of specific needs during development, e.g. the alcoholic is an oral personality, is in conflict over masculinity (or presumably femininity), has poorly developed ego strength, is self-destructive, or is fulfilling a need for punishment. A dependency need is also postulated, which suggests that a low rate of alcoholism in women is due to society's tolerance of their dependence, whereas men must use alcohol to achieve such a state. The reported low rate of alcoholism in women is now being seriously questioned, however.

Other theories suggest that alcohol is used as a bolster against low self-esteem and for achievement of feelings of power.

Personality Theories

Psychological test batteries such as the M.M.P.I. (Minnesota Multiphasic Personality Inventory) and the 16 P.F. (16 Personality Factors) have been used in an attempt to establish a personality profile for the alcoholic, but the general consensus is that there

is no one measurable personality type.

The range of personality types of alcoholics does not differ from that of the general population and it is not clear whether personality characteristics are the cause or the result of alcohol abuse. (Worthington, 1977; Estes and Heinemann, 1977).

Transactional Theory

This theoretical framework is concerned with identifying the behaviour of individuals in terms of ego states. Communication occurs by means of ongoing interpersonal exchanges, which are the transactions, both verbal and non-verbal. When individuals interact with one another they behave according to which ego state is in operation. Ego state is related to the memory and feelings associated with the person's past. The alcoholic may use drunkenness and helplessness as an interactive style. A vicious circle develops which reinforces this behaviour.

Again it is difficult to differentiate cause and effect.

SOCIO-CULTURAL THEORIES

This approach is based upon the interaction of the person with the norms and values of the society to which he or she belongs. Alcoholism is said to occur in societies which combine a lack of indulgence of children, overly high demands for achievement, and restrictive behaviour towards dependency in adults (Bacon, 1974).

Some sociocultural theories emphasise the learning experiences of adolescents as being important in the development of alcoholism. Such theories cite imitation of adult behaviour; peer pressure; parental models; exposure to alcohol relative to socio-economic status; ethnicity; geographic location and cultural stress. Others include response to impulsiveness in handling life's problems and to alienation. Women confused about their sex roles are said to be at risk. Factors that influence alcoholism rates in one culture may have little or no effect in another, e.g. low incidence in Italy, high incidence in France, in spite of a similarity in customs (Rubington, 1972). Advertising of alcohol is believed to play a part in its abuse (Estes and Heinemann, 1977).

These theories are complex and difficult to test.

BIOLOGICAL THEORIES

Research has been, and is being, done in attempts to discover any differences in anatomy, physiology or pathology, or any abnormalities of metabolism or tissue chemistry to distinguish the potential alcoholic from his fellows. An example is the study of acetaldehyde metabolism. (Batt, 1974).

The Lederman Equation

Lederman has shown that all drinking patterns, i.e. light, social, heavy, problem and compulsive, exist along a unimodal lognormal distribution.

> If alcoholics were different in genetic background, personality and behaviour, as was supposed or hoped by many, then they would exist along a different curve, that is, a bimodal distribution. (Moon, 1979).

The implication is that the prevalence of heavy users is likely to increase when the total consumption in a country increases. (Schmidt, 1977).

Genetic

There may be a genetic disposition in some anxiety states or liver pathologies implicated in causation. Forty five years of studies in Switzerland, Denmark and the United States of America show that alcoholism and alcohol-related diseases have a definite familial tendency. (Lowenfish, 1981; Asher, 1979). Kessel and Walton (1975) argue that the sons of alcoholics, who have a much higher incidence of alcoholism than their peers, attain this by imitation and not biological laws. More convincing evidence of a genetic influence on the pattern of drinking is being provided through studies of adopted children who are the offspring of alcoholic parentage. (Lowenfish, 1981).

Studies of twins in Scandinavian countries have yielded inconsistent findings, although they indicate an apparent inherited factor for the amount of drinking but not for dependence consequences.

In the case of such adoption and twin studies, adoptive parents have usually been middle class with stable backgrounds, which tends to restrict the range of environmental influences available to act on the adopted children. However, environmental

factors must play some part in determining whether a person becomes a problem drinker. The steady increase in alcohol consumption, abuse and related problems in many Western countries in recent years, discussed in Chapter 1, is not likely to have a genetic basis. Adopted children in Saudi Arabia would probably be less at risk of becoming alcoholic than in France. (British Medical Journal editorial, 15/11/80).

Studies using genetic markers, such as colour blindness or blood type, have to date been too diverse to allow any definite conclusions. (Schuckit and Haglund, 1977; personal communication Beider, 1980).

However, Lowenfish (1981) reports significant findings from studies of the production of acetaldehyde which show a difference in alcoholics compared with non-alcoholic offspring, and also inter-racial difference. In a 1979 study, Schuckit and Rayses report the results of the giving of alcohol to a group of young men who had an alcoholic parent or sibling and a control group without such a family history. Within 15 minutes and over the next three hours, the first group had higher concentrations of acetaldehyde in the blood than did the controls. Acetaldehyde is a major substance produced when alcohol is broken down in the body. It has been suggested as a factor in the formation of potentially addictive substances, tetrahydroisoquinalines (British Medical Journal editorial, 15/11/80). If results can be replicated, prospective investigations of children of alcoholics may lead to a means of diagnosing potential alcoholism.

Women and Alcoholism

Women have, to date, been largely excluded from the body of research, but current data is beginning to suggest the possibility of women being carriers of alcoholic genes. (Lowenfish, 1981). Physiological or genetic predispositions towards alcoholic disorders are suggested by Gomberg (1977). Alcoholism becomes an inevitable response when these predispositions are present and combined with dysfunctional coping behaviour produced by certain life circumstances. These may be early emotional deprivation, poor impulse control, lack of trust in others, resentment and anger, sex role conflict, feelings of failure in traditional roles of marriage and motherhood, and loneliness.

There has been recent recognition of a "tragic and preventable disorder" (Smith, 1977, P. 144), the fetal alcohol syndrome. This name describes the abnormal offspring of chronically alcoholic women. Mental deficiency and growth deficit are major aspects in the affected children. Alcohol readily gains access to all fetal tissues and is a serious teratogen.

Abnormal Body Functioning

Members of Alcoholics Anonymous have postulated an allergic factor in the alcoholic's physical make-up (even prior to his beginning to drink) which causes both the craving for alcohol and the dependence on it. (Kessel and Walton, 1975; Schuckit and Haglund, 1977).

In biochemical-physiological studies acetaldehyde concentration in the blood has been suggested as a potential factor in the

production of a morphine-like addictive substance in the brains of certain individuals.

Abnormalities of sugar metabolism have been implicated, but as alcoholism causes hepatic and pancreatic disease and consequent abnormal sugar or carbohydrate metabolism, there is little to support this as an antecedent of alcoholism.

Batt (1974) considers that alcohol studies in the context of overall nutrition and with special reference to the effect of food on acetaldehyde metabolism, may prove of importance.

Theories of endocrine, nutritional and structural dysfunction need to demonstrate the existence, before drinking starts, of craving or dependence, and this has not yet come about. (British Medical Journal Editorial, 15/11/80; Schuckit and Haglund, 1977; Batt, 1974; Kessel and Walton, 1975).

Disease Concept

The work of Jellinek promoted the concept of alcoholism as a disease rather than as a symptom of immorality, weakness or self-indulgence, and promoted its management on a medical model. Worthington (1977) reminds that emphasis on disease overlooks such variables as sociological and psychological causes, beguiles researchers into the metabolic field, and most importantly, ignores recognition of problem drinking in its early stages, thus hindering prevention. Szasz (1979) introduces a political element with a caution against "politically motivated and mandated redefinitions

of (bad) habits as diseases". (P. 78).

Certainly, understanding and rehabilitation of the alcoholic requires management of a person with a chronic disease which is subject to relapses (Santamaria, 1975), yet alcoholism cannot be defined in the simple terms of a physical disease which implies a set of signs and symptoms, morbidity and particular treatment. Robinson (1979) goes so far as to suggest that, to a certain extent, control over the disease concept of alcoholism has been lost.

A SINGLE ENTITY WITH PROGRESSIVE PHASES

Approaches to the variability problem have been dealt with by considering alcoholism a single entity characterized by different, progressive phases or stages. Those of Jellinek (1952) and Moon, (1979) are shown in Table 2.1. Here alcoholism is presented as a continuum with its beginnings in "normal, social" drinking. This suggests that there is little to show specific vulnerability to problem drinking, and that any person, therefore, is potentially vulnerable. The problem drinker may present at any point along the continuum. Although 25 years separates the two theorists, there are marked similarities in their progression descriptions.

The danger here is that it is often assumed that one stage in the developmental process inevitably follows another, and that therefore there is no way of preventing the progression through the stages until "rock bottom" is reached. Jellinek's exploratory and tentative work advanced to a reality and finality far beyond its purpose.

Table 2.1: A comparison of Jellinek's Phase and Moon's Stage Theories of Alcoholism

Progressive Phases of Jellinek	Progressive Stages of Moon
Pre-alcoholic: Use of alcohol to relax and to deal with everyday tensions and anxieties.	Beginning: Socially deviant change, initially unobtrusive.
Early alcoholic: Blackouts, sneaking drinks, growing preoccupation with drinking, defensiveness about drinking, feelings of guilt about drinking, denial.	Second: More overt expressions of distress, increased tension, reduced performance, lowered stress threshold, obsessional priority for alcohol supply, defensive denial.
Crucial: Loss of control, physiological dependence, willingness to risk everything to continue drinking.	Third: "Hour hand" type of behaviour, lack of appreciation of major destructive changes in health, family, work and social function.
Chronic: Physical damage, withdrawal syndrome, paranoia, suicidal hopelessness, self-loathing. (Living to drink and drinking to live, and drinking away the symptoms of drinking in a vicious circle).	Fourth: Physical complications, loss of reality, memory disturbances, withdrawal effects, delirium tremens, loss of self-respect. (Alcoholism the great imitator, replacing syphilis in this regard).

Jellinek's Typology

Jellinek (1960) also proposed a typology based on certain underlying dimensions:

- psychological dependence vs physiolgical dependence
- inability to abstain from drinking vs loss of control over drinking
- daily vs episodic drinking
- physical health vs disease

Table 2.2 sets out the typology characteristics.

Table 2.2: Jellinek's Typology and Characteristics

Type of Alcoholism	Characteristics
Alpha	Psychological dependence
Beta	Nutritional deficiency associated with alcoholic drinking
Gamma	Increased tissue tolerance, physiological dependence, withdrawal, loss of control, can abstain on given occasions.
Delta	Increased tissue tolerance, physiological dependence, withdrawal, loss of control, cannot abstain, steady-state drinker.
Epsilon	Periodic drinker

However, these categories are not sufficiently independent to be of much value in practice.

A PHENOMENOLOGICAL ANALYSIS

Wallace (1977) proposes a phenomenological analysis as a solution to this problem of variability among alcoholics, and describes the alcoholic's epistemological quandary, his difficulties in coming to know about himself, in the following terms:

- a massive uncertainty about the drinking history itself
- incongruity of recalled images (mild early intoxication, current extreme intoxication and its consequences)
- The disjunctive nature of the category of alcoholism (membership requires the presence of all, any combination of some, or any one of the defining attributes)
- the complex, probabilistic relationships of attributes
- social comparison information (the alcoholic can always find others who seem in a far worse condition than he)

From his perspective, internally, he says, the viewpoint is very different from the external one of a terrible self-destructive urge

> .... the alcoholic is in the grip of a powerful hypothesis that can never be invalidated completely. He believes that if he searches long enough and hard enough he will find a way to control and enjoy his drinking. (P. 10)

Acceptance of the fact of alcoholism, with all its implications is different from acceptance of the label "alcoholism". For a person to "know" that he is an alcoholic does not mean an immediate cessation of drinking. He may come to the conclusion that he must change something about his drinking, but the fact that he should

abstain entirely may not occur to him.

> He may switch from one beverage to another, change the time and pattern of his drinking, decide to drink only on a full stomach, drink only when he is feeling happy, stay away from certain bars, drop certain friends, get a divorce, change jobs, move and make other changes. (P. 10).

The controlled-drinking hypothesis is never completely invalidated, it remains an elusive possibility. The recovering alcoholic may finally accept the nearly certain probability that he can never again control his drinking, but the possibility that he might, under some remote ideal circumstances, may remain after many years of sobriety.

PROFILE OF THE PROBLEM DRINKER/ALCOHOLIC

There has been much controversy as to the existence of a true "alcoholic personality". Problem drinkers, it is generally agreed, are heterogeneous apart from their excessive alcohol consumption. Factors which contribute to the development of an alcoholic are biological, social and psychological. Nevertheless, "there may be specific personality characteristics which tend to be associated with problem drinking and which, while probably insufficient in themselves, by implication might make for a vulnerability or a predisposition toward an addictive pathology such as chronic inebriety, rather than toward a non-addictive pathology". (Worthington, 1977). Such specific personality characteristics have not been identified, but the following emerge as possibly supported personality correlates of male problem drinkers:

- pathological dependency conflicts predisposing towards reliance on external substances.
- impaired masculinity
- schizoid characteristics - alienation from interpersonal relationships.
- undifferentiated ego functioning - field dependency.
- intense aggression, poorly controlled, acting out facilitated by alcohol.
- defective ego characteristics - inadequate self-criticalness and self-management.
- tough, socially deviant, unconventional attitude - under-socialization (Op. cit., P. 48).

An idea that has emerged from survey investigations of drinking practices of populations is that many people who were once in trouble with their drinking are no longer experiencing that trouble when approached some time later. People move in and out of troubled drinking, which suggests that alcoholics are a proportion of the population defined only by a cutting point on a continuum. (Edwards, 1977).

Should we talk about "the alcoholic" at all? Chafetz (quoted in Worthington, op cit.) says

> any recognizable discomfort, disequilibrium, or dysfunction with alcohol is a symptom of a disturbed state. This contention has nothing to do with amount or excess - it even includes non-consumption .... if the mere thought of drinking alcohol produces discomfort or disequilibrium, then an alcohol problem exists. (P. 332).
>
> .... there is no such thing as an alcoholic. Just as there is no headache-ic, no fever-ic, no pain-ic, there is no alcoholic .... For too long we have been impaled upon the stereotype of "the alcoholic" and we have not dared to look below the surface. (P. 333)

Many people, including the alcoholic deep in denial, hold on to a stereotype

> ... the image of an unkempt, vagrant derelict, of an institutionalized prematurely demented female; of the hospital patient with a swollen abdomen due to cirrhosis, ascites and liver failure. It brands the person with the stigma of a self-inflicted disorder, of an inability to face up to social responsibilities from which he escapes by sedating his conscience with alcohol.
>
> The alcoholic is often viewed as a blatant liar, an offensive drunk, a violent, irresponsible creature, a con man or manipulator and an irritating social bore. He is a menace on the roads, an embarrassment to his family and an inefficient, irritable employee with a low level of frustration. (Santamaria, 1975).

In fact, he (or she) may be aged between 15 - 75, and not even recognized as an alcohol addict for years. After all, alcohol is socially approved and readily available as a means for reducing tension. He may be from any socio-economic level and engaged in any occupation, though certain ones have been associated with higher rates of alcoholism. According to Casswell's (1980) recent survey in New Zealand there is some degree of association between particular age, socio-economic and racial groups and heavy drinking (i.e. >60 mls of absolute alcohol per day for men, and >40 mls for women), but the latter occurs among many different groups. Professional women, men who are managers or who have degrees drink more heavily than others. An important finding is that in every demographic category there is a significant segment of heavy drinkers. Different drinking patterns exist among heavy users, e.g. for some large amounts are consumed relatively infrequently, while others consume smaller amounts often. Young men figure prominently in the former group, and they are over-represented in alcohol-related motor vehicle accidents (Bailey, 1981).

The family of the problem drinker endures disharmony, neglected children, inconsistent behaviour, unstable relationships, children with degrees of psychological disturbance, including nocturnal enuresis, and anxious spouses.

The drinker tends not to go to his general practitioner, nor to seek help at an early stage. With hindsight, he often says he was aware of his drinking being "different" from that of others. He is a member of society and shares the moralistic attitudes which label his problem as sin, vice, lack of moral fibre, lack of will-power, etc. His fear of the truth serves to increase his conflict and his drinking, and goes on to alcohol-induced behavioural abnormalities. In turn this leads to more anxiety, guilt, depression and isolation, until eventually cause and effect of drinking become one, completing a vicious circle. He is unable to make decisions about taking action on his own behalf as his behaviour and thinking are ruled by a chemical that distorts normal, rational processes. He does much talking without thinking as Esser (1961) notes.

On the other hand he may cling to the erroneous belief that he is still able to control his alcohol intake if his pattern is a periodic one with intervals of relatively "social" drinking.

If, and when, he does seek help, he may present with anxiety, depression, insomnia, physical complaints such as indigestion, rather than the real problem. He is likely to deny it if directly asked. He may come to the notice of a helping/social/medical agency via a suicide attempt, or with tension, fear of going mad, paranoid ideas, hallucinations or marital problems.

Often it is a family member other than the problem drinker who approaches the doctor, or a helping agency - again, the real problem may not surface, but rather complaints of "bad nerves", or economic hardship.

Drinking behaviour is often an insidious process, and there may be a progressive increase in frequency and consumption. The following detailed description gives a vivid picture of problem drinking. As such, it forms a backdrop for the investigation reported here. It has therefore been included in its entirety.

> Drinking occurs when it is unnecessary by social standards. Instead of enjoying and savouring his drinks, the alcoholic tends to gulp them. He begins to take several before going to social events. He starts asking himself, 'Where is the next drink coming from?'. He will plan his day so as to be near public houses when they are open, or arrange for other sources of supply. He will choose occupations which lend themselves to drinking. Without drink for any length of time he becomes miserable, irritable, restless, and feels unbearably tense. In time, he may develop 'the shakes' on waking in the morning and be unable to face the day, or work efficiently, without several drinks. By the time his drinking has reached this stage, he will justify and rationalize it. He says such things as 'It's for my sinuses', 'It's my indigestion', 'It's good for my circulation', 'My doctor told me I was anaemic' or other similar excuses. If he has not already done so, he will change to stronger beverages, and in time begins to be hazy after drinking bouts, and eventually he will experience the characteristic, so-called 'alcoholic blackouts'. In these, there is complete amnesia for the period of the drinking which may be for as little as one evening, or as long as several weeks. In the latter case, the patient may go on an extensive fugue. The episode may at times assume medico-legal importance because the alcoholic frequently appears 'normal', seldom 'drunk', in the amnesic period.
>
> He will start building up stores in various places and taking drink home on every available opportunity. He will go to greater and greater lengths to hide his stock of supplies. Instead of boasting about his ability to hold vast quantities of drink as he used to do, he will minimise to a ridiculous degree the amount he drinks. The 'dry'

> periods of the periodic drinker get shorter and shorter. Remorse follows each bout and he gives promises he cannot keep. His tolerance for alcohol diminishes and he neglects his food and his appearance. Concern for the welfare of the family fades, and may disappear altogether, and eventually the spouse may live in constant fear of not knowing what next to expect. The children may appear frightened, or show signs of anxiety or behaviour disorder, which, if left untreated, may lead to personality or dependence problems arising in the next generation, and so on. Wives frequently describe the personalities of their alcoholic husbands as 'like Jekyll and Hyde'. Aggressive outbursts are by no means constant features of alcoholism, but can be very prominent in some cases. Verbal aggression is more common than frank brutalisation. The patient's amiable social front is frequently in sharp contrast to his behaviour at home with the family. Eventually, he may get into debt and start pawning or selling his home. Petty crimes may start, leading to greater offences, but always with one aim in view: maintaining the source of supply. The majority of car-driving alcoholics often drive when seriously drunk. Indeed, this one aspect of behaviour may be an early diagnostic pointer to addiction. The craving outweighs all the possible physical and legal consequences, of which he is well aware. (James, Salter and Thomas, 1972, P. 15).

This profile describes Everyperson - the Problem Drinker, without whom this research would not have been undertaken.

S U M M A R Y

It can be seen that the behaviour of the problem drinker is very complex, which makes for both difficulty and variety in theory-building, and indicates the need to continue the search for relationships between theory and practice. As Wallace (1977) writes, "In actuality, the epistemological quandaries of the alcoholic himself are perfect mirror images of the quandaries that confront the thoughtful professional engaged in alcoholism treatment .... ". (P. 9)

In this thesis, both the alcoholic and the professional contribute to an understanding of the most profitable (and unprofitable) directions that treatment can take.

C H A P T E R 3

TREATMENT OF ALCOHOLISM

In the following pages, a discussion of the treatment of alcoholism is presented as a further part of the analysis of the stated problem. From the foregoing chapter it is obvious that there are a great many ways to approach the problem of alcoholism, "It would appear that with some, psyches are treated; with others, bodies; and with some, whole people are the focus of treatment efforts". (Einstein et al, 1970, P. 50)

I N T R O D U C T I O N

Relevant Assumptions

Assumptions concerning the treatment of alcoholism are still open to question, but some reasonable conclusions appear to be:

- little difference among remission rates for various treatment methods
- there may be as high as a 50 per cent rate of spontaneous remission
- intensive, costly therapeutic interventions do not appear to be any more effective in bringing about remission than do simpler, more economic approaches
- some alcoholics apparently become able to drink at moderate levels without getting into difficulty

Clare (1977) suggests that abstinence is not necessarily the most important outcome criterion. A finding that challenges

traditional views.

Treatment Outcomes

Much emphasis has been put on the success rates of treatment and much effort has been put into comparing the success rates of various treatment programmes and helping agencies, but it seems that success can be defined and measured in different ways. Baekeland et al (1975) report that spurious treatment outcomes have been reported in studies which, for example, have used a biased sample, and have failed to acknowledge a variable such as attrition rates. They state that Alcoholics Anonymous have claimed higher success rates than hospitals and clinics, but that the evidence suggests that Alcoholics Anonymous actually serve an entirely different population from thosecustomarily treated in hospitals and clinics.

These authors also claim that outcome differences have more to do with what the patient brings to treatment than what happens to him there. Useful predictors appear to be the patient's social stability, length of stay and participation in group therapy. Factors which are viewed by Baekeland et al (1975) and Smart (1978) as neither useful predictors nor important treatment variables are sex, employment status, type of drinker, length of drinking career, dry days in past year, treatment unit, type of medication received, the profession of principal therapist and the receipt of medical assessment.

Jacob's suggestion that patient perception is important in treatment outcome is in line with the work of Baekeland et al and Smart.

> The most specific suggestion in the literature of how patient involvement may be defined is that of eliciting the patient's perception of his situation - his clinical reality - and incorporating that perception into his plan of care .... practical implications because of its potential for influencing the outcomes of care. (Jacobs, 1980, P. 505)

Chapter 4 expands this concept of patient perception which is relevant and central to the research design.

ISSUES IN ALCOHOLISM TREATMENT

Inpatient versus Outpatient

The literature abounds with studies presenting arguments for a variety of treatment modalities. The author of an editorial in the British Journal of Addiction (1979) states "the alcoholic who would not come into hospital when offered admission was either cast into outer darkness or told to go away and think again". By contrast, in Holland, the emphasis is on out-patient consultation. It is questionable whether a preference for in-patient treatment rests on evidence of its efficacy or on traditional and historical processes. The suggestion is put forward that perhaps in-patient treatment, with its expensive resources (such as staff and space) is no longer justified. There is also the assumed status of "the treater as teacher and expert", and the inconvenience or social damage to the patient who is out of circulation for quite some time usually. The expectation of the drinker appears to be one of a willingness to become abstinent, although this is not explicit.

Minimal versus Intensive

Minimal treatment was apparently as effective as more intensive

treatment, at least after one year, (Edwards et al, 1977; Stinson et al, 1979). In addition, the point made by Edwards et al that the patient's view of things may be different from those of the treatment agency, is relevant to this thesis; Stinson et al recognized that a readier awareness of the patient's own report as to what helps in treatment is of value in the research process.

Position of Professionals

Einstein et al (1970) carried out a study to determine the positions held by various health professionals regarding the treatment of alcoholism. The major conclusion they drew from their pilot study was "that a variety of problem drinkers are generally perceived as being not so different from one another, and are treated by professionals who may or may not be trained in alcoholism, but who want to treat motivated problem drinkers who will abstain". (P. 67).

According to Zimberg (1978) mental health professionals, including physicians and psychiatrists, have been ineffective and have lost interest in attempting to treat alcoholics. This is not altogether unexpected since their training focusses on pathology, diagnosis and treatment. A lack of agreement on treatment outcomes, defined as successful, combined with lack of training in understanding the behaviour of problem drinkers often leads professionals to label alcoholism as untreatable. The illness/cure orientation of the treatment outcome of "total abstinence" supports this position.

Treatment versus No-treatment

In an extensive review of reports on the psychologically oriented treatment of alcoholism, Emrick (1974) concluded that once an alcoholic

decides to do something about his drinking and accepts help, he stands a good chance of improving. At the same time, he wondered whether:

- an alcoholic could increase his chances of improvement by having one treatment rather than another.
- the likelihood of improvement would be just as strong or stronger with no formal treatment.

In 1975 he found that treatment did seem to increase an alcoholic's likelihood of at least reducing his drinking problem, but took comfort to also find that many alcoholics improve without formal treatment.

Smith (1981) reports on a study of a treatment group and a control group who were not referred to a treatment centre after "drying out". The former long-term patients had more re-admissions to the drying-out centre and to the hospital as in-patients, and also appeared again sooner, than the others. In many cases, the difference, although not significant, was in favour of the control group.

Self-Support Groups....

The contribution of Alcoholics Anonymous, which for so long has been the only community agency working in the field, is commented on by a number of authors who take one of two conflicting positions. They view the contribution of Alcoholics Anonymous as:

- a cornerstone of the work of probably all alcoholic units, or the only effective form of treatment (Glatt, 1978; Zimberg, 1978)

or, they profess

. scepticism about claims made for it. (Baekeland et al, 1975; James et al, 1972)

The fellowship's recognition of alcoholism as a family illness is commended by Glatt (1978). Most professionals in the field consider it to be effective for many, but by no means all, problem drinkers.

.... Plus Family Therapy

Attempting to change the attitudes of relatives to more helpful ones is part of treatment, in which Al Anon can play a valuable role. Family therapy is becoming recognized as a necessary component of the alcoholism treatment process. (James et al, 1972; Flanzer et al, 1976; Bailey, 1961; Meeks and Kelly, 1970; Bowen, 1974; Drew et al, 1974; Dulfano, 1978; Fisch, 1976; Forrest, 1978; Baekeland et al, 1975).

Variety of Orientations

Heinemann (1974) notes the variety of differently oriented treatment facilities available, from detoxification units, extensions of these, vocational rehabilitation, social rehabilitation, a religious orientation that requires the person to be a penitent, a medical orientation expects acceptance of the patient role, a corrective orientation requires an inmate, and in a family orientation he is a relative.

There are problems associated with concentrating exclusively on the drinking behaviour while neglecting the vocational functions,

physical health, social relationships, emotional and psychological functioning, or only on the psychological processes, family therapy and physical health, leaving out the drinking behaviour. Pattison (1980) also suggests that there needs to be improvement in matching the patient with the optimal treatment modality. The effectiveness of treatment is determined more by the person's involvement and willingness to participate than by the specific treatment offered. Another key factor is help with the transition back into the community.

Multi-disciplinary Teams

Most alcoholics still go untreated or are inadequately treated says Rathod (1977). The numbers who drop out, relapse or are rejected exceed those who achieve or sustain the goals of treatment. Many are missed or misdiagnosed in the early stages, and it is not acceptable that therapists collude in such ignorance (failure to relate insomnia, or a spouse's depression, to drinking). Greater awareness is needed that drinking is a possible cause of a wide variety of commonly presented symptoms.

There is a need for free communication and constructive action among multidisciplinary teams. There can be disadvantages for the patient when one particular treatment modality is uncritically over-emphasized e.g. group psychotherapy, or in-patient treatment, or where therapists fail to take advantage of others' experience and research evidence to guide patients towards appropriate help. A therapeutic relationship depends very much on the crucial first interview, and the onus here is more on the therapist than on the patient. Associated is the perception by both of labels such as

"alcoholism" and "illness", which requires at least an exploration of the patient's point of view.

Spontaneous Recovery

This aspect is included as, although it may be regarded as an extension of "treatment versus no treatment", it is not the same. Smart (1975/76) reviewed spontaneous recovery in alcoholics but made no clear statements. Possible reasons for the failure of alcoholics to apply for treatment are their perception that prognosis is good or that their symptoms are controllable. Where spontaneous recovery does occur reasons may be changes in health, jobs, relationships and residence. A 33 per cent recovery rate has been found in alcoholics being treated for physical illness as a consequence of drinking. In 1966 Kendall and Staton produced evidence suggesting that recovery rates with and without treatment may be very close, but theirs was not an experimental study with matched treated and untreated groups. A relevant but often neglected factor to be considered in investigating spontaneous recovery is that of informal "treatment" by friends, relatives, A.A. members.

Psycho-therapeutic Methods

A proposal for the use of psychotherapeutic techniques specific to the disease of alcoholism is made by Wallace (1978). These consist of making strategic choices among multiple hazardous alternatives:

denial	versus	premature self-disclosure
guilt	versus	sociopathy
self-blame	versus	blaming others
rebellion	versus	compliance
acting-out	versus	repression
obsession with past	versus	refusal to consider it
indiscriminate dependency	versus	stubborn independence
compulsive socializing	versus	alienation
perfectionism	versus	inferiority
self-obsession	versus	obsession with others
pessimist	versus	Pollyanna

He discusses the hidden dangers at each choice-point and indicates the most reasonable compromises among these "Scyllas and Charybdises", as he calls them.

PSYCHODYNAMICS OF ALCOHOLISM

Some detail is now included in presenting Zimberg's (1978) model as it is central to the design of the research in this study. The model sets out the psychodynamics of alcoholism, and indicates possible intervention points for approaches to treatment. (Figure 3.1).

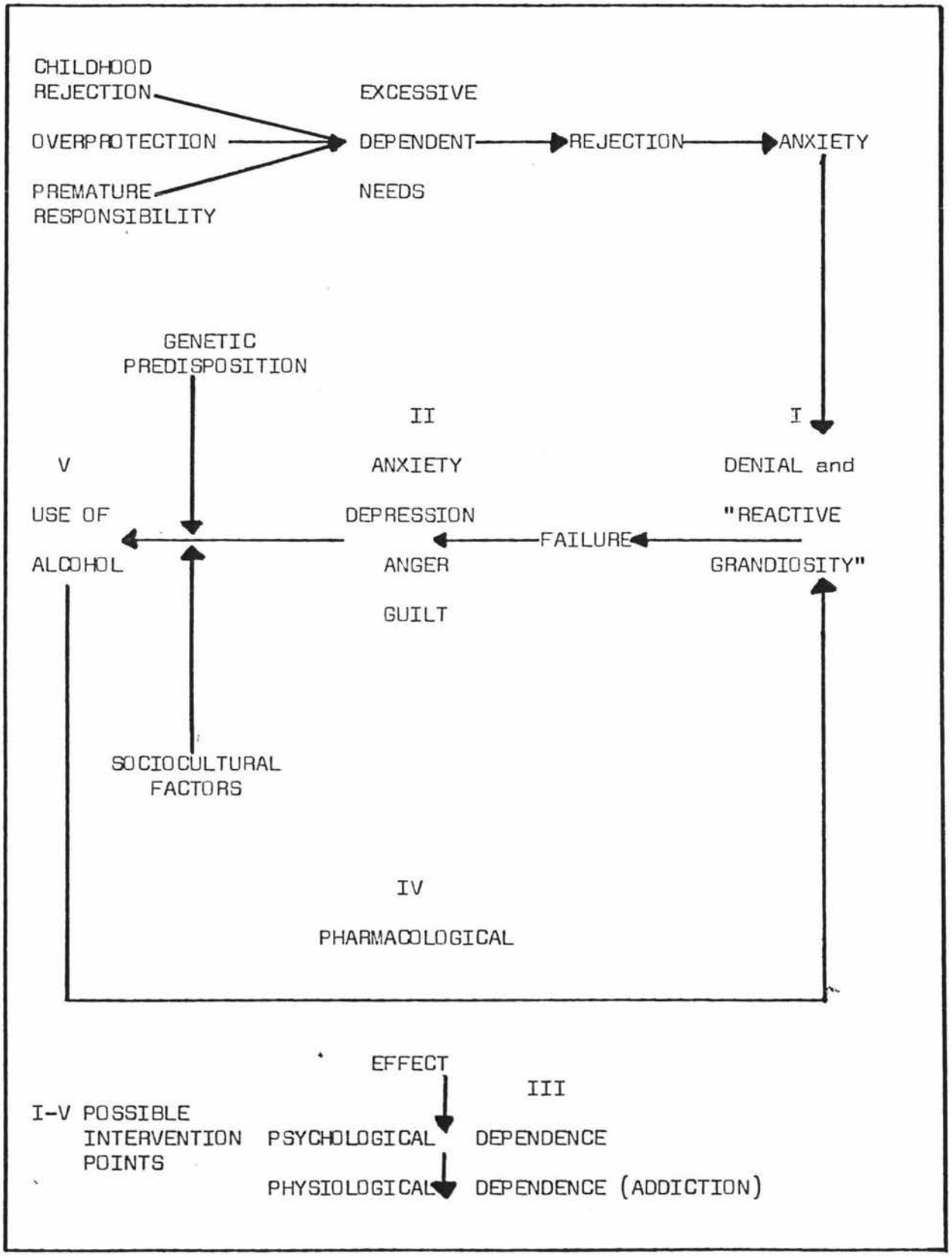

Figure 3.1: Paradigm of the Psychodynamics of Alcoholism

In Figure 3.1 the intervention points represent:

I. the therapist working backwards from the defences to uncover the underlying psychological conflicts.

II. the use of mood-altering drugs which might reduce the need to use alcohol to reduce dysphoric feelings.

III. the use of drugs or other modalities that would change the effect of alcohol on the brain and reduce craving, lessen the pleasant effect of alcohol, and/or reduce the degree of physiological dependence.

IV. the interception of pleasurable feelings associated with drinking which become repetitively reinforced and lead to alcoholism.

V. the elimination of the use of alcohol by directive approaches and by helping the alcoholic learn to live without alcohol in the face of stress and unpleasant feelings i.e. psychotherapy.

Zimberg suggests that the future of alcoholism treatment is probably represented at the third point. Intervention here proposes the use of some modality (such as drugs) that would alter the effect of alcohol on the brain and result in a reduced craving for alcohol, a lessening of its pleasant effects, and/or a reduction in the degree of physiological dependence. The tools are not yet discovered. The current approach to alcoholism psychotherapy is at the fifth point, and involves abstinence on the part of the problem drinker together with helping him to learn to live without alcohol in the face of stress and unpleasant feelings. Insight into underlying psychological conflicts, at point I, fails to overcome the pharmacological effects of alcohol and may cause further anxiety and need to drink. Other mood-altering drugs have proved useful for only a small subpopulation who probably did not have primary alcoholism - point II. Intervention at the fourth point aims at interrupting the pleasurable feelings associated with taking in alcohol, but the

results of research in this area are equivocal. Some authors report considerable success in aversive conditioning with electric shocks to enable alcoholics to discriminate their blood alcohol levels and control their drinking (Lovibond and Caddy, 1970, cited in Zimberg 1978). Others, using a similar approach, report relapse of the subjects into loss-of-control drinking during the 27 - 55 month follow-up period. (Ewing and Rouse, 1976, cited in Zimberg, 1978). Zimberg explains further.

> Childhood rejection, over-protection, or premature responsibility leads to an unconscious need for nurturance which cannot be met in reality and results in rejection. The rejection leads to anxiety which in turn leads to the development of a number of defence mechanisms, particularly denial, and a compensatory need for grandiosity. The grandiosity causes such individuals to try harder and results in inevitable failure. The failures lead to more anxiety, depression, anger, and guilt. The unpleasant effects can be reduced by alcohol, at least for a time, and lead to the pharmacologically induced feelings of power and omnipotence, thus reinforcing the denial and reactive grandiosity.
>
> An individual with such a psychological conflict will become an alcoholic if there is a genetic predisposition to alcoholism and if he lives in a society in which the use of alcohol is sanctioned as a way to feel better or in which there is considerable ambivalence regarding the use of alcohol. In any particular individual, one or more of these etiological factors may predominate and lead to alcoholism. (Pp 5 - 6).

The central task is to break through the reactive grandiosity that produces the massive denial of profound feelings of inferiority and dependency that allow the self-destructive drinking pattern to continue. The principles involved are listed in Table 3.1.

Table 3.1: Principles of Psychotherapy with Alcoholics

PRINCIPLES OF PSYCHOTHERAPY WITH ALCOHOLICS
1. Direct intervention in relation to drinking. 2. Transference: intensely ambivalent; testing; denial and grandiosity. 3. Countertransference: intense feelings of frustration and anger; therapist's need for omnipotence. 4. Support and redirect various defences rather than attempt to remove. 5. Look for therapeutic leverage, (i.e. utilization and understanding of social, family and economic circumstances). 6. Therapy carried out in stages designed to achieve control over impulse to drink.

(Zimberg, 1978, P. 13).

Zimberg points out that Alcoholics Anonymous, being based on an intuitive understanding of the alcoholic's psychological conflict and needs, is successful in directing the grandiosity to fulfilment in social usefulness and meeting of dependency needs in the Alcoholics Anonymous group.

S U M M A R Y

In this chapter a wide range of treatment issues are discussed. Zimberg's (1978) psychodynamic model and principles of psychotherapy with alcoholics are described in detail as they are central to the development of the research design.

Chapter 4 discusses therapist behaviour, in particular that of the nurse therapist.

CHAPTER 4

THE NURSE, THE PROBLEM DRINKER AND HELPING BEHAVIOUR

INTRODUCTION

As many problem drinkers have no formal treatment, contact with a nurse may provide the only context with any potential for helpful intervention. In the previous chapter it appears that the problem drinker's improvement largely depends on the person himself. The author suggests that treatment outcome also has to do with the helping behaviour of therapists. This chapter discusses helping behaviour in relation to nurses' attitudes to problem drinkers, motivation and the nurse-patient relationship.

HELPING AS A PROCESS

Helping means behaving in ways that assist out of a difficulty; remedy a situation; sometimes preventing something; at other times refraining from doing something. Synonyms for helping include encouraging, supporting, restoring, serving, and healing.[1] A suggested antonym is aggravating, therefore behaving in ways that may be detrimental is not helping.

As Edwards (1979) points out, a wide variety of persons may be engaged in helpfully responding to the disordered problem drinker, and delivery of help may be achieved in a variety of different ways.

1. The Nuttall Dictionary of English Synonyms and Antonyms, London: Frederick Warne and Co. Ltd: 1975

He suggests a three-level helping process. These levels are modelling by the community, helping by the non-specialist agency, and caring by specialists.

Modelling by the Community

Society has well-developed folkways for teaching people what is, and what is not, acceptable drinking. Different societies model more or less successfully. Problem drinkers who recover in a relatively short time, without formal intervention, are the people who respond to the informal sanctions of their community. The term "first-line help" describes this kind of community response, which may well encompass the role of the helping agency. Edwards (1979) points out that teaching the community how to deal with the person who is using alcohol in a dangerous way does not mean conveying the message that everyone who drinks too much has to be referred to the specialist. Such teaching would undermine the community's firstline helping response "when the proper aim should be to maximise the efficiency of that response". (P. 244).

Helping by the Non-Specialist Agency

A proportion of problem drinkers are in contact with some type of non-specialist agency, such as the court. While there is no evidence that the help offered is less effective than at specialist treatment centres it is reasonable to suppose that, unaided, the courts are not entirely appropriate. Edwards suggests that specialist and non-specialist agencies work more closely together.

Caring by Specialists

There is continuing need for specialised care, but the actual setting may be the community centre concerned with the integration, activation and support of those who help the alcoholic. The specialist is someone who aids the setting up and ongoing function of facilities for responding to a wide range of drinking patterns. The community itself is such a facility.

Such a process is about prevention as well as treatment. Although the nurse functions at all three levels, in this study the focus is on the nurse as a non-specialist helper, rather than as a professional with special training in the treatment of problem drinkers. (Refer to the Glossary for definition of nurse and non-specialist helper).

HELPING BEHAVIOUR AND MOTIVATION

The author has defined helping behaviour as interaction, based on trust and effective communication, which facilitates a change in life style (Glossary). The nurse is seen as a practitioner of helping behaviour in the context of the helping process described earlier in this chapter. This section examines motivation as a facet of helping behaviour in nursing care associated with problem drinkers.

The Problem Drinker and Motivation

Much importance has been attributed to motivation, or lack of it, on the part of the problem drinker. People who respond to the variety of processes which occur within treatment institutions are

said to be well motivated, whereas those who do notrespond are labelled poorly motivated. (Edwards, 1979; Sterne and Pitman, 1965; Crawford, 1976; Clare, 1977; Craig, 1979). The generally accepted notion appears to be that only those problem drinkers who enter treatment fully motivated can be helped (Glatt, 1978). Numbers of alcoholics are rejected, drop out, or relapse following treatment. A popular alibi used to excuse such shortcomings is not being motivated for treatment (Rathod, 1977). It seems easier to blame the patient than to take a more constructive approach (Ferneau and Morton, 1968).

An assumption exists that for treatment to succeed the alcoholic must already want to change his drinking behaviour. There is more concern over the patient's motivation to recover in alcoholism than in any other illness. (Sterne and Pitman, 1965). Other conditions do not usually apply such reservations to acceptance as clients. The possibility of health and welfare personnel themselves enhancing the alcoholic's motivation for sobriety does not seem to be considered. "The motivation concept, as frequently applied to alcoholics, serves as a convenient rationale for unwillingness to review and modify current policies and practices so as to encourage the alcoholic to seek treatment and stay with it". (P. 56). The dismissal of a large proportion of problem drinkers as unmotivated is termed an abdication of professional responsibility by Plaut (1967).

Motivation Defined

A broad spectrum of views on the concept of motivation is observed by Rossi and Filstead (1976). These range from a "narrow

intrapsychic emphasis" to a "broad processual view of human conduct" that is affected meaningfully by overall social contingencies, both in and out of treatment. The narrow version explains failure in treatment as inadequate motivation on the part of the patient i.e. motivation equals acceptance of alcoholism, and vice versa. The dynamic version links well with the definition used by Moon.

Moon (1979) comments that motivation is a vexed word, "particularly in psychological parlance" (P. 35), but defines it as

> a desire to change sufficient to ensure action toward desired goals.

Motivation and the Helper

Rossi and Filstead (1976) suggest that the therapist has an initial responsibility to induce the patient's acceptance of help, and that "meeting the patient where he is is dealing with what he is motivated for" (P. 207). Innovations in therapeutic options have shown consistently that alcoholics formerly thought to be unreachable have been reached and helped. For this to occur, the important factors are meeting patients in the time of crisis; assessing patients' individual needs; and preparing for continued support after the crisis has passed. The writers provide examples to show that the therapist assumes a motivating responsibility and that this can have beneficial and therapeutic effects.

THE NURSE-PATIENT RELATIONSHIP

Burkhalter (1975) states that the nurse is often the first member of a helping profession with whom the problem drinker comes in contact.

This may be in a general hospital setting or that of a multidisciplinary alcoholism treatment team. The encounter may involve an in-depth interview or be very brief.

This position is supported by Cornish and Miller (1976) who state that the registered nurse is usually the first member of the treatment team to be involved with a newly admitted alcoholic. Acres (1977) sees the practice nurse in the primary health care team as one of the principal participants in prevention and treatment of alcohol problems. In Fortin's (1980) study student nurses initiated contact with patients in the detoxification unit, and followed them throughout treatment and into the community. At the McKinnon unit in Sydney patients are seen on arrival, by a nurse "who welcomes the patient and arranges admission by mutual agreement" (Wilmot, 1975, P. 23). Mueller (1974) asserts that the nurse is in a unique position, when she sees the physically and psychologically suffering alcoholic, for demonstrating warmth, concern and knowledgeable understanding.

The attitude component of nursing behaviour in any situation is important because of its potential facilitative or detrimental effects. Mueller and Schwardtfeger (1974) use a simple criterion to evaluate attitude - is it helping or hindering in the fulfilment of the role? From the discussion on the helping behaviour of professional in Chapter 3 it appears that the first contact is crucial, and that the initiation of a therapeutic relationship is associated with some allowance for expression of the client's point of view, an important focus in this study.

The literature indicates that nurses' attitudes are generally not facilitative in the overall treatment of problem drinkers. Nurses are noticeably more moralistic about alcoholism than doctors or social workers. (Sterne and Pitman, 1965). Nurses and nursing assistants hold inconsistent attitudes, reflecting a fairly frequent finding that a moralistic approach varies inversely with professionalization. Nurses tend to believe that alcoholism is an illness, but both groups also tend to view the alcoholic as "weak-willed". (Ferneau and Morton, 1968). The apparent inability of nurses to function as members of a therapeutic team when dealing with alcoholic patients is seen as a phenomenon caused by an "alcoholic prejudice". Some helping professionals reject the alcoholic individual in spite of the reasonable assumption that if alcoholism is considered to be an illness the alcoholic is a readily acceptable person. Schmid and Schmid (1973) report that nurses' attitudes towards physically disabled persons match those of the norm professional group but that they are less accepting of alcoholic persons than of physically disabled persons. These attitudes remained stable through $2\frac{1}{2}$ years. Cornish and Miller (1976) describe the results of a study in which the negative results were overwhelming, and they suggested that there was a rather pervasive negative halo effect, as registered nurses look upon the alcoholic in a highly unfavourable light.

As an occupational health nurse in an alcohol addiction treatment programme Millsap (1972) reports her own change of attitude. She admits to having been affected by the fears, prejudices and other, often unrecognized and unconscious negative feelings that cause ineffectiveness in the treatment situation. She observes that when the sick person comes to the health service the conversation of the nurse must be

"therapeutic", that "the interview must help move the person with the health problem one step further toward healthy living" (P. 127). A study by Craig (1979) substantiates Millsap's view. Craig reports the development of negative attitudes to alcoholic patients over time. He asserts, however, that this trend can be reversed in the same staff members.

The researcher corresponded with Ann Williams, Clinical Nurse Specialist at East Orange General Hospital, New Jersey, and author of "The Student and the Alcoholic Patient" (Nursing Outlook Vol.27 No. 7, 1979, 470 - 472) whose letter, with her permission, is included in Appendix M). Attention is drawn to her comment ".... Lack of recognition of alcoholism as a nursing concern is indeed an international problem". She carried out a study with recovering alcoholics in Alcoholics Anonymous. Her questionnaire concerns which attitudes or actions of nurses, in any setting, Alcoholics Anonymous members encounter that encourage them to seek recovery. The nursing actions she identifies are psycho-social skills rather than physical tasks. They involve listening skills, the ability to empathise with the patient, and the ability to project hope. In this study, Williams showed that positive perception by the patient assists in the development of positive attitudes in the nurses and stimulated their ability to provide helping nursing actions.

Ambivalent attitudes by the public and professionals have been a major barrier to the development of adequate services for persons with drinking problems, according to Plaut (1967). Rathod (1977) asserts that patients who question, e.g. alcoholics, get labelled unco-operative, unmotivated and lacking in insight. "It is our own attitudes that have

gone awry and need mending". (P. 312).

There is a large body of international literature which confirms the negative attitudes and behaviour of nurses, doctors and other health professionals to problem drinkers. Most researchers believe the attitudes of doctors are not unusual but merely reflect the attitudes of society as a whole. Crawford (1976) mentions the over-sensitiveness of alcoholics which leads them to be quick to pick up antipathy, and asks doctors to be aware of their harsh attitudes towards problem drinkers. The author of the study presented in this thesis has formed similar impressions about the effect of nurse attitudes on problem drinkers.

The Nurse as Counsellor

Effective treatment or counselling requires a positive attitude toward the alcoholic and alcoholism. Nurses tend to avoid mentioning the subject of alcohol to patients even when there is ample evidence that it is the major problem. As the nurse usually spends more time with the patient than anyone else in the health team she is "frequently in the best position to begin the process of motivating the patient toward recovery". (Mueller and Schwardtfeger, 1974, P. 28). The setting may allow a few minutes only, or quite some time, for counselling. The nurse's characteristics determine the individual approach, but "Five C's of counselling" that are productive and helpful are suggested, in Table 4.1. The potential for influencing the alcoholic patient's life is there if nurses are willing to tap it and to apply the factors which enhance it. These are ascribed positive qualities such as friendliness; knowledge; competence; ability to ease

pain; opportunity to spend more time with patients than other professionals; and being there when the patient is hurting and more amenable to looking at the cause and treatment of the hurt. The qualities described are relevant to the research design. The author points out that the responses elicited in the course of the research are closely linked with those described above. (Chapter 6).

Table 4.1: The Five C's of Counselling

Contact:	acquiring and extending diagnostic skills.
Concern:	getting alongside the patient.
Communication:	making the connection between alcohol and problems being experienced and treated.
Confrontation:	a therapeutic tool when used honestly and constructively to emphasize reality and point out discrepancies.
Community:	referral to treatment, supportive, and follow-up agencies.

(Mueller and Schwardtfeger, 1974).

Nurses can help the person to achieve a change of life-style. Messages that a nurse can convey include alcoholism is an important illness; talking about it communicates concern; behaving in a manner which conveys respect that here is a human being of worth; encouraging him that he has the ability to overcome expected difficulties; indicating that there are people to help him achieve his goals, and that there is hope to get well. Hope is what makes man act, move and achieve; the essence of motivation. (Heinemann, 1974). The giving of a modicum of hope via someone who is interested in the person and his future

contributes to improvement in both in-patient and out-patient treatment. (Baekeland et al, 1975).

Just like any other person, the person who has alcohol problems wants to be understood. He looks for genuineness in a relationship, acceptance as a worthwhile human being, a person who needs help in overcoming an illness. Two responses from a study, in which Heinemann (1974) asked alcoholic patients what they thought nurses could have done to be of help in their recovery, illustrate this. They are:

> There's been a period of four years now that I haven't known what was wrong with me. If they had told me at that time it was due to alcohol, it would have relieved my mind so much.
>
> I believe both doctors and nurses could have stressed alcoholism while I was in the hospital. But they don't do it. They more or less concentrate on your ailments other than your alcoholism. (P. 36).

A nurse may be able to be of great help if she is convinced that the alcoholic is a sick person. For then she is able to approach him as she does any other sick person. She is able to discuss his illness with him, to help him overcome his loneliness and to deal with his guilt. "She will transmit to him that there is hope for recovery, and should the patient suffer relapses of the illness, she views them as such and proceeds to use her skills and knowledge to help the patient through this crisis and to continue planning for his future". (Heinemann, 1974, P. 38). However, one drawback to this approach is that it leads the nurse to expect total cure (abstinence) as the only acceptable outcome. (Refer P.41 Ch. 3).

Personal Characteristics of the Nurse Counsellor

Potential for the enhancement of the therapeutic process lies in the personal characteristics of the counsellor. Qualities found to be facilitative are empathy, non-possessive warmth, genuineness,

flexibility, and the capacity to make treatment decisions about client's needs without being judgemental. Truax and Carkhuff (1967), who describe these personal characteristics, prefer the term client for the person being helped. They point out that the frequently used term patient creates the image of a person who is passive, being acted upon by the doctor, and who can help himself only by taking medicine and following medical prescriptions. Although client implies the purchasing of services and therefore still lacks the essential interpersonal meaning inherent in the therapeutic relationship, it is an improvement. To simply use the word person is too confusing.

A great deal of evaluative and developmental work is being done on the role of the nurse as therapist in a variety of settings. Awareness of one's own personal identity and interpersonal style assist in deciding upon options for rehabilitation in each individual case, and in functioning as a change agent in working with people. (Clarke, 1978). Nurses who work with alcoholics usually develop personalized approaches that are both effective in achieving therapeutic goals and comfortable for them. The nurse experiences personal growth and development just as the problem drinker does. The experience is sometimes unpleasant, but it is also rewarding and fulfilling. (Burkhalter, 1975).

Towards a Relationship

When the nurse and the problem drinker each perceives the other as a unique human being a relationship is possible. The humanity of each can be reached. Travelbee (1971) states that the task of the professional nurse is to establish a human-to-human relationship. Such a relationship has the characteristics outlined in Table 4.2.

Table 4.2: Characteristics of a Human-to-Human Relationship

An experience, or series of experiences, between a nurse and the recipient(s) of her care, in which the individual needs of the individual, family, group, etc, are met.

The experiences are of a mutually significant kind.

Significance and meaning derive from the relationship because both recipient and helper have needs met.

The human-to-human relationship is a reciprocal process.

The process functions by open disclosure.

Potential barriers of title, position, status must be transcended.

There is no place for stereotyping in the relationship.

Consistent and unconditional meeting of the recipient's needs, for this is what makes the relationship different from a purely social one, a mere association.

Participants perceive and respond to the human-ness of each other, which means that:

- each one's view of the other is real and true.
- each perceives the other as he is - a unique and entirely different human being.

(Travelbee, 1971)

Patient involvement, or practice in a patient-centred way (as implied by Travelbee (1971); Truax and Carkhuff, (1967); Rogers, (1961) means

- comprehensive assessment of the person's own analysis of his needs;
- establishment of goals which represent the person's aspirations;

- concurrent evaluation of nursing actions designed to promote the person's own efforts toward health-sustaining behaviour;

- the nursing process, dependent on the person as an active participant, promotes user satisfaction and a personalized, individual approach.

What is important, apparently, is the human relationship between ... and the patient. The personal encounter or .... the "existential communication" seems to matter. "The warm, subjective encounter of two persons", Carl R. Rogers says,

> is more effective in facilitating change than is the most precise set of techniques growing out of learning theory or operant conditioning.

In another place, Rogers states:

> Personality change is initiated by attitudes which exist in the therapist, rather than primarily by his knowledge, his theories, or his techniques. It may be a new way of experiencing, experiencing in a more immediate, more fluid way, with more acceptance which is the essential characteristic of therapeutic change, rather than, for example, the gaining of insight or the working through of the transference relationship, or the change in the self-concept. (Frankl, 1967, P. 78).

Perhaps the main problem with nursing practice in the alcoholism field is that the patient-as-consumer role conflicts with the traditional sociologic sick role in which patients are seen as passive recipients (Jacobs, 1980).

Brysson Whyte states:

> It takes some nurses a long time to learn that the foundation of all nursing is the relationship between nurse and patient, and even longer to learn that something which seems as natural as listening and talking can in fact be the technique by which the foundations of the relationship can be laid.
>
> (quoted by Dunn, 1980, Editorial).

S U M M A R Y

In this chapter the helping process in relation to the problem drinker is described. Relevant helping behaviour is discussed in relation to motivation and nurse-patient interaction.

Three major themes emerge from this review of the literature:

1. nurses are increasingly involved in alcoholism management.
2. very little work has been done to determine what behaviour by alcoholism management team members, in particular nurses, is actually perceived as helpful by problem drinkers;
3. the management of people with alcohol problems has more to do with what is considered desirable by those providing the helping service than what is experienced as helpful by the users of the service.

P R O P O S I T I O N

The following proposition has been derived from the literature review.

There are differences between the non-specialist helper nurse and the problem drinker in their perception of helpful and unhelpful behaviour in the management of alcohol-related problems.

C H A P T E R 5

DESIGN, METHODOLOGY AND PROCEDURE

DESIGN OF THE STUDY

This study is designed to identify similarities and differences in helpful and unhelpful behaviour as perceived by providers and users of care. Figure 5.1 demonstrates a flow chart of the sequences of events in the project. The design was prompted by the predominantly idiographic direction of nursing research at present (Diers, 1979). The research process in this study is located at the situation describing level of inquiry, the discovery of relationships.

The aim of nursing research is to improve clinical judgment, by a process which combines both art and science "to arrive at decisions about how, when, where, with what means, why and toward what end any nursing act is done". (Diers, 1979, P. 31). As a practice profession, nursing exists to bring about change in the real world. Relating factors and concepts, as in this kind of descriptive theory, leads to improvements in nursing practice.

M E T H O D O L O G Y

A variety of instruments have been used to collect data.

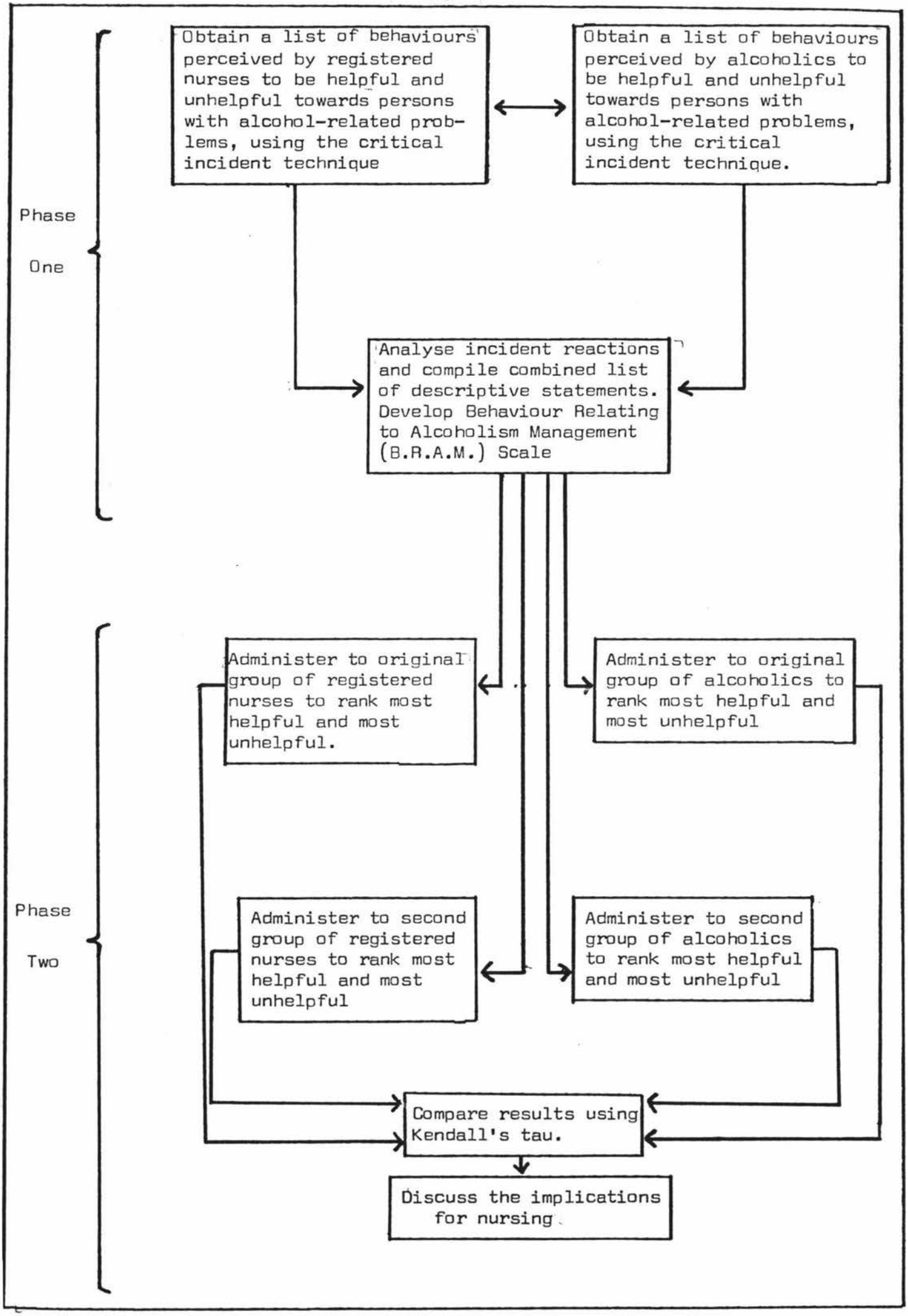

Figure 5.1: Flow Chart of Study Design

Biographical Data

Two questionnaires have been used. One was used for registered nurses and the other for Alcoholics Anonymous members. Copies of these are to be found in Appendices G, G1 and G3. The questions have been designed to elicit information about age, sex, qualifications and experience on the part of registered nurses. For the Alcoholics Anonymous members the information being sought was about age, sex, occupation and length of sobriety.

Perceptual Data

There were two phases in the collection of perceptual data. (Refer to Figure 5.1). In Phase One lists of helpful and unhelpful behaviours were obtained, using the critical incident technique. (Appendices G2 and G4). In Phase Two the B.R.A.M. Scale was administered to registered nurses and Alcoholics Anonymous member subjects. (Appendices I1 and I2).

Critical Incidents

For the purposes of this study definitions of the term incident and critical incident employed were:

Incident:

> An observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act.

Critical Incident:

> Extreme behaviour, either outstandingly effective or ineffective with respect to attaining the general aims of the activity. (Flanagan, 1954).

The critical incident technique is a procedure for collecting a comprehensive list of observed behaviours from those in the best position to make the necessary observations and evaluations. The two basic principles of this flexible technique are summarized by Flanagan (1954), who developed it:

> a. reporting of facts regarding behaviour is preferable to the collection of interpretations, ratings and opinions based on general impressions;
>
> b. reporting should be limited to those behaviours which, according to competent observers, make a significant contribution to the activity. (P. 355).

Competent or qualified observers are those who, by virtue of their position, are able to make judicious appraisal concerning the effects of the observed behaviour. Thus, when focusing on nursing behaviours, such observers would include patients, nurses practising in the area of the activity being observed, charge nurses and nurse tutors familiar with the goals of nursing activites in that area, and doctors involved in conjoint care. The aim of using qualified observers is to achieve a high level of objectivity.

The critical incident technique was developed by Flanagan through research procedures during World War II used to explicate methods for selections and classification of air crews. The technique has proved particularly pertinent to the job characteristics aspect of occupational research, and has been used to study the behaviour

of nurses. (Bailey, 1956; Gorham, 1963; Corry, 1976; Clamp, 1980). Clamp's (1980) work shows that the effects of care on patients can be seen by examination of vignettes of the daily work of the nurse, and the technique has the advantage of providing a "sharply focused description in which opinions, generalisations and personal judgements are reduced to a minimum". (P. 1756).

There is no simple answer to the question of the number of incidents required, according to Flanagan (1954). He suggests 50 - 100 incidents for a relatively simple activity; 1,000 - 2,000 for semi-skilled and skilled jobs; and 2,000 - 4,000 for those of a supervisory nature. A large number is likely to yield more stable results. (Bailey, 1956).*

Critical incidents may be acquired through the use of questionnaires and/or partially structured interviews. The latter may be conducted on an individual basis or in groups. (Flanagan, 1954; Bailey, 1956; Gorham, 1963). The technique is often used to collect data on previously made observations which are described from memory. When the reported incidents are fairly recent and the observers were moved to give detailed attention to the incident at the time this is usually satisfactory. However, there are some situations in which ample compass requires inclusion of other than very recent incidents.

In this study questionnaires were administered to 27 registered nurse subjects (Appendix G2) and 12 Alcoholics Anonymous member subjects (Appendix G4) as shown in Phase One in Figure 5.1. The instrument was designed to elicit incidents, from a small group of subjects, of helpful and unhelpful behaviour of nurses towards problem drinkers.

Behaviour Relating to Alcoholism Management (B.R.A.M.) Scale

This scale was developed, in the course of this research, for administration to groups of registered nurses and Alcoholics Anonymous members. Its purpose is to identify similarities and differences in helpful and unhelpful behaviour of nurses as perceived by providers and by users of care.

The B.R.A.M. Scale has been developed from the critical incident reactions of registered nurses and Alcoholics Anonymous members. The analytical process is shown in Figure 5.2.

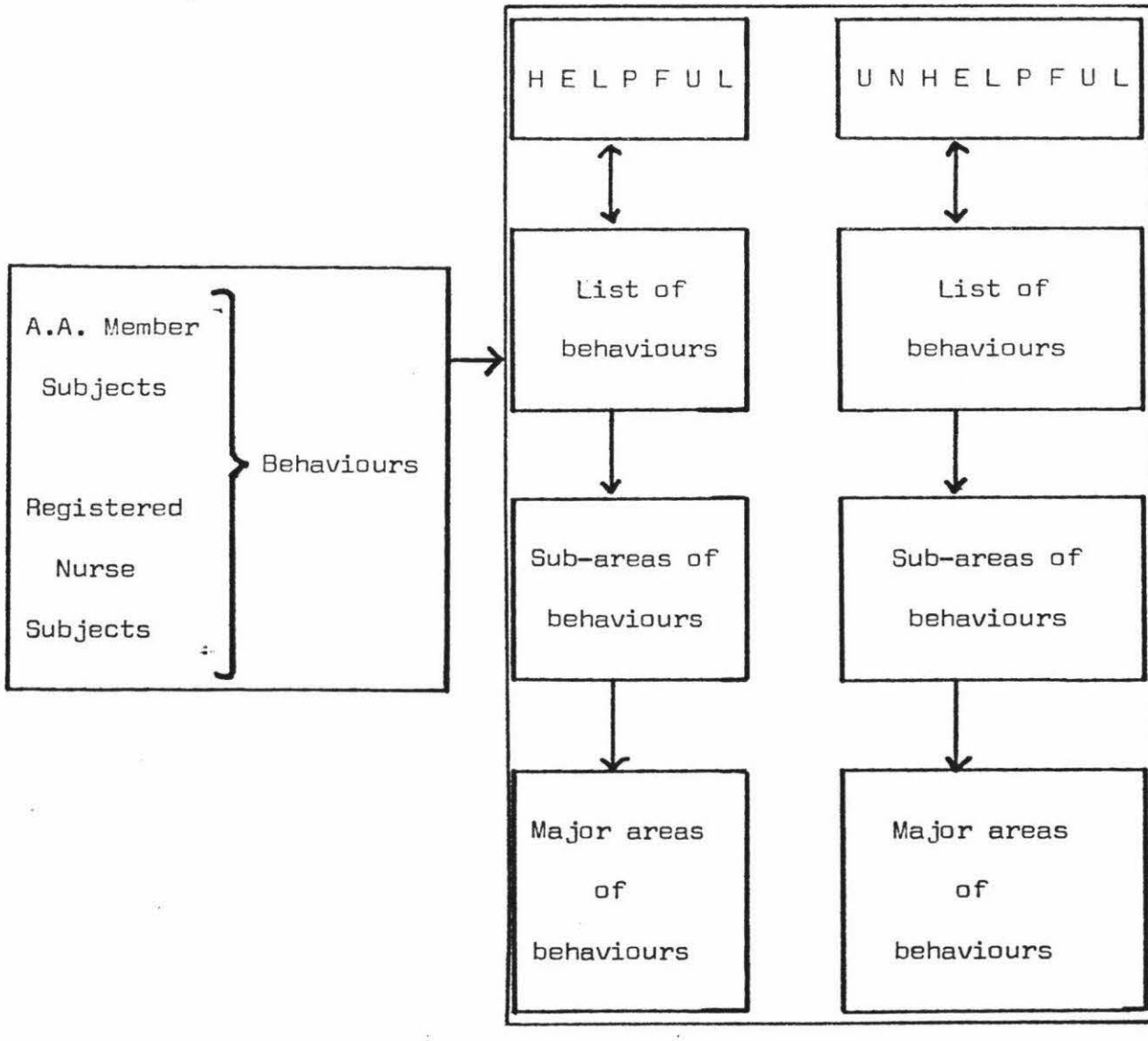

Figure 5.2: Flow Chart of Incident Reaction Analysis

From the major areas of behaviours shown in Figure 5.2 two lists of behavioural items were compiled. List One is composed of items of helpful behaviour, and List Two is composed of items of unhelpful behaviour, reported by the subjects. The B.R.A.M. Scale is included as Table 5.5.

Early Analysis of Helpful Behaviours

From 22 usable incident reactions reported by registered nurses the total number of helpful behaviours analysed is shown in Table 5.1.

Table 5.1: Method for Ascertaining Total Number of Helpful Behaviours Reported by Registered Nurses

Number of Critical Incident Reactions	Number of Helpful Behaviours in Each	Total Number of Behaviours
6	1	6
3	2	6
5	3	15
4	4	16
2	5	10
-	6	-
1	7	7
1	8	8
22	Totals	68

Thus 68 behaviours were analysed from 27 returned questionnaires, which is a response rate of 65.85%. Examples of the method used are given.

> A nurse who sat with a patient who was in an intoxicated state on admission / and just talked to him about his behaviour when he had been drunk and told him how abusive he had been to her when he had been admitted.

She wasn't judgemental just honest with him. (two behaviours, broken down by the stroke /).

Early noting of signs of D.T.s by nurse / and medication commenced early / prevented any complications due to drinking problem. (three behaviours).

From 11 usable incident reactions reported by A.A. members the total number of helpful behaviours analysed is shown in Table 5.2.

Table 5.2: Method for Ascertaining Total Number of Helpful Behaviours Reported by A.A. Members

Number of Critical Incident Reactions	Number of Helpful Behaviours in Each	Total Number of Behaviours
2	1	2
3	2	6
3	3	9
1	4	4
11	Totals	21

A total of 21 behaviours were analysed from 12 returned questionnaires, which is a response rate of 54.55%. The same method was used as for registered nurses.

Staff or Senior Nurses who wish me to give up smoking. Agree giving up drinking comes first with the hope of Non Smoking as a follow up / Many a nurse I spoke to gave Me Hope for a Better Future. /

This would involve about 5 Nurses. (2 behaviours).

Two Examples of unusable incident reactions are given.

This doesn't apply as I had sobriety for many years before going into hospital.

Have not been in that situation to where a nurse has helped me in my recovery.

It was notable that, in spite of a specific instruction not to identify persons or hospitals, two the the 12 A.A. members did so.

A further breakdown and grouping of the total numbers of behaviours yielded from the critical incident questionnaires is to be found in Chapter 6.

Early Analysis of Unhelpful Behaviours

From 20 usable incident reactions reported by registered nurses the total number of unhelpful behaviours analysed is shown in Table 5. 3.

Table 5. 3: Method for Ascertaining Total Number of Unhelpful Behaviours Reported by Registered Nurses

Number of Critical Incident Reactions	Number of Unhelpful Behaviours in Each	Total Number of Behaviours
7	1	7
8	2	16
3	3	9
1	4	4
1	5	5
20	Totals	41

A total of 41 unhelpful behaviours were analysed from 27 returned questionnaires, in comparison with a total of 68 helpful behaviours from the same number of returns, and the same responders. A possible explanation is that nurses see themselves as more helpful than

unhelpful in behaviour towards persons with drinking problems. Examples of incident reactions are given.

> A genuine belief that whatever was done for the patient following an acute admission was going to be undone once the person was discharged / and continued to booze. (two behaviours).
>
> The only incidence I can think of was where a nurse was speaking within earshot of an alcoholic in a derogatory fashion. (one behaviour).

An example which was unusable is given.

> No incident stands out after 30 years.

From only seven usable incident reactions reported by A.A. members the total number of unhelpful behaviours analysed is shown in Table 5. 4.

Table 5. 4: Method for Ascertaining Total Number of Unhelpful Behaviours Reported by A.A. Members

Number of Critical Incident Reactions	Number of Unhelpful Behaviours in Each	Total Number of Behaviours
7	1	7
7	Totals	7

Thus 12 returned questionnaires yielded but seven items of unhelpful behaviour. Two examples are given.

To me it is least helpful to alcoholics when nursing staff don't contact Alcoholics Anonymous when alcoholic patients are admitted to hospital. (one behaviour).

A total lack of education on alcoholism (one behaviour).

A further breakdown and grouping of these behaviours also is to be found in Chapter 6. Table 5.5 shows the B.R.A.M. Scale which has been compiled from the major areas of behaviours analysed in the manner just described. *

Table 5.5: The Behaviour Relating to Alcoholism Management (B.R.A.M.) Scale

B.R.A.M. Scale

List One: Helpful Behaviours

1. Specific information exchange between nurse and patient
2. Awareness of patient's special needs
3. Attention to patient's physical needs
4. Acceptance of drinking problem as a medical problem or illness
5. Demonstration of professionally ethical behaviour
6. Involvement of others significant to the patient
7. Provision of emotional support for the patient
8. Demonstration of clinical competence

List Two: Unhelpful Behaviours

1. Evidence of insufficient education about alcoholism
2. Non-acceptance of drinking problem as a medical problem or illness
3. Needs of the nurse preventing awareness of patient's needs
4. Denial of emotional support for the patient
5. Demonstration of professionally unethical behaviour

It can be seen that three items in List Two (items 2, 4 and 5) are directly opposite in practice to three items in List One (items 4, 7 and 5).

This instrument was administered in Phase Two of this study. (See Figure 5.1).

P R O C E D U R E

Permission was obtained from the Chief Nursing Officer and Principal Nurses of the two hospitals chosen for this study. (SeeAppendices F, F1 and H) to carry out the research. The proposed procedure was explained to the day supervisors. The author was also permitted to attend all Alcoholics Anonymous meetings, in two cities, for the purpose of requesting member participation in the research. For a detailed description of subjects and locations refer to Chapter 6.

Phase One

For Phase One the registered nurse subjects were located at the general hospital in City A and A.A. subjects at their group meeting venues in City B. Critical incident and biographical data questionnaires (Appendices G, G1 and G2) were distributed over three days to the registered nurse subjects. Envelopes were supplied for the return of the completed questionnaires to a collection point.

Critical incident and biographical data questionnaires (Appendices G, G3 and G4) were distributed to members at three open meetings of the two A.A. groups in City B. Envelopes were provided and it was arranged that they be collected at the next weekly meeting in each case.

Phase Two

For the second phase also staff nurses and charge nurses on one day shift participated, but in two general hospitals of comparable

characteristics, one of which is the hospital included in the first phase. The instrument administered was the B.R.A.M. Scale, and a biographical questionnaire was not included. (Appendices I.1 and I.2).

The writer was able to collect data on one day in one hospital, but in the other hospital data collection was spread over three consecutive day shifts. For this part of the study subjects responded to the questionnaire while the researcher was present. Thus responses were collected without any delay.

The B.R.A.M. Scale questionnaire was similarly presented at A.A. meetings each night of the week, Monday through Thursday, and on a Sunday night, (Appendices I.1 and I.2) to cover all groups in City A and City B. The instrument was administered and collected at the same meeting thus eliminating the necessity for return of collection of data at a later date. See Figure 5.1.

* See also critical discussion Appendix N in back pocket with particular reference to marked sections.

C H A P T E R 6

DATA ANALYSIS AND RESULTS

This chapter is presented in two main sections. The first describes the results and analysis pertinent to Phase One of the study. The second part is concerned with Phase Two, and the comparison and discussion of the results. See Figure 5.1.

P H A S E O N E

In this phase the critical incident reactions were further analysed and refined into combined lists of descriptive statements.* This process is briefly described in Appendix J. The descriptive statements constitute the B.R.A.M. Scale. (Appendix I).

Locations in Phase One

The locations of the subjects in Phase One, as briefly stated in Chapter 5 (page 79) are shown in the first part of Figure 6.1, which sets out the overall location design and is referred to in the description of Phase Two.

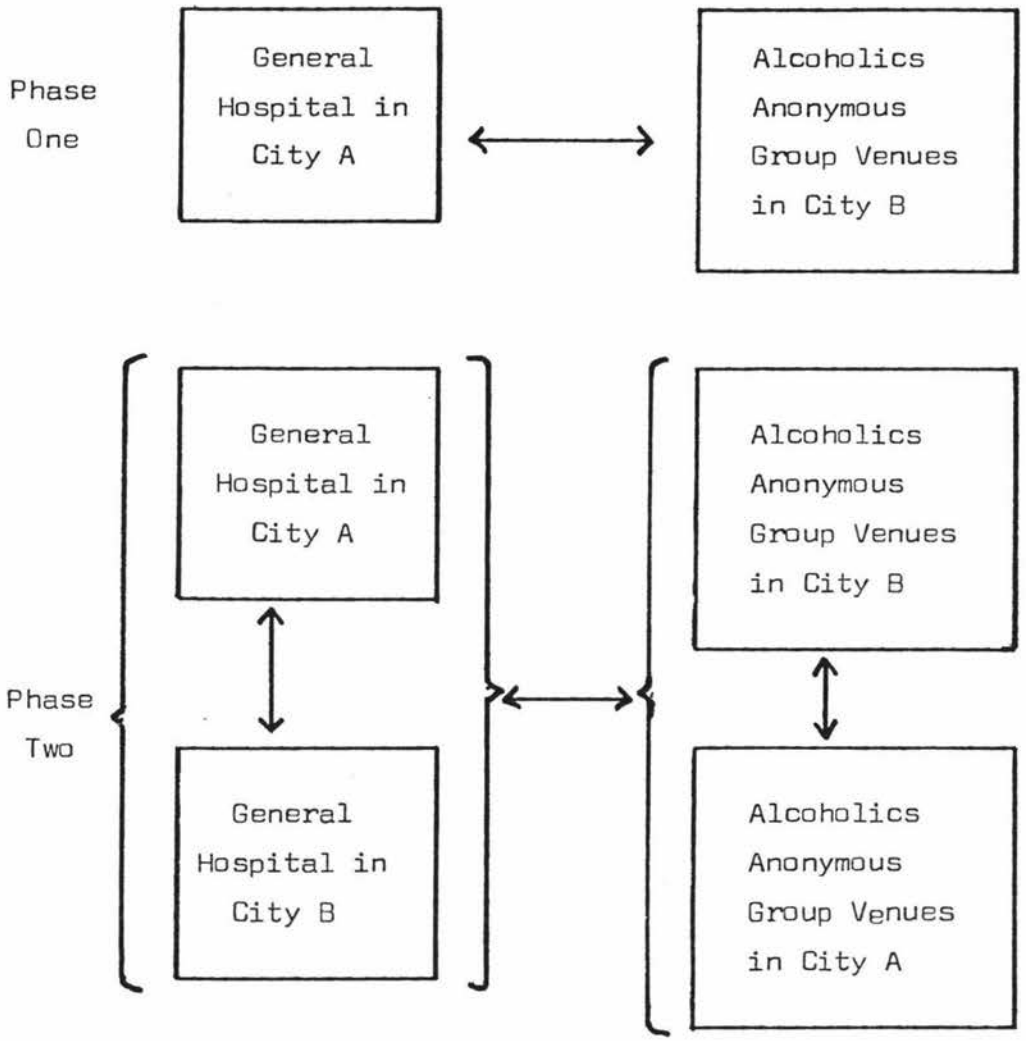

Figure 6.1: Flow Chart of Location Design

Table 6.1 has been constructed to illustrate that the distribution of wards and departments in both general hospitals used in the study is similar. The registered nurse subjects in each phase are drawn from similar location backgrounds. Further reference to this table is made on the section on Phase Two. See also Figure 6.1. Subjects in Phase One were located in the general hospital in City A.

Table 6.1: Distribution of Wards and Departments in both General Hospitals used in the Study

General Hospital in City A		General Hospital in City B	
Departments		Departments	
Accident and Emergency		Accident, Emergency, Outpatient	
District Nurse		Geriatric	
Obstetric		Obstetric	
Outpatient			
Wards	Numbers	Wards	Numbers
Ear,Nose and Throat	1		
Geriatric	2		
Medical	2	Medical	2
Ophthalmic	1		
Orthopedic	2	Orthopedic	1
Pediatric/Burns Unit	1	Pediatric	1
Surgical	2	Rehabilitation	1
		Surgical	2

Table 6.2 has been constructed to illustrate the close similarity between the Alcoholics Anonymous group venues in both cities. The A.A. member subjects in each phase are located in similar venues. Further reference to this table is made in the section on Phase Two. A.A. member subjects in Phase One were located in the A.A. groups in City B. See also Figure 6.1.

Table 6.2: Distribution of A.A. Groups Venues

A.A. Groups In City A	A.A. Groups In City B
City Council Community Services	City Council Community Services
The older-established group which holds two weekly meetings	The older-established group which holds two weekly meetings
Church Hall	Church Hall
The group which holds one weekly meeting.	The group which holds one weekly meeting.

Description of Subjects Included in the Study

For this study registered nurses and alcoholics are considered to be competent observers.* (Refer to discussion on page 70). The former are providers, while the latter are users, of care in alcohol-related problems. As this is a descriptive study which takes the idiographic approach random sampling was not indicated.

Registered Nurse Subjects

Registered nurses have qualified from a basic educational programme (see Glossary - Nurse), and have had at least three years' nursing experience in various clinical areas in order to obtain registration. During the qualifying period they are therefore likely to have come in contact with one patient, or several patients, with alcohol-related problems. Such patients are to be found in any clinical area.

For the first phase all the charge nurses and staff nurses on duty in the wards and departments in the general hospital in City A specified in Table 6.1 were asked to participate. This request was aided by an official notice sent to the wards and departments concerned. (Appendix H). By this means it was hoped to include a range of ages and nursing experience at one point in time and thus to obtain as high a level of validity and reliability as possible.

Of 44 registered nurses approached, three refused to participate. Two of these, in the same ward, said that their negative attitudes towards alcoholics precluded their inclination to be honest. They could not be persuaded to see that this need not be so. These two registered nurses work in the ward in which the majority of identified

alcoholics are to be found, in the particular hospital. The third nurse who refused had a negative attitude towards participating because of a previous experience in taking part in a research exercise.

A total of 41 questionnaires were accepted by the registered nurses, although some stated that they might not be able to supply any examples of incidents. They agreed to think about it, however. The number returned was 27.

Registered Nurses - Biographical Information

This was obtained from the biographical questionnaire (Appendix G1) and is presented in tables which follow.

Table 6.3: Percentage Distribution of Age; Registered Nurses (N = 27)

Age (years)	Number	Percentage
20-29	7	25.9
30-39	3	11.1
40-49	4	14.8
50-59	10	37.0
Blank	3	11.1
Totals	27	99.9 (100)
Median = 40-49 years		

Table 6.4: Percentage Distribution of Length of Time Registered; Registered Nurses (N = 27)

Number of Years	Number	Percentage
1-10	9	33.3
11-20	5	18.5
21-30	9	33.3
31-40	2	7.4
blank	2	7.4
Totals	27	99.9 (100)
Median = 11-20 years		

Table 6.5: Percentage Distribution of Sex; Registered Nurses (N = 27)

Sex	Number	Percentage
Female	23	85.2
Male	2	7.4
Blank	2	7.4
Totals	27	100.0

The mean age of the registered nurses was 40.75 years, and the mean number of years registered was 18.6.

Table 6.6: Percentage Distribution of Post-basic Qualifications; Registered Nurses (N = 27)

Number of Years Registered	No.	Type of Post-basic Qualification	Percentage
1-10	2	Advanced Diploma Medical-Surgical Nursing	
	1	Advanced Diploma Medical-Surgical Midwifery Nursing	18.5
	1	Diploma of Nursing	
	1	Midwifery	
11-20	-		
21-30	1	Midwifery	
		Ear, Nose and Throat } Certificates	3.7
		Community Health	
31-40	1	Midwifery	3.7
Blank	2		7.4
Totals	9		33.3
	18	No Post-basic Qualifications	66.7
	27		100.0

A.A. Member Subjects

A.A. groups keep no record of members so attendance at meetings is the only way to obtain data. Participation by A.A. members ensures as far as is possible that the subjects are in fact persons who are alcoholics. Not all such persons have been the recipients of any sort of care by nurses. A.A. members are often peripatetic, so that some attend all meetings in their area regularly, and not only the one or two of a particular group. This was the case with some subjects in this study. It was simple, however, to ensure that no subject

participated more than once. The numbers were relatively small* and most A.A. members were known to the writer. Phase One was completed on trust. Where members declined to participate, the reason given in all cases was that the person had not had any contact with nurses which was relevant to their alcohol problem. Of the 21 questionnaires accepted 12 were completed and returned.

A.A. Members - Biographical Information

This was obtained from the biographical questionnaire (Appendix G3) and is presented in the tables which follow.

Table 6.7: Percentage Distribution of Age; A.A. Members (N = 12)

Age (years)	Number	Percentage
40-49	2	16.7
50-59	9	75.0
Blank	1	8.3
Totals	12	100.0
Median = 50-59 years		

Table 6.8: Percentage Distribution of Length of Time Sober; A.A. Members (N = 12)

Number of Years	Number	Percentage
0-½	2	16.7
½-1	-	-
1-5	5	41.7
5-10	2	16.7
10-20	2	16.7
Blank	1	8.3
Totals	12	100.0
Median = 1-5 years		

Table 6.9: Percentage Distribution of Sex; A.A. Members (N = 12)

Sex	Number	Percentage
Female	3	25.0
Male	8	66.7
Blank	1	8.3
Totals	12	100.0

Table 6.10: Frequency Distribution of Occupation; A.A. Members (N = 12, but 1 not completed)

Female A.A. Members		Male A.A. Members	
Housewife	2	Salesman-Driver	3
Company Director	1	Driver	
		Stock Representative	1
		Carpenter	1
		Company Director	1
		County Foreman	1
		War Pensioner	1
Total	3	Total	8

The mean age of A.A. members was 52.1 years and the mean length of sobriety was 60.8 months, five years approximately.

In City A alcoholic patients from an addiction treatment centre are encouraged to attend meetings. There were patients present at two of the meetings. Such patients are often likely to be in a very early stage of abstinence. They did not take part in Phase One (See Figure 6.1).

Critical Incident Reactions *

The method for analysing the incident reactions into helpful and unhelpful behaviours has been outlined in Chapter 5.

Response to Questionnaires

The registered nurse subjects returned 27 of the 41 questionnaires distributed. Of these 22 were usable (see Chapter 5), while the five listed below were not.

One was too late to be included

One was too late to be included, and blank

One was blank, but included a covering note to explain that the subject had no experience on which to draw

One stated "No incident stands out after 30 years"

One stated "Never had a patient who recovered"

Appendix K sets out the 47 helpful behaviours identified by registered nurses.

The A.A. member subjects returned 12 of the 22 questionnaires distributed. Of these 11 were usable (see Chapter 5), and one was returned blank. Appendix K1 sets out the 17 helpful behaviours identified by A.A. members. Appendices K3 and K4 list the unhelpful behaviours identified by both subject groups.

Critical Incident Analysis *

Helpful Behaviours

The two lists of helpful behaviours thus identified by both subject groups were combined and grouped under appropriate major categories. These are listed in Appendix K2. Refinement of this crude categorization is shown in Table 6.11.

Perusal of Table 6.11 suggests that up to this first phase of the study, respective concerns about what constitutes helpful

Table 6.11: Refined List of Major Areas and Sub-areas of Helpful Behaviour, Showing Which Sub-areas Were Contributed by Registered Nurse, and AA Member, Subjects

Major Areas and Sub-areas of Helpful Behaviour	Registered Nurse Subjects	AA Member Subjects
A. Demonstration of Clinical Competence		
1. Recognizing and recording significant symptoms	•	
2. Taking appropriate action when condition of patient changes	•	
3. Having regard for prevention of complications	•	
4. Acting to include patient in overall ward environment	•	
5. Being aware of specific aspects associated with the diagnosis	•	
6. Communicating with patient	•	
7. Referring patient to specialist helper		•
B. Provision of Emotional Support		
1. Recognizing apprehension and attempting to give reassurance	•	
2. Talking with patient about his/her self as a person	•	•
3. Being available so that patient knows a caring person is near	•	
4. Listening to patient, thereby showing interest, understanding, empathy	•	•
5. Taking time to be attentive		•
6. Being non-judgmental	•	•
C. Involvement of Significant Others		
1. Liaising with family and other visitors	•	
2. Involving the spouse or significant other in care of patient	•	
D. Demonstration of Professionally Ethical Behaviour		
1. Regulating personal conduct	•	
2. Furthering professional knowledge	•	
3. Assuring confidentiality	•	
4. Developing person-to-person relationship	•	
E. Acceptance of Drinking Problem as Medical Problem/Illness		
1. Caring for patient as a person with a medical problem	•	
2. Accepting alcoholic patients as people with problems	•	
F. Attention to Patient's Physical Needs		
1. Ascertaining that specific needs are met	•	
2. Providing relevant symptomatic care	•	
3. Being mindful of patient's safety	•	
G. Awareness of Special Needs		
1. Orienting patient to strange environment	•	
2. Realizing that patient very likely has a low self-esteem	•	
3. Emphasizing that there is hope for patient's future		•
4. Referring patient to A.A., a specific community self-support group	•	•
5. Attending open meetings of A.A. in order to know alcoholic persons		•
6. Giving positive feedback about patient's efforts to attain and maintain sobriety		•
7. Encouraging actively alternative activities that have the goal of changing patient's lifestyle	•	
8. Assisting patient to be in touch with reality and overcome fears, hallucinations	•	
H. Specific Information Exchange		
1. Letting patient know the nurse cares		•
2. Being open and direct with patient	•	•
3. Making efforts to learn about alcoholism		•
4. Following up any mention by patient of actual or potential alcohol problem		•
5. Relating the illness to the drinking of alcohol	•	•
(Eight major areas of helpful behaviour, comprising 37 sub-areas)		

behaviour of nurses towards patients with drinking problems appear to fall into fairly well defined areas on the whole. There are some areas of joint agreement between nurses and A.A. members.

Registered nurses appear to be concerned about:

the physical care:

> .... and seeing adequate fluids were available, warmth applied when tremors were distressing ....
>
> support
>
> comfort
>
> protection from self-injury

relationship building;

> .... Good display of empathy which in time led on to an in-depth of understanding between the two ....
>
> The Nurse was most helpful because she approached the patient from the start in what I thought was the right way. She was direct and to the point, but was sympathetic and had a listening ear ....

positive attitudes towards alcoholics;

> ....with no stigma attached as fully aware of reoccurring admissions ....
>
> Accepting the patient as a "human" and treating him with courtesy and concern and in a caring manner (particularly necessary as this patient had a low opinion of himself and desperately needed to be accepted).

management aspects;

> Aware, but unafraid of the management problem presented ....
>
> .... This was probably a lucky case. It is extremely hard to gain the co-operation for help from a person with a drinking problem. They don't think they have a problem.

specific features of alcoholism;

> .... was successful in involving this man's wife - there had been a communication problem between husband and wife recently ....
>
> Attendance of nurse at Alcohol Management lectures ....

medication;

> .... knowledge of drug regime required necessary for pts peace of mind.
>
> .... medication commenced early ....

and health education;

> Nurse explained relationship of the high alcohol intake to physical degeneration ....

A.A. Members' concerns are:

a caring attitude towards alcoholics;

> .... but I feel in myself that the ones that do have real feeling for Alcoholics and people that have recovered from the problem because they can feel and know where he is at.

> Her actions were non-judgmental but generated a genuine concern .... (Registered nurse).

demonstrating understanding and helping behaviour;

> The care, understanding and help from the nursing staff .... (A.A. Member).
>
> .... listening interestedly and understandingly .... (Registered Nurse).

directness re the alcohol/illness relationship;

> .... He gave me a very honest assessment of myself and he just told me in plain words that if I wanted to die or go insane just carry on the way I was going .... (A.A. member).
>
> Nurse explained the relationship of the high alcohol intake to physical degeneration .... (Registered nurse).

orientation to A.A.;

> I also found it helpful in the early years of my sobriety when nursing Sisters in charge would let me know when an alcoholic was admitted so I had a chance to visit and carry the message. (A.A. member).
>
> This nurse was able to get the patient interested in seeking help from A.A..... (Registered nurse).

and time awarded the alcoholic person;

> after about 10 or 11 months sobriety I was in hospital for a few days and found that only one nurse .... took the time to talk to me .... (A.A. member).
>
> Being available to be with the patient and to remain near for support and assistance and reassurance. (Registered nurse).

It is apparent that the A.A. members are more pre-occupied with having personal psycho-social needs met than with clinical competence. They are asking to be cared about as persons. The nurses are concerned with establishing a relationship with the alcoholic patient. Both groups agree that there should be no stigma and that helping and understanding are desirable.

These concerns are readily subsumed under the major areas of helpful behaviour which make up List One of the B.R.A.M. Scale. (Appendix I). These are set out in Table 6.12.

Table 6.12: Major Areas of Helpful Behaviour

Major Areas of Helpful Behaviour
A. Demonstrating clinical competence
B. Attending to patient's emotional needs
C. Involving significant others
D. Displaying professional behaviour
E. Accepting drinking problem as a medical problem
F. Attending to physical needs
G. Awareness of special needs.
H. Specific information-giving (See Table 6.1)

Unhelpful Behaviours

The two lists of unhelpful behaviours identified from critical incident reactions by both subject groups were combined and grouped under appropriate major categories. These are listed in Appendix K5. Refinement of this crude categorization is shown in Table 6.13.

Again, there appear to be well-defined concerns about what constitutes unhelpful behaviour of nurses towards patients with drinking problems.

Registered nurses report negative attitudes and negative behaviour as follows:

> Scorn and judgement, and complete lack of compassion or help. Pt. belittled in front of staff and patients.
>
> The attitude of the Nurse who refused to give more analgesia to a patient because he was a heavy drinker.
>
> "If you didn't drink so much what we gave you before for pain would have been quite sufficient!!"

A.A. members report a lack of initiation of contact with A.A.

> To me it is least helpful to alcoholics when nursing staff don't contact A.A. when alcoholic patients are admitted to hospital.

Both groups indicate concern about conveying the hopelessness of the future, ignorance about alcoholism resulting in inappropriate behaviour by nurses, and alcoholic patients being treated as non-persons.

> Only one who gave me the impression I would live a dull life. (A.A. member).

Table 6.13: Refined List of Major Areas and Sub-areas of Unhelpful Behaviour, Showing Which Sub-areas were Contributed by Registered Nurse, and A.A. Member, Subjects

Major Areas and Sub-areas of Unhelpful Behaviour	Registered Nurse Subjects	A.A. Member Subjects
A. Demonstration of Professionally Unethical Behaviour		
1. Allowing negative emotions to dictate inappropriate care	•	
2. Treating alcoholic patients differently from other patients	•	
3. Persisting in attempts to impose personal morals, inappropriately	•	
4. Not regulating personal conduct	•	
B. Denial of Emotional Support for Patient		
1. Failing to recognize alcoholic patient as another human person	•	•
2. Showing antagonism to patient	•	
3. Behaving in aggresive, dictatorial manner to patient, "preaching"	•	•
4. Making no attempt to use listening skills	•	
5. Being as unavailable as possible	•	•
6. Withdrawing from patient contact	•	
C. Needs of Nurse Preventing Awareness of Patient's Needs		
1. Coping with own negative attitudes by putting patient down	•	
2. Showing negative attitudes towards patient's condition	•	
3. Not dealing with own fear and apprehension	•	
D. Non-acceptance of Drinking Problem as a Medical Problem or Illness		
1. Demonstrating moralistic attitude	•	
2. Behaving in judgmental manner	•	
3. Going over past history which patient doesn't want to hear, and already knows	•	•
E. Evidence of Insufficient Education About Alcoholism		
1. Lacking awareness of specific aspects of alcoholism, e.g. that it is a relapsing condition	•	•
2. Giving negative impression of future without alcohol	•	•
3. Not contacting an appropriate helping agency		•
4. Conveying hopeless attitude, making statements indicating lack of hope for patient's future	•	•
(Five major areas of unhelpful behaviour, comprising 20 sub-areas)		

A genuine belief that whatever was done for the patient following an acute admission was going to be undone once the person was discharged and continued to booze. The nurse has a so-called realistic attitude to life. (Registered nurse).

A total lack of education on alcoholism (A.A.member).

A nurse who within a patient's hearing stated that he may as well carry on as it was too late to do anything about it now! (Registered nurse).

.... most nurses at that time seemed not to be bothered to find out about the person behind the patient. I feel if a little interest was shown more alcohol problems would come to the surface. (A.A. member).

Abhorrent towards reoccurring admissions plus their excessive consumption - Patient general condition on admission eg. clothing and personal hygiene - Generally apprehensive about patient's mental state and their preference not to attend in their care. (Registered nurse).

These areas of concern about unhelpful behaviour link with the major areas which constitute List Two of the B.R.A.M. Scale (Appendix I). These are shownin Table 6.14.

Table 6.14: Major Areas of Unhelpful Behaviour

Major Areas of Unhelpful Behaviour
A. Demonstration of professionally unethical behaviour
B. Denial of emotional support for patient
C. Needs of nurse preventing awareness of patient's needs
D. Non-acceptance of drinking problem as a medical problem or illness
E. Evidence of insufficient education about alcoholism (See Table 6.13)

The same conclusions could have been arrived at by developing lists of helpful and unhelpful behaviour according to the concerns described. The author did, in fact, compile lists of behaviours and concerns. These are attached as Appendices L and Ll.

Development of B.R.A.M. Scale

The B.R.A.M. Scale was generated by the major areas listed in both helpful and unhelpful behaviour, but with some syntactic re-arrangement. It is composed of the items of major areas of behaviour, both helpful (List One) and unhelpful (List Two) as shown in Appendix I.

P H A S E T W O

In this section the results of the ranking of the B.R.A.M. Scale by the two groups of registered nurses and the two groups of A.A. members are presented and compared. (See Figure 5.1).

In Phase Two the general hospitals in two cities, City A and City B, were the settings, along with A.A. group meeting venues in both City A and City B. The location design is shown in Figure 6.1. (See Table 6.2).

General hospitals in City A and City B are comparable in size and general characteristics. They are both administered by the same hospital board. (See Table 6.1).

The actual registered nurse subjects in Phase two included some, but not all, of the same subjects as in Phase One in City A

hospital. There were some subjects who had not participated in Phase One. The A.A. member respondents in Phase Two included some, but not all, of the same subjects as in Phase One in City B. Some of these had not participated in Phase One.

Ranking of Helpful Behaviour

A total of 67 registered nurses completed List One of the B.R.A.M. Scale questionnaire. (Appendices I1 and I2). One of these could not be used as the respondent placed a "1" for each of the 8 items. Another respondent added the words "with psych components" to item 4 but this response was not excluded.

Not anticipating that there would be eight categories of helpful behaviour developed from the critical incident questionnaire, the author had decided on the ranking of five items at the time of designing the study.

The following tables show the results of the ranking of helpful behaviours by registered nurses.

Table 6.15: Frequency Distribution of Helpful Behaviours Registered Nurses (N = 66)

Item	List One	1st	2nd	3rd	4th	5th	Totals
1.	Specific information exchange between nurse and patient	4	6	11	7	9	37
2.	Awareness of patient's special needs	13	17	18	9	7	64
3.	Attention to patient's physical needs	1	4	4	13	16	38
4.	Acceptance of drinking problem as a medical problem or illness	45	10	2	-	3	60
5.	Demonstration of professionally ethical behaviour	-	-	5	4	4	13
6.	Involvement of others significant to the patient	-	9	13	17	20	59
7.	Provision of emotional support for the patient	3	20	11	15	5	54
8.	Demonstration of clinical competence	-	-	2	1	2	5
	Totals	66	66	66	66	66	330

The three items ranked least often of the five are 8, 5 and 1. Items 8 and 5 receive a great deal less support than any of the others. Item 1 gets almost as much support as Item 3, which is ranked last of the five.

A.A. members also rank items 8 and 5 least often, but rank item 1 ahead of item 3. (Table 6.17).

Table 6.16: Percentage Distribution of Helpful Behaviours: Registered Nurses (N = 66)

Item	List One:	1st	2nd	3rd	4th	5th
1.	Specific information exchange between nurse and patient	6.1	9.1	16.7	10.6	13.6
2.	Awareness of patient's special needs	19.7	25.7	27.3	13.6	10.6
3.	Attention to patient's physical needs	1.5	6.1	6.1	19.7	24.2
4.	Acceptance of drinking problem as medical problem or illness	68.2	15.2	3.0	-	4.5
5.	Demonstration of professionally ethical behaviour	-	-	7.6	6.1	6.1
6.	Involvement of others significant to the patient	-	13.6	19.7	25.7	30.3
7.	Provision of emotional support for the patient	4.5	30.3	16.7	22.7	7.6
8.	Demonstration of clinical competence-	-	-	3.0	1.5	3.0

List One of the B.R.A.M. Scale questionnaires were completed by a total of 46 A.A. members. Two of these could not be used as one respondent marked all items with a tick ("✓"), and another marked all items with a cross("X"). In addition, one respondent had written "A.A." beside three items, but the response was included as the ranking had been carried out.

The following two tables show the results of the ranking of helpful behaviours by A.A. members.

Table 6.17: Frequency Distribution of Helpful Behaviours A.A. Members (N = 44)

Item	List One:	1st	2nd	3rd	4th	5th	Totals
1.	Specific information exchange between nurse and patient	4	4	6	4	11	29
2.	Awareness of patient's special needs	5	10	12	8	5	40
3.	Attention to patient's physical needs	1	4	5	5	8	23
4.	Acceptance of drinking problem as a medical problem or illness	29	8	1	2	3	43
5.	Demonstration of professionally ethical behaviour	1	2	4	1	6	14
6.	Involvement of others significant to the patient	1	6	10	9	2	28
7.	Provision of emotional support for the patient	2	8	5	10	5	30
8.	Demonstration of clinical competence	1	2	1	5	4	13
	Totals	44	44	44	44	44	220

Table 6.18: Percentage Distribution of Helpful Behaviours A.A. Members (N = 44)

Item	List One:	1st	2nd	3rd	4th	5th
1.	Specific information exchange between nurse and patient	9.1	9.1	13.6	9.1	25.0
2.	Awareness of patient's special needs	11.4	22.7	27.3	18.2	23.0
3.	Attention to patient's physical needs	2.3	9.1	11.4	11.4	18.2
4.	Acceptance of drinking problem as a medical problem or illness	65.9	18.2	2.3	4.5	6.8
5.	Demonstration of professionally ethical behaviour	2.3	4.5	9.1	2.3	13.6
6.	Involvement of others significant to the patient	2.3	13.6	22.7	20.4	4.5
7.	Provision of emotional support for the patient	4.5	18.2	11.4	22.7	11.4
8.	Demonstration of clinical competence	2.3	4.5	2.3	11.4	9.1

Ranking of Unhelpful Behaviour

A total of 67 registered nurses completed List Two of the B.R.A.M. Scale questionnaire. (Appendix I2). Two of these could not be used as one respondent assigned two items the same ranking, and another had not completed List Two (although List One was completed).

The following two tables show the results of the ranking of unhelpful behaviours by registered nurses.

Table 6.19: Frequency Distribution of Unhelpful Behaviours Registered Nurses (N = 65)

Item	List Two	1st	2nd	3rd	4th	5th	Totals
1.	Evidence of insufficient education about alcoholism	6	15	15	17	12	65
2.	Non-acceptance of drinking problem as a medical problem or illness	39	8	6	5	7	65
3.	Needs of nurse preventing awareness of patient's needs	9	9	15	24	8	65
4.	Denial of emotional support for the patient	3	26	22	8	6	65
5.	Demonstration of professionally unethical behaviour	8	7	7	11	32	65
	Totals	65	65	65	65	65	325

Table 6.20: Percentage Distribution of Unhelpful Behaviours Registered Nurses (N = 65)

Item	List Two:	1st	2nd	3rd	4th	5th
1.	Evidence of insufficient education about alcoholism	9.2	23.1	23.1	26.2	18.5
2.	Non-acceptance of drinking problem as a medical problem or illness	60.0	12.3	9.2	7.7	10.8
3.	Needs of nurse preventing awareness of patient's needs	13.8	13.8	23.1	36.9	12.3
4.	Denial of emotional support for the patient	4.6	40.0	33.8	12.3	9.2
5.	Demonstration of professionally unethical behaviour	12.3	10.8	10.8	16.9	39.2

A total of 46 A.A. members completed List Two of the B.R.A.M. Scale questionnaire but only 43 of these could be included in the results as three were returned blank.

The following two tables show the results of the ranking of the unhelpful behaviours by A.A. members.

Table 6.21: Frequency Distribution of Unhelpful Behaviours A.A. Members (N = 43)

Item	List Two:	1st	2nd	3rd	4th	5th	Totals
1.	Evidence of insufficient education about alcoholism	15	6	14	4	4	43
2.	Non-acceptance of drinking problem as a medical problem or illness	16	11	8	6	2	43
3.	Needs of nurse preventing awareness of patient's needs	2	5	8	16	12	43
4.	Denial of emotional support for patient	2	14	6	12	9	43
5.	Demonstration of professionally unethical behaviour	8	7	7	5	16	43
	Totals	43	43	43	43	43	215

Table 6.22: Percentage Distribution of Unhelpful Behaviours A.A. Members (N = 43)

Item	List Two:	1st	2nd	3rd	4th	5th
1.	Evidence of insufficient education about alcoholism	34.9	13.9	32.5	9.3	9.3
2.	Non-acceptance of drinking problem as a medical problem or illness	37.2	25.6	18.6	13.9	4.6
3.	Needs of nurse preventing awareness of patient's needs	4.6	11.6	18.6	37.2	27.9
4.	Denial of emotional support for patient	4.6	32.5	13.9	27.9	20.9
5.	Demonstration of professionally unethical behaviour	18.6	16.2	16.2	11.6	37.2

Comparison of Results

In order to examine differences between perceptions of helpful behaviour towards alcoholics by providers (nurses) and consumers (A.A. members) it was necessary to rank overall the response of both groups. This was done by assigning weightings to the responses, and obtaining the mean for each item, in order to rank the items from first most helpful to fifth most helpful. The following two tables show the results of ranking as described.

Table 6.23: Ranking by Registered Nurses of List One of B.R.A.M. Scale (Helpful Behaviours)

Item	1st (x5)	2nd (x4)	3rd (x3)	4th (x2)	5th (x1)	Total	Mean (÷8, No.of items)	Rank
1.	20	24	33	14	9	100	12.5	5
2.	65	72	51	18	7	213	26.6	2
3.	5	16	12	26	16	75	9.3	(6)
4.	225	40	6	-	2	273	34.1	1
5.	-	-	12	10	5	27	3.3	(7)
6.	-	36	39	34	20	129	16.1	4
7.	15	80	33	30	5	163	20.3	3
8.	-	-	6	2	2	10	1.2	(8)

Table 6.24: Ranking by A.A. Members of List One of B.R.A.M. Scale (Helpful Behaviour)

Item	1st (x5)	2nd (x4)	3rd (x3)	4th (x2)	5th (x1)	Total	Mean (÷ 8, No. of items)	Rank
1.	20	16	18	8	11	73	9.1	5
2.	25	40	36	16	5	122	15.2	2
3.	5	16	15	10	8	54	6.8	(6)
4.	145	32	3	4	3	187	23.3	1
5.	5	8	12	2	6	33	4.1	(7)
6.	5	24	30	18	2	79	9.8	4
7.	10	32	15	20	5	82	10.2	3
8.	5	8	3	10	4	30	3.7	(8)

The next two tables show the results of ranking of unhelpful behaviours by both groups, using the same method as for helpful behaviours.

Table 6.25: Ranking by Registered Nurses of List Two of B.R.A.M. Scale (Unhelpful Behaviour)

Item	1st (x5)	2nd (x4)	3rd (x3)	4th (x2)	5th (x1)	Total	Mean (÷ 5, No. of items)	Rank
1.	30	60	45	32	12	179	35.8	4
2.	195	32	18	10	7	262	52.4	1
3.	45	36	48	46	8	183	36.6	3
4.	15	104	66	18	6	209	41.8	2
5.	40	28	21	22	32	143	28.6	5

Table 6.26: Ranking by A.A. Members of List Two of B.R.A.M. Scale (Unhelpful Behaviour)

Item	1st (x5)	2nd (x4)	3rd (x3)	4th (x2)	5th (x1)	Total	Mean (÷ 5, No. of items)	Rank
1.	75	20	42	8	4	149	29.8	2
2.	80	48	24	12	2	166	33.2	1
3.	10	20	24	32	12	98	19.6	5
4.	10	56	18	24	9	117	23.4	3
5.	40	28	21	10	16	115	23.0	4

A coefficient of rank correlation was obtained by applying Kendall's tau (τ) to the five rankings from List One (helpful behaviour) and five from List Two (unhelpful behaviours). Table 6.27 shows Kendall's tau for helpful behaviours. (Ferguson, 1976).

Table 6.27: Kendall's Tau for Helpful Behaviours

x	1	2	3	4	5	(6)	(7)	(8)
y	1	2	3	4	5	(6)	(7)	(8)

$$\tau = \frac{S}{\frac{1}{2} N (N-1)}$$

$S = 10$

$\tau = +1$

That is, there is a perfect correlation, as the paired ranks are in the same order exactly. This is so not only for the five required items, but also for the whole eight items.

$S = 28$

$\tau = +1$

A coefficient of rank correlation for unhelpful behaviours is shown in Table 6.28.

Table 6.28: Kendall's Tau for Unhelpful Behaviours

x	1	2	3	4	5
y	1	3	5	2	4

The y ranks exhibit a degree of disarray with respect to x, and S = 4.

$\tau = \cdot 40$

Applying a significance test, z = .731; the association between the paired ranks is not significant at .05 and .01 levels. (Ferguson, 1976). There is a difference between providers and users in their ranking of unhelpful behaviour in the B.R.A.M. Scale.

Discussion of Results

There is no difference between providers and users in their ranking of List One (helpful behaviour) of the B.R.A.M. Scale. (See Tables 6.23 and 6.24). Therefore, with regard to helpful behaviour the proposition prompting this research fails to be supported. There is no discrepancy between perception of helpful behaviour in the management of alcohol-related problems as seen by the nurses and by the problem drinkers who are members of A.A.

Table 6.29 compares brief profiles of the ranking of the eight items of helpful behaviour by both subject groups.

Table 6.29: Profiles of Ranking of List One of B.R.A.M. Scale by Registered Nurses and A.A. Members Compared

Item	Comments on Ranking - 66 Registered Nurses as percentages	Comments on Ranking - 44 A.A. members as percentages
1.	16.7 ranked it 3rd	16.7 ranked it 5th
2.	25.7 ranked it 2nd; 27.3 ranked it 3rd	27.3 ranked it 3rd
3.	24.2 ranked it 5th	18.2 ranked it 5th
4.	68.2 ranked it 1st; no one ranked it 4th; only 3.0 ranked it 3rd and 4.5 ranked it 5th	65.9 ranked it 1st
5.	No one ranked it 1st or 2nd	13.6 ranked it 5th
6.	30.3 ranked it 5th; no one ranked it 1st	22.7 ranked it 3rd; 20.4 ranked it 4th
7.	30.3 ranked it 2nd	22.7 ranked it 4th
8.	No one ranked it 1st or 2nd	11.4 ranked it 4th; 9.1 ranked it 5th

Clearly, the majority choice for the most helpful behaviour overall is

Acceptance of drinking problem as a medical problem or illness

Two behaviours received very little support overall. These are

Demonstration of professionally ethical behaviour

and

Demonstration of clinical competence

This would seem to suggest that, in the case of problem drinking professional-clinical aspects of care are less important than what might be called people-specific aspects. The results of this study indicate that both providers and users of the helping service are in agreement about this.

The proposition is supported however, with regard to unhelpful behaviour (See Table 6.25 and 6.26). That is, there is a discrepancy between perception of unhelpful behaviour in the management of alcohol-related problems as seen by the nurses and by the alcoholics.

Table 6.30 compares brief profiles of the ranking of the five items of unhelpful behaviour by both subject groups.

Table 6.30: Profiles of Ranking of List Two of B.R.A.M. Scale by Registered Nurses and A.A. Members Compared

Item	Comments on Ranking - 65 Registered Nurses as percentages	Comments on Ranking - 43 A.A. Members as percentages
1.	26.2 ranked it 4th; 23.1 ranked 2nd and 3rd	34.9 ranked it 1st; 32.5 ranked it 3rd
2.	60.00 ranked it 1st	37.2 ranked it 1st
3.	36.9 ranked it 4th	37.2 ranked it 2nd
4.	40.0 ranked it 2nd; 33.8 ranked it 3rd	32.5 ranked it 2nd
5.	39.2 ranked it 5th	37.2 ranked it 5th

The registered nurses most often ranked

> Non-acceptance of drinking problems as a medical problem or illness

as their first choice for least helpful behaviour. This links in with their choice of the opposite as the most helpful. Nurses chose as the least important unhelpful behaviour

> Demonstration of professionally unethical behaviour

The opposite behaviour in List One received very little support as a helpful behaviour, and was not ranked among the five most helpful.

A graphic list is shown, in Figure 6.2, for a continuum from most helpful to least helpful as seen by the registered nurse subjects.

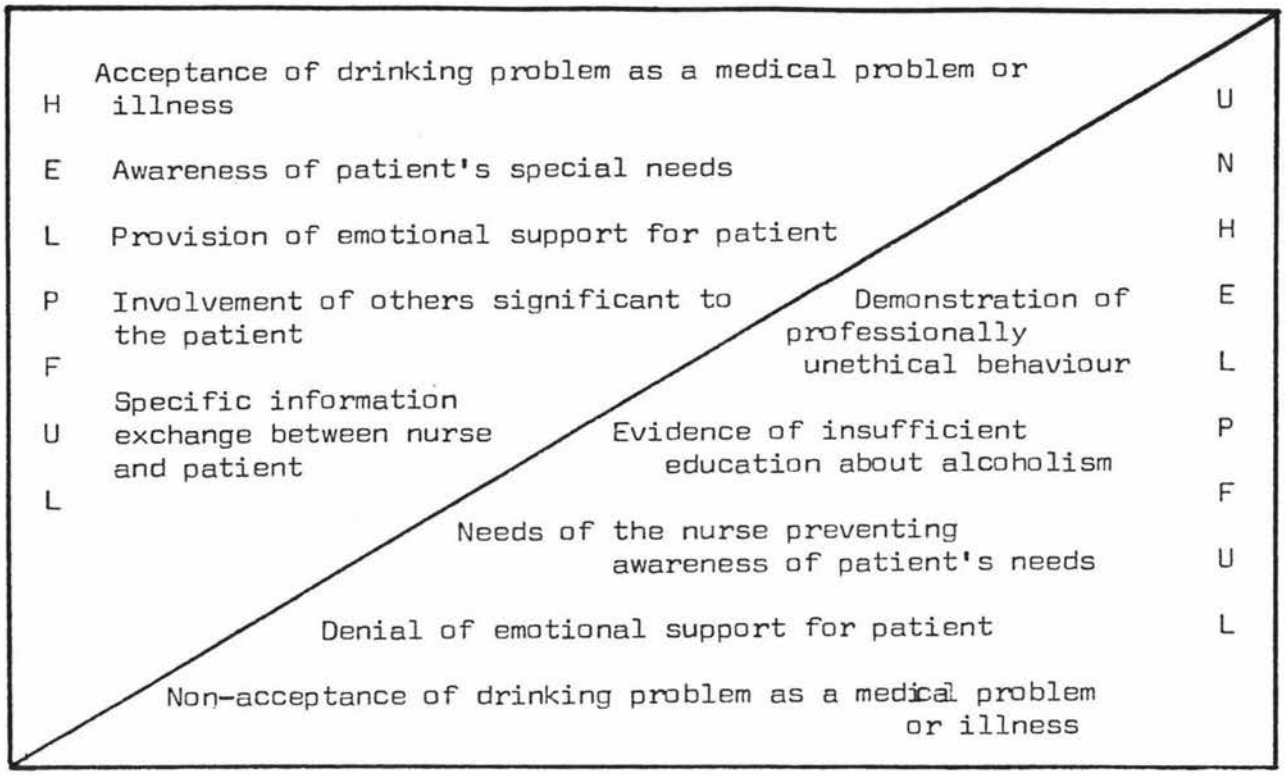

Figure 6.2: Registered Nurse continuum of Behaviour from Most Helpful to Least Helpful, as Ranked in B.R.A.M. Scale

The first two items were ranked almost equally first by A.A. member subjects. That is,

> Evidence of insufficient education about alcoholism

was considered almost equally least helpful with

> Non-acceptance of drinking problem as a medical problem or illness

The one item of complete agreement with registered nurses is the latter (Tables 6.25 and 6.26). The former item was considered less important as unhelpful by the nurses.

Figure 6.3 graphically lists the A.A. member view of the continuum of behaviours from most to least helpful.

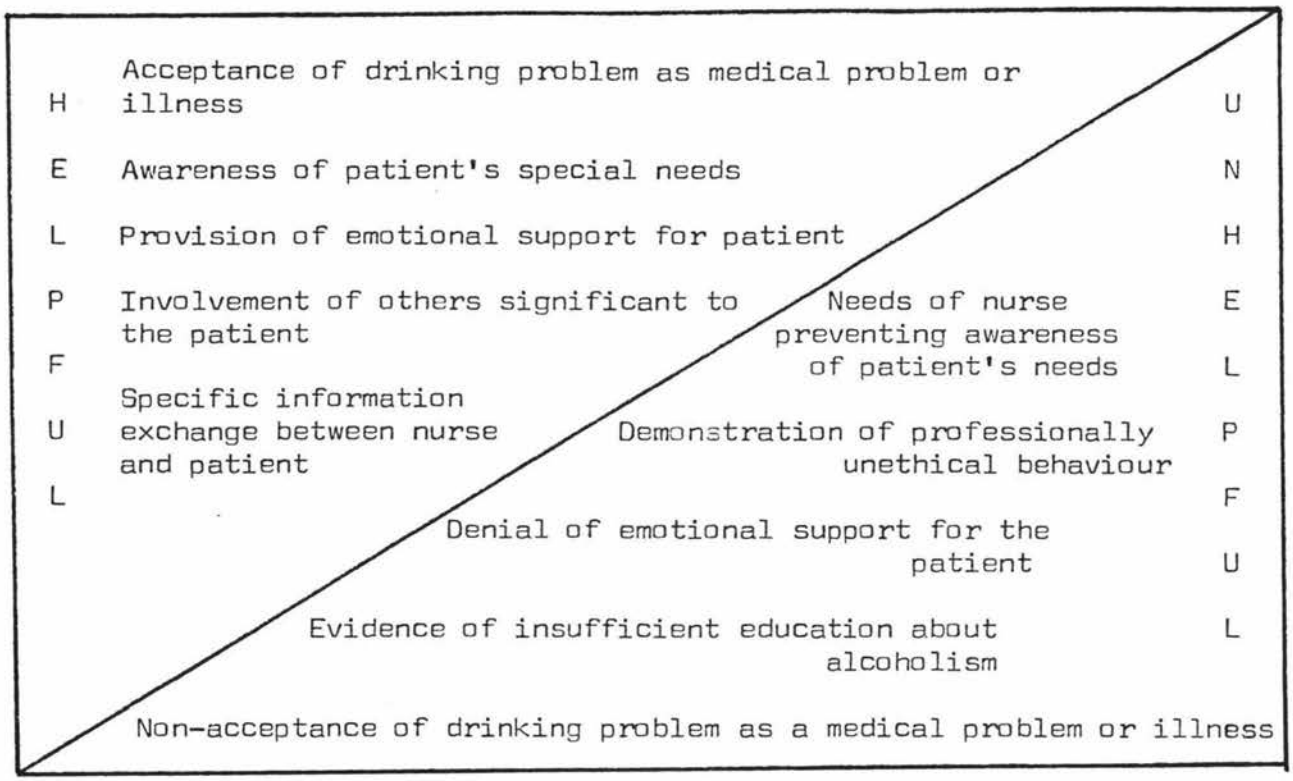

Figure 6.3: A.A. Member Continuum of Behaviour from Most Helpful to Least Helpful as Ranked on the B.R.A.M. Scale

The A.A. members apparently take the view that it is less helpful for nurses to lack education about alcoholism than for their needs to get in the way of meeting the patient's needs. It is interesting that nurses do not consider professionally unethical behaviour, in the care of persons with alcohol-related problems, as unhelpful as all the other four items.

Variables which may have had some influence on the nurse respondents are the existence of an alcohol management team as part of the hospital

board community services, conferring a degree of visibility; the availability in each ward and department of an alcoholism resource folder containing copies of articles relevant to the care of people with alcohol problems; some involvement of the alcohol team nurse in nursing inservice education programmes; the presence of the alcohol team nurse and social worker in the wards at various times; the devoting of the February (1981) issue of the New Zealand Nursing Journal to the topic of alcoholism; the sometimes verbalized attitude that caring for alcoholics is not a real function of nurses (implying that "sick" people should receive priority); the publication this year of Education for the Nursing Role in Alcoholism Treatment (McEwan, 1981). These are all nursing-related variables.

Other, more general potentially influential factors are media publicity-educational programmes such as the A.L.A.C. (Alcoholic Liquor Advisory Council) television vignettes; and alcoholism-oriented talk-back programmes on local and national radio.

A.A. members too, are exposed to influences in their environment. Some of these are a degree of acquaintance with alcohol management team members; their co-option onto a half-way house (for problem drinkers) committee; a work scheme in the area, run by a recovering alcoholic; participation in the area co-ordinating committee on drug addiction and alcoholism; attendance at seminars on these subjects; attendance of team members at open A.A. meetings; as well as the same media publicity.

The reliability and validity of the instrument need to be tested by replication, and over a wider sample of subjects, it is a small

study at this stage. Because of its size no assessor other than the writer was involved in analysing and categorizing the reactions from the critical incident questionnaires. *

Different timing may have produced different results. The study was designed with Phase Two to be implemented quite soon after Phase One, but circumstances prevented this. An unplanned three months elapsed before Phase Two data could all be collected. The B.R.A.M. Scale is a prototype and its sensitivity as an instrument may increase with further development. Such an instrument by its very nature limits the choices available to the respondent and a degree of in-built leading obtains, whereas at the critical incident stage there is no comparable limitation of choice, or element of leading, apart from the setting of the specific general topic of the observed behaviour. Paradoxically, this can also be a strength in the scale instrument, which was developed from the critical incident self-reports.

A possible explanation for such absolute agreement on what constitutes helpful behaviour of nurses towards problem drinkers might be that, in spite of the critical incident technique as a basis for the development of the B.R.A.M. Scale, either or both groups of subjects have tended to select items rather more ideal than actual. It is possible that some responses may have been what the subject thought the researcher would like, or expect, to find.

Registered nurses and A.A. members both emphasize acceptance of problem drinking as a medical problem. Both rank it first as a helpful behaviour. (Tables 6.23 and 6.24). By implication, not all persons with medical problems recover, so perhaps the widely held criterion

of abstinence as an outcome requires modification (Clare, 1977). Refer to the discussion on treatment variables in Chapter 3. Both groups also rank non-acceptance of problem drinking as a medical condition as the most unhelpful behaviour. It is the only item in List Two (Appendix I) about which both groups concur. Perhaps it is easier for nurses to provide care when they are able to orient alcohol-related problems within a medical model of alcoholism, a traditional attitude. The attitudes of professionals towards problem drinkers has been discussed in Chapter 4. The disease theory of alcoholism is widely adhered to in A.A. since Jellinek (1960) promoted its respectability.

It is not altogether surprising to find that the A.A. member subjects focus on promoting the fellowship as helpful behaviour, to the exclusion of most other services for problem drinkers. (Table 6.11). Some of the latter were in existence at the appropriate stage for some of the subjects. For others such services were not available. The contribution of Alcoholics Anonymous has been described in Chapter 3. (Glatt, 1978; Baekeland et al, 1975). Polarization of views is noted.

Replication should clarify some of the aspects discussed, and affirm or deny the reliability and validity of the instrument developed from this study. One refinement that suggests itself to the author is to have subjects rank all eight items of List One (Appendix I). While the advantages of having five ranked are that the number of items ranked is then the same for both kinds of behaviour, and it complies with the original design, there are disadvantages. These arise from setting out a design before any data are collected, and not knowing how each subject group really rank the three items "left over".

In this study it appears that two items are ranked quite distinctly least often, but it is not possible to make such a statement about the third item. (Tables 6.15 and 6.17).

A second refinement in the implementation of the design is to include in Phase Two every subject who participated in Phase One. This would provide a check on the consistency of perceptions of the subjects from one phase to the other. This would necessitate implementing the second phase sooner than circumstances, beyond the control of the author, allowed in this study. The original design did not include the longer time interval between phases.

The results partially support the proposition derived from the review of the literature. There is complete agreement between the non-specialist helper nurse subjects and the problem drinker subjects on their perception of helpful behaviour in the management of alcohol-related problems. However, in their perception of unhelpful behaviour there is a significant difference.

This discussion of the results completes Chapter 6, in which the data have been presented and analysed.

* See also critical discussion Appendix N in back pocket with particular reference to marked sections.

C H A P T E R 7

REVIEW, CONCLUSIONS AND IMPLICATIONS

In this final chapter some conclusions are offered, and some implications are discussed.

GENERAL CONCLUSIONS

> Why do some problem drinkers change their behaviour while others do not?

This original question led to an extensive review of the literature. In Chapter 1 reference has been made to the proportion of admissions to hospitals in New Zealand which is attributable to alcohol-related accidents and diseases, and to an estimated 25% of all general medical beds being occupied by persons with ethanol-induced disorders. A further question evolved, one which relates to the nursing profession:

> Is there some helping behaviour by the nurse that encourages some problem drinkers to change?

This question became the basis for this research, which began by describing alcohol the chemical (page 4), and the problems associated with its use and abuse. National and international evidence suggests that the emphasis has shifted from the consideration of alcohol-related problems as moral ones to viewing them as a public health concern of some magnitude. (page 8). The discussion on definitions of

alcoholism illustrate the difficulty in being specific as well as the implications of alcohol abuse. (page 11).

Conclusions, Chapter One

1. Alcohol abuse is of sufficient concern in New Zealand to arouse the interst of the media.

2. Alcohol abuse in New Zealand has become a public health problem of some magnitude.

3. Alcoholism is difficult to define precisely but it is clear that it has physical, emotional, spiritual and social effects.

4. These effects encompass both the problem drinker and his (or her) significant others (Glossary).

A variety of theories of alcoholism (Chapter 2) are discussed, but no one theory is sufficiently global to be applied exclusively. A useful analysis is that of Wallace (1977) whose approach is phenomenological, and relevant to the design of this study. (page 30).

Everyperson Problem Drinker is presented in a graphic profile format to provide an appropriate back drop for the research (page 35), that of very complex behaviour.

Conclusions, Chapter Two

1. The variety of theories illustrates the range of complex behaviour that may be found in the problem drinker.

2. Such variety can serve to provide a wide range of potentially profitable directions that helpers can take.

3. Problem drinking is probably a more universal entity than has been recognized.

4. Progressive phases are recognizable within this entity, but are not an inevitable process; intervention is possible and can be effective.

Chapter 3 provides further analysis of the stated problem (page 1) by discussing issues that pertain in treating the problem drinker. These include in-patient or outpatient, group or individual, minimal or intensive, professionals or self-support groups, individual or family involvement, and no treatment at all. Zimberg's (1978) psychodynamics theory of alcoholism is presented in some detail (page 46) for its relevance to the development of the research design.

Conclusions, Chapter Three

1. There is no universally applicable treatment modality for problem drinking.

2. Abstinence, relevant to the illness/cure orientation of the disease concept of alcoholism, is but one outcome option.

3. Another treatment outcome can be an improvement in the quality of life or the lifestyle.

4. Treatment modalities may need to take more cognizance of patient perception than has been taken to date.

5. Improvement appears to depend largely on the problem drinker him/herself.

6. Communication and constructive action among multidisciplinary teams may result in better match between the individual problem drinker and a relevant treatment modality.

Nurses as non-specialist helpers are examined in Chapter 4. Helping behaviour is defined (Glossary) and related to the concept of motivation which has been regarded as an important attribute of the problem drinker who wishes to benefit from treatment (page 54). Moon's (1979) definition is presented, and the statement made that the therapist has a motivating responsibility toward problem drinkers. (page 56).

The nurse practises in many settings (as does the problem drinker) and is often the first person with whom the problem drinker comes in contact. Nurses' attitudes are therefore important and these are described in some detail (page 57), because of their relevance to the study design. It is suggested that attitudes of both the public and professionals have been barriers to the development of adequate services for problem drinkers. Negative attitudes can change over time, and positive attitudes contribute to helping persons to achieve a change

of life-style.

Counselling is part of professional nursing practice. The personal characteristics of the nurse can enhance the therapeutic process. In particular certain qualities are known to be facilitative (page 62). These are empathy, non-possessive warmth, genuineness, flexibility, and being non-judgmental. These are the kinds of behaviours, contributed by the subjects in this research, perceived as helpful to problem drinkers seeking recovery. (Chapter 6). These qualities link closely with the characteristics of the professional nursing relationship (page 64).

Conclusions, Chapter Four

1. Specialists are not always necessary to help the problem drinker.

2. Prevention is part of a community helping process.

3. The attitudes of professionals, including nurses, are relevant to treatment outcomes.

4. Negative attitudes towards problem drinkers can change over time.

5. Positive attitudes towards problem drinkers on the part of nurses can enhance the therapeutic relationship.

6. The therapist, including the non-specialist nurse helper, has a responsibility towards the problem drinker for motivation.

7. Qualities in the helper known to be facilitative are empathy, non-possessive warmth, genuineness, flexibility, and non-judgmental behaviour.

From this literature review the following proposition was derived:

> There are differencesbetween the non-specialist helper nurse and the problem drinker in their perceptions of helpful and unhelpful behaviour in the management of alcohol-related problems.

No differences could be discerned in the perceptions of helpful behaviour, but the two groups perceived unhelpful behaviour in different ways. (Chapter 6). Although the critical incident data (Figure 5.1) was obtained from a small group of subjects* the ranking of the behavioural items in Phase Two of the study (Figure 5.1) was carried out by a much larger group, 124 subjects in toto. As the sample was drawn purposively (Diers, 1979, P. 86) generalizations cannot be made to other populations.

IMPLICATIONS FOR NURSING PRACTICE

One of the noticeable aspects of the responses of both A.A. members and registered nurses in the first phase of the study (see Chapter 6) was the tendency to confine recall of incidents to a hospital situation. To the writer this suggests a kind of tunnel vision, and this in spite of the instruction

> .... behaviour of a nurse, in any setting, which you perceive ....
> (Appendix G4)

and a comment to the same effect at the time of presentation of the questionnaires to the subjects.

Although a proportion of patients in hospitals is there from an alcohol-related cause, many problem drinkers do not receive hospital care for their problem. Some of the A.A. member subjects in Phase One of this study did not.

> This doesn't apply as I had sobriety for many years before going into hospital.

Although this subject misinterpreted the instructions, as commented upon above, it is clear that he or she began recovering outside a hospital setting. Some treatment centres, not regarded as hospitals, do employ nurses and it is possible that the subject just quoted received help in such a centre without perceiving nurse-therapists/staff members/counsellors as nurses. The writer herself has experienced this. Perhaps nurses have some difficulty in seeing a counselling and/or therapist component in their role as nurses.

Nurses working in community health are certain to come in contact with either problem drinkers or those people who are affected by them (Gowan, 1981); that is practice nurses, district nurses, public health nurses, Plunket nurses, dental nurses, and occupational health nurses. The Alcoholic Liquor Advisory Council and Accident Compensation Commission have published a booklet, Employee Alcohol Impairment (Stockwell and Rajasingham, editors, 1981) which sets out ways to identify and help problem drinkers at the workplace. As Cowan (1981) says "The nurse has a valuable contribution to make in her own right but sadly, is often missing or well in the background". (P. 11).

This need not be.

Nurses deal with the results of accidents, violence and illness, many of which are alcohol-related, and preventable. As a group of professionals they are in a good position to ask questions about what behaviour does or does not make a difference in its effectiveness, as does this study.

The Williams (1979) study referred to in Chapter 4 identifies helpful nursing actions. These helpful actions, listening skills, ability to empathise with the patient, and to project hope, also link closely with the characteristics of the human-to-human relationship which Travelbee (1971) states to be the task of the professional nurse (page 63).

It was an A.A. member subject who reported the giving hope for the future as a helpful behaviour by nurses. (Chapter 6). Conversely, unhelpful behaviour reported by both subject groups in this study are concerned with negative expectations, lack of hope, and minimal patient contact (page 97).

Guidelines suggested in the literature are thus supported by the findings of this study. It is known what behaviour is perceived as unhelpful, as well as that perceived as helpful. This kind of knowledge can lead to planned, rather than casual, helping behaviour. That there is a significant difference in perceptions of unhelpful behaviour suggests that some changes need to be made in nursing practice. If a patient views one nurse as helpful he is likely to perceive other nurses, at other times, and in other places, as

helpful also. The more the nurse is attuned to the patient as a feeling, thinking, doing person, the more the patient is likely to experience her as helpful through the nurse-patient interaction. Nurses who are aware of the multidisciplinary task involved in helping experience the interaction as more of "doing with"than "doing to".

In nursing practice helping behaviour can occur in any context. What is needed is some background of alcoholism theories for the nurse to be free to choose from among, move about in, and combine such theories.

IMPLICATIONS FOR NURSING EDUCATION

> The primary professional disciplines engaged in alcoholism work are medicine, nursing, social work, psychology, and to a lesser extent occupational therapy and the ordained ministry. Not one of these professions provides an adequate training in the recognition, diagnosis or treatment of alcoholism.
>
> These existing training systems provide, at best, a superficial description of alcoholism without exploring its complexities and treatment approaches. Yet alcohol misuse is the single most common element of physical and emotional disease confronted by each of these professions. (Johnstone, 1979, P. 10).

Alcohol-related problems have significantly increased in New Zealand in the last two decades (Chapter 1). Nurses from general, psychiatric and comprehensive programmes, working in both hospital and larger community, are coming in contact with people who have these problems. There is a need for nursing education to reflect this trend, and for nurses to know how to manage persons with such problems. Nurses could be in a very strong position to induce

motivation, i.e. hope of recovery, long before problem drinkers assay to graduate as chronic alcoholics.

Nurses live and work and learn in a social milieu, and are in a position of being potential role models re attitudes to drunkenness in society. Concomitantly they are in a position to emphasize and teach healthy, non-chemical ways of dealing with stress, which nurses understand from their own experience.

A background of at least some of the theories, as in Chapter 2, confers on the nurse the freedom alluded to at the end of the previous section, which in turn provides the tools for planned helping behaviour. Importantly, such knowledge leads the way to understanding what Wallace (1977) calls "the alcoholic's never invalidated hypothesis", the possibility of a return to controlled drinking, the desire for which is responsible for so many lapses from abstinence. Indications are that the basic nursing education programme, rather than the post-registration inservice programme, is a useful and necessary place to include an alcoholism module. Support for this position is found in Rotheram's (1980) study. Overall,

> student nurses are as knowledgeable about alcohol and its problems as their more qualified peers and also have more positive attitudes towards patients with such problems. This latter finding could reflect the fact that students come into nursing with a fresh enthusiasm, untainted by the prejudices of long experience. (P. 2197).

Further backing is to be found in a recently published report by the Alcoholic Liquor Advisory Council, (McEwan, 1981).

This study has identified behaviours which can be taught to, and practised by, student nurses as part of their basic education programme. (Chapter 6).

Where the importance of including significant learning experiences in alcoholism nursing is recognized it is mainly in psychiatric and technical institute nursing schools. (McEwan, 1981). A great deal is said in two short statements by one student nurse at the close of her clinical experience in a community nursing course in alcoholism.

> Understanding what alcoholics go through helps me not to avoid them in the hospital. Now I find I'm not helpless when I take care of an alcoholic patient. (Fortin, 1980, P. 114).

IMPLICATIONS FOR NURSING ADMINISTRATION

Alcohol abuse produces social, political and economic complications (Chapter 1). With more involvement of nurses in overall planning of health services comes the need to examine and make decisions about such issues as savings in agency expenditure versus extra costs of alcohol damage; health folio policies and the allocation for alcohol services from Vote Health; social implications of alcohol abuse affects the lifestyle of nurses too; economics of staff establishment; and the effects on nursing staff of cuts in expenditure, indirect though they may be.

A question with bioethical overtones concerns whether people should be at liberty to damage their health even though in so doing

they eventually involve trained professional personnel, and occupy hospital beds needed by others who assume more responsibility for their own health than the problem drinkers.

As a professional group nurses occupy a potentially influential position. This is shown in Table 7.1.

Table 7.1: Potential Sphere of Influence of Nurses

Practice in public and private hospitals, centres, institutions
Practice in a variety of community settings
Contact with patients/clients over 24 hours
Contact with individuals of all ages
Contact with individuals and their families or significant others
Acceptable as visitors in people's homes
Perceived as people who have knowledge, especially about health and illness
Membership of a professional association
Requirement to be registered or enrolled, and to hold a certificate in order to practise
Involvement in a variety of available services (obstetrics, geriatrics, schools, etc)
Educated in a variety of settings including baccalaureate and graduate programmes
Contact with other health professionals
Involvement in nursing research

The communication network is there, and only lately an alcoholism module for basic nursing programmes has been recommended. (McEwan, 1981). Nurses would seem to be in an ideal position to raise their level of suspicion about alcohol problems, and their ramifications,in health services in New Zealand.

IMPLICATIONS FOR NURSING RESEARCH

This study drew on the responses of registered nurses,* but different results may have been obtained had the subjects been student nurses. Further research could discover more about what nurses actually do in their management of problem drinkers, and in what situations which behaviour is helpful.

This study has also utilized a method, apparently not much in vogue in the alcoholism arena, for obtaining accurate data. That is the incorporation of the user of the service in the study design. More could be made of this different way of thinking about how the nurse can help the problem drinker. Nursing's societal mission is to give excellent patient care, and to continually develop and improve its practice. (Diers, 1979). Research of this nature contributes to theory-building that will help nursing achieve such a mission.

As Diers (1979) also points out:

> The improvement of practice will be advanced much faster when researchers and practitioners are the same people, or at least when they have constant communication .... (P. 94)

Such activities must surely supply part of the answer to how different treatments work and what it is they have in common.

A further avenue for research in this field is possible differences in results for segregated problem drinker subjects. There is a paucity of research on female alcoholics, for example.

Curiosity about treatment outcomes, in leading the writer and others to formulate specific questions, has built on previous work, e.g. attitudes of nurses towards problem drinkers. This in turn has led to an investigation of nurse behaviour and culminated in some suggestions for future research.

If this study stimulates others to undertake research in nursing management of persons with drinking problems, or helps those in clinical practice to be more aware of their role as motivators or hope-givers in the therapeutic relationship then this project will have been well worthwhile.

* See also critical discussion Appendix N in back pocket with particular reference to marked sections.

APPENDIX A

Characteristics of Addiction

1. An overpowering desire or need (compulsion) to continue taking alcohol and to obtain it by any means.

2. A tendency to increase the amount taken - tolerance.

3. Development of physical dependence and an abstinence syndrome on abrupt discontinuance of alcohol.

4. Detrimental effects on the individual or on society.

(Adapted from Cohen, 1976, P. 7)

APPENDIX B

Characteristics of Dependence

1. A desire, but not a compulsion, to continue taking alcohol for the sense of improved well-being which it engenders.

2. Some degree of psychic dependence on the effect of alcohol, but absence of physical dependence (and hence of an abstinence syndrome).

3. Detrimental effects, if any, primarily on the individual.

(Adapted from Cohen, 1976, P. 7).

APPENDIX C

Why Does An Alcoholic Drink?

1. As an escape from situations of life which he cannot face.

2. As evidence of a maladjusted personality (including sexual maladjustments).

3. As a development from social drinking to pathological drinking.

4. As a symptom of a major abnormal mental state.

5. As an escape from incurable physical pain.

6. Because of basic feelings of inferiority-emotional instability, a sick personality. A person who drinks because he likes alcohol, knows he cannot handle it (but does not care), is considered emotionally unstable.

7. Usually one cannot pinpoint any glaring reason why the alcoholic drinks. In most cases it is more than a suspicion that the alcohol is consumed to relieve a vague restlessness or boredom. The liquid escape temporarily lessens the conflict between physical and emotional networks and the ordinary strains of life.

The above are general reasons. Where the individuality or personality of the alcoholic is concerned, these reasons may be divided as follows:

1. A self-pampering tendency which manifests itself in refusal to tolerate, even temporarily, unpleasant states of mind such as boredom, sorrow, anger, disappointment, worry, depression, dissatisfaction and feelings of inferiority and inadequacy. I want what I want when I want it seems to express the attitude of many alcoholics toward life.

2. An instinctive urge for self-expression, unaccompanied by determination to translate the urge into creative action.

3. An abnormal craving for emotional experiences which calls for removal of intellectual restraint.

4. Powerful hidden ambitions without the necessary resolve to attain them, coupled with discontent, irritability, depression, disgruntledness and general restlessness.

5. A tendency to flinch from the worries of life and to seek escape from reality by the easiest means available.

6. An unreasonable demand for continuous happiness or excitement.

7. An insistent craving for the feeling of self-confidence, calm and poise that some obtain temporarily from alcohol.

(Staub and Kent, 1979, 145-146)

APPENDIX D

Physical and Psychological Manifestations of Excessive Alcohol Consumption

Physical

Bronchitis, possibly related to heavy smoking among alcoholics

Acute alcoholic hepatitis

Cirrhosis of the liver

Alcoholic hypoglycaemia

Pancreatitis

Cardiomyopathy

Poly neuropathy

Wernicke's encephalopathy

Korsakoff's psychosis

Chronic cerebellar degeneration

Alcoholic dementia

Alcoholic myopathy

Psychological

Depression - a significant number of alcoholics commit suicide, even more significant numbers attempt it.

Anxiety

Pathological jealousy

Alcoholic hallucinations

(Delany, 1979)

APPENDIX E

Criteria for Judging Whether A Phenomenon Is A Public Health and Medical Problem (Burns, 1975)

It is a problem if it involves:

- large numbers of the population
- regular use of dangerous quantities
- biological, physical or chemical agent
- inducement of serious medical disorders and/or traumatic injuries
- a certain level of deterioration in well-being and working capacity of affected persons
- seeking of medical attention contingent upon deterioration in the emotional climate of the homes of affected persons

Criteria for Evaluation of the Seriousness of Alcohol-induced Health Problems (Burns, 1975)

Criteria are obtained from the:

- incidence of serious physical illness and accidents resulting from absorption of the agent
- hospital bed occupancy by patients admitted with agent-induced illness
- incidence of lesser physical and emotional illness and accidents in those people who absorb the toxic agent, and/or members of their families and significant others who require help from their general practitioners or from the accident and emergency, or specialist, service of general hospitals
- incidence of fatal accidents, suicide and homicide directly or indirectly resulting from the effects of the toxic agent on brain function.

- incidence of fatal accidents, suicide and homicide directly or indirectly resulting from the effects of the toxic agent on brain function

- loss of working time through absenteeism and decrease in working efficiency in employees and self-employed persons, resulting in diminished earning power and productivity

- extent to which living standards and nutritional state of affected persons and their significant others are reduced

- degree to which social work agencies are involved as a result of the use, misuse and abuse of the agent

- accident and mortality rates induced by diminished intellectual judgement and capacity to carry out sophisticated activities such as driving motor vehicles, including public transport

APPENDIX F

Letter to Chief Nursing Officer

Dear .....,

I am a graduate student of the Nursing Studies Unit, Massey University, at present engaged on a research project under the supervision of Ms N.J. Kinross, Senior Lecturer-in-Charge, Nursing Studies Unit.

I enclose my research proposal, the purpose of which is to examine aspects of the behaviour of nurses towards patients with alcohol-related problems.

The study is designed in two phases. The first phase requires the completing of a questionnaire, which should not take longer than ten to fifteen minutes, by registered nurses in one hospital. The second phase requires the completing of another questionnaire, which should take about the same time, by registered nurses in two hospitals.

I would be very grateful if I could approach the Principal Nurses by letter, requesting assistance in supplying me with the names of staff nurses and charge nurses in each hospital, and enclosing copies of the appropriate questionnaire.

Thank you for your help in this project.

Yours sincerely

Jean Bramley

Jean Bramley
Researcher

APPENDIX F1

MASSEY UNIVERSITY

Nursing Studies Unit

RESEARCH PROPOSAL

Purpose: To identify the behaviours of professional nursing staff perceived by registered nurses and alcoholics as "helpful" and as "unhelpful".

Proposed Research Project:

1. By using a critical incident technique, to obtain from registered nurses and alcoholics examples of what they consider constitutes helpful and unhelpful behaviour towards persons with alcohol-related problems.

2. From the information obtained to analyse the incident reactions and compile a list of such behaviours.

3. By then asking the first and another group of registered nurses and alcoholics, to rank the examples from the list thus obtained, to identify the most helpful and the least helpful aspects of behaviour.

4. To compare the information obtained from the second questionnaire.

Timetable

January: Distribution and collection of critical incident questionnaire.

February: Distribution and collection of second questionnaire.

February/March: Analysis of data.

March: Write up report, with emphasis on the implications for nursing.

Researcher: C. Jean Bramley, R.G.O.N., Diploma of Nursing, B.A.

APPENDIX G

Preamble to Questionnaire

MASSEY UNIVERSITY

Nursing Studies Unit

I am a graduate student of the Nursing Studies Unit, Massey University, engaged in a research project under the supervision of Ms N.J. Kinross, Senior Lecturer-in-Charge, Nursing Studies Unit.

I am interested in finding out what behaviour of nurses is helpful to the person with an alcohol problem.

It would greatly assist me if you would provide information about this by answering the accompanying questionnaire about behavioural incidents.

In order to ensure the confidentiality of your answers please do not include in them any information which might lead to the identification of the hospital or the people involved.

When you answer each question please be as brief as possible --- perhaps only one sentence, if that is enough to describe the whole incident. When you have completed your answers please fold and seal your forms in the envelope provided, and return to me next Wednesday February 18, 1981.

Thank you very much for your assistance.

Jean Bramley

Jean Bramley
Researcher

APPENDIX G1

MASSEY UNIVERSITY

Nursing Studies Unit

GENERAL INFORMATION:

Your name is not required.

1. Age: _____

2. Sex: _____

3. For how long have you been a registered nurse? _____

_____

4. Post basic qualifications: _____

_____

_____

APPENDIX G 2

MASSEY UNIVERSITY

Nursing Studies Unit

HELPFUL BEHAVIOUR:

Please describe briefly, in the space below, a specific behaviour of a nurse, in any setting, which you perceive to have been most helpful to a patient's recovery from a drinking problem.

MASSEY UNIVERSITY

Nursing Studies Unit

UNHELPFUL BEHAVIOUR:

Please describe briefly, in the space below, a specific behaviour of a nurse, in any setting, which you perceive to have been least helpful to a patient's recovery from a drinking problem.

APPENDIX G 3

MASSEY UNIVERSITY

Nursing Studies Unit

GENERAL INFORMATION:

Your name is not required.

1. Age: _____

2. Sex: _____

3. How long have you had your sobriety? _____

_____

4. Occupation: _____

APPENDIX G 4

MASSEY UNIVERSITY

Nursing Studies Unit

HELPFUL BEHAVIOUR:

Please describe briefly, in the space below, the specific behaviour of a nurse, in any setting, which you perceive to have been most helpful to your recovery from a drinking problem.

MASSEY UNIVERSITY

Nursing Studies Unit

UNHELPFUL BEHAVIOUR:

Please describe briefly, in the space below, the specific behaviour of a nurse, in any setting, which you perceive to have been least helpful to your recovery from a drinking problem.

APPENDIX H

22nd January 1981

MEMORANDUM TO:

REGISTERED NURSING STAFF - ..... HOSPITAL

Miss Jean Bramley (District Nurse, Alcohol Management Team) is presently engaged in a research project as part of her post-graduate study programme.

The purpose of her project is to examine aspects of nurses' behaviour towards patients with alcohol-related problems. Miss Bramley has asked if a group of registered staff could be approached with a view to completing two questionnaires - the first to be completed before the end of January 1981, and the second, during February, 1981.

Miss Bramley has approval to visit the hospital during the week commencing 26th January 1981. She will visit wards and departments and may approach registered staff for the purpose of obtaining assistance with her project.

No staff member is obliged to participate.

(Signed)

.....

Principal Nurse

APPENDIX I

Behaviour Relating to Alcoholism Management (B.R.A.M.) Scale

B. R. A. M. Scale

List One: Helpful Behaviours

Specific information exchange between nurse and patient
Awareness of patient's special needs
Attention to patient's physical needs
Acceptance of drinking problem as a medical problem or illness
Demonstration of professionally ethical behaviour
Involvement of others significant to the patient
Provision of emotional support for the patient
Demonstration of clinical competence

List Two: Unhelpful Behaviours

Evidence of insufficient education about alcoholism
Non-acceptance of drinking problem as a medical problem or illness
Needs of the nurse preventing awareness of patient's needs
Denial of emotional support for the patient
Demonstration of professionally unethical behaviour

APPENDIX I 1

MASSEY UNIVERSITY
Nursing Studies Unit

I am a graduate student of the Nursing Studies Unit, Massey University, engaged in a research project under the supervision of Ms. N.J. Kinross, Senior Lecturer-in-Charge, Nursing Studies Unit.

I am interested in finding out what behaviour of nurses is helpful to the person with an alcohol problem.

It would greatly assist me if you would provide information about this by ranking the behaviours on the accompanying lists.

In order to do this please indicate what you consider to be the order of importance of the items you select, by placing a number beside the specified number of items, beginning with (1) for the most important, and finishing with the largest number for the least important item.

Please note that there are two lists to be ranked, neither of which should take more than a few minutes.

I would be grateful if you would complete this procedure while I am here.

Your individual answers will be completely confidential.

Thank you very much for your assistance.

Jean Bramley
Researcher

APPENDIX I 2

MASSEY UNIVERSITY

Nursing Studies Unit

Below you will find two lists of items about the behaviour of nurses towards patients with drinking problems. Please follow the instructions for each list.

List One:

Please rank five of the following items, beginning with (1) for the behaviour you consider to be the most helpful, from (1) to (5):

( ) Specific information exchange between nurse and patient.
( ) Awareness of patient's special needs.
( ) Attention to patient's physical needs.
( ) Acceptance of drinking problem as a medical problem or illness.
( ) Demonstration of professionally ethical behaviour.
( ) Involvement of others significant to the patient.
( ) Provision of emotional support for the patient.
( ) Demonstration of clinical competence.

List Two:

Please rank five of the following items, beginning with (1) for the behaviour you consider to be the least helpful, from (1) to (5):

( ) Evidence of insufficient education about alcoholism.
( ) Non-acceptance of drinking problem as a medical problem or illness
( ) Needs of the nurse preventing awareness of patient's needs.
( ) Denial of emotional support for the patient.
( ) Demonstration of professionally unethical behaviour.

APPENDIX J

Analysis of Critical Incidents

Once the data have been collected the incidents are analysed, similar behaviours grouped together, and descriptive statements constructed for each category and sub-area. Analysis continues until no new types of behaviour are noted. Although the grouping of behaviours is relatively subjective an improved level of objectivity can be obtained through analysis by independent judges, with re-arrangement of incidents if necessary until agreement is reached as to respective categories of incidents.

(Flanagan, 1954)

Appendix K

LIST OF HELPFUL BEHAVIOURS IDENTIFIED BY REGISTERED NURSES

1 Early noting of signs of D.T.s (delirium tremens)
2 Medication begun early in potential D.T.s
3 Prevention of complications of D.T.s
4 Awareness of management problems
5 Communicating relationship of illness/drinking to patient
6 Involving patient with others in ward, and its activities
7 Referral to specialist helper
8 Listening to patient
9 Empathy which encouraged openness by patient
10 Being supportive
11 Being non-judgemental
12 Providing emotional support
13 Being available
14 Remaining near
15 Being understanding
16 Being sympathetic
17 Being kind
18 Talking with patient
19 Showing empathy
20 Consideration given to putting at ease when anxious
21 Showing personal concern and willingness to help
22 Liaising with family and other visitors
23 Involving spouse
24 Provision of help
25 Attendance at alcohol management lectures
26 Confidentiality assured
27 Unafraid of management problems
28 No stigmatising attached to recurrent admissions
29 Giving time to development of person-to-person relationship
30 Openness with other staff to encourage acceptance of patient
31 Gaining knowledge of specific drug regime
32 Treating patient as a person with a medical problem
33 Acceptance as people with problems
34 Providing comfort
35 Protection from self-injury
36 Providing adequate fluids
37 Providing warmth when tremors distressing
38 Leaving light on at night
39 Orientation to surroundings
40 Providing diversional therapy
41 Promoting interest in A.A.
42 Active encouragement in new hobby with goal of change in life-style
43 Concern for physical and social potential in future
44 Realization of likely low self-esteem
45 Letting patient know that the nurse cares about him/her
46 Being direct with patient
47 Relating illness to drinking problem

APPENDIX K 1

List of Helpful Behaviours Identified by A.A. Members

1. Caring shown
2. Understanding shown
3. Help given
4. Priority to abstaining from drinking rather than smoking
5. Hope for the future
6. Being attentive
7. No condemnation, being non-judgmental.
8. Approving of efforts at maintaining sobriety
9. Attendance at open A.A. meetings
10. Learning more about alcoholism
11. Getting to know alcoholics
12. Letting A.A. member know when an alcoholic admitted
13. Being interested enough to take time to talk to patient as a person
14. Asking about life of alcoholic outside of hospital
15. When alcohol problem mentioned by patient nurse showed interest and asked questions
16. Firmness in dealing with the situation of drinking
17. Being direct about the effects of alcohol

Appendix K2

CRUDE LIST OF COMBINED SUB-AREAS OF HELPFUL BEHAVIOURS

A. Demonstrating Clinical Competence

1 Early noting of signs of D.T.s (delirium tremens)
2 Medication begun early in potential D.T.s
3 Prevention of complications of D.T.s
4 Involving patient with others in ward, and its activities
5 Awareness of management problems
6 Communicating relationship of illness/drinking to patient
7 Referral to specialist helper

B. Attending to Patient's Emotional Needs

1 Consideration given to putting anxious patient at ease
3 Being supportive
3● Caring shown
3 Being available
3 Remaining near
2 Talking with patient
2● Asking about patient's life outside hospital
4 Listening to patient
4 Empathy which encouraged openness by patient
4 Being understanding
4 Being sympathetic
5 Being kind
4 Showing empathy
4● Understanding shown
1 Providing emotional support
5 Showing personal concern and willingness to help
5● Being attentive
2● Interested enough to take time to talk to patient as a person
6● Being non-judgemental
6 Being non-judgemental

C. Involving Significant Others

1 Liaising with family, and other, visitors
2 Involving spouse

D. Displaying Professional Behaviour

1 Provision of help
1● Helping
1 Unafraid of management problems
1● No condemnation
1 No stigmatizing attached to recurrent admission
2 Attendance at alcohol management lectures
2 Gaining knowledge of specific drug regime
3 Confidentiality assured
4 Giving time to development of person-to-person relationship
4 Openness with other staff to encourage acceptance of patient

E. Acceptance of Drinking Problem as Medical Problem

1 Treating patient as person with medical problem
2 Acceptance of alcoholics as people with problems

F. Attending to Physical Needs

1 Providing comfort
3 Protection from self-injury
1 Providing adequate fluids
2 Providing warmth when tremors distressing

G. Awareness of Special Needs

1 Orientation to surroundings
2 Realization of likely low self-esteem
3 Concern for physical and social potential in the future
3● Hope for the future
4● Letting A.A. member know when alcoholic admitted
4 Promoting interest in A.A.
5● Attendance at open A.A. meetings
5● Getting to know alcoholics
6● Approving of efforts to maintain sobriety
6● Priority to abstaining from drinking before abstaining from smoking
7 Providing diversional therapy
7● Firmness in dealing with situation of drinking
7 Active encouragement with new hobby, with goal of change in lifestyle
8 Leaving light on at night

H. Specific Information Giving

1 Letting patient know the nurse cares about him/her
2 Being direct with patient
2● Being direct about effects of alcoholism
3● Learning more about alcoholism
4● When alcohol problem mentioned by patient nurse showed interest and asked questions
5 Relating illness to drinking problem (X two)

KEY

● = item contributed by A.A. member

1-8 = assigned categories of sub-areas

Appendix K3

LIST OF UNHELPFUL BEHAVIOURS IDENTIFIED BY REGISTERED NURSES

1 Non-acceptance of alcohol problem
2 Showing dislike/distress
3 Fear, leading to nurse wanting to offer patient alcohol
4 Ignoring patient
5 Rudeness and sarcasm towards patient
6 Aggressiveness
7 Dictatorial, overpowering "dictative" behaviour
8 Not listening to patients with an open mind
9 Sympathetic attitude
10 Telling patient what he/she should be doing
11 Lack of compassion
12 Lack of helping
13 Scorn and judgement shown
14 Belittling patient in front of other patients and staff
15 Apprehension
16 Preference to not attend in care of alcoholics
17 Abhorrence of recurring admissions for excessive alcohol consumption
18 Abhorrence of general condition - clothing, personal hygiene
19 Antagonistic attitudes
20 Refusal to administer analgesic because patient a heavy drinker, with comment, "If you didn't drink so much what we gave you before for pain would have been quite sufficient."
21 Disdainful attitude
22 Minimal contact during the course of a duty
23 Unsympathetic behaviour towards alcoholic patients
24 Impatience when dealing with alcoholic patients
25 Long discussion on how patient should "seek help from the Lord"
26 Took every opportunity to press such advice in spite of patient's objection
27 Involved other staff in using considerable tact to help patient continue in treatment
28 Belief that any benefit from being in hospital would be undone upon discharge
29 Antagonistic behaviour towards alcoholic patients
30 Destructive attitudes towards alcoholic patients
31 Making comments in patient's hearing which convey nurse's hopeless attitude, and ignorance

APPENDIX K 4

List of Unhelpful Behaviours Identified by A.A. Members

1. Negative impression of future conveyed
2. Failure to contact A.A. when alcoholic admitted to hospital
3. No attempt to find out about the person behind the patient
4. Lack of education on alcoholism
5. "Preaching"
6. Going on about self-destruction during patient's withdrawal
7. Not wanting to know

Appendix K5

CRUDE LIST OF COMBINED SUB-AREAS OF UNHELPFUL BEHAVIOURS

A. Demonstration of Professionally Unethical Behaviour

1 Destructive attitude
3 Nastiness in response to patient's objections
4 Showing dislike
1 Offering alcohol to patient
2 Being rude and sarcastic to patient
2 Sympathetic attitude
2 Lack of compassion
2 Lack of help
4 Disdainful attitude
2 Non-sympathetic behaviour
4 Impatience
1 Preference not to attend to care of patient

B. Denial of Emotional Support for Patient

2 Antagonistic behaviour
6 Ignoring patient
3 Aggressiveness
3 Dictatorial behaviour
4 Not listening with an open mind, or when patient wished to talk.
1 Lack of the understanding expected from a nurse
3• "Preaching"
6• Not wanting to know
1• No attempt to find out about the person behind the patient
5 Not spending time with the person
6 As little verbal contact as possible while on duty

C. Needs of Nurse Preventing Awareness of Patient's Needs

3 Showing distress
3 Fear of patient shown
1 Belittling patient in front of others
2 Abhorrence of excessive consumption of alcohol
3 Apprehension about patient's mental state
1 Speaking about alcoholic in derogatory fashion within his earshot
2 Belief that patient would continue to booze

D. Non-acceptance of Drinking Problem as Medical Problem or Illness

1 Long discourse to patient to "seek help from the Lord"
2 Non-acceptance of problem
2 Scorn and judgement shown
2 Refusal to give further analgesic because patient drank heavily
3 Going on about self-destruction while alcoholic in withdrawal
3 Going over patient's past history, which he doesn't want to hear

E. Evidence of Insufficient Education about Alcoholism

1 Negative attitude towards recurring admissions
1 Lecturing patient on dangers of alcohol
2• Negative impression of patient's future
3• Failure to contact AA when patient admitted to hospital
1• Lack of education on alcoholism
2 Belief that good done in hospital would be undone on discharge
4 In patient's hearing, stating that liver so damaged he may as well carry on drinking

KEY

• = item contributed by AA Member

1 - 6 = assigned categories of sub-areas

APPENDIX L

Lists Of Major Areas Of Behaviour And Areas Of Concern In Helpful Behaviour, From Critical Incident Reactions

Major Areas of Helpful Behaviour	Areas of Concern in Helpful Behaviour
A. Demonstrating clinical competence	1. Physical care of alcoholic
B. Attending to patient's emotional needs	2. Relationship-building with alcoholic
C. Involving significant others	3. Positive attitude toward alcoholic
D. Displaying professional behaviour	4. Management aspects
E. Accepting drinking problem as a medical problem	5. Specific aspects of alcoholism
F. Attending to physical needs	6. Medication aspects
G. Awareness of special needs	7. Health education
H. Specific information-giving	8. Caring attitude towards alcoholics
	9. Interest in alcoholics as persons
	10. Encouragement in sobriety
	11. Knowledge of A.A., alcoholism
	12. Hope for future
	13. Firmness in drinking situation
	14. No judgement
	15. Demonstrating help and understanding
	16. Being direct re alcohol/ illness relationship

APPENDIX L1

Lists of Major Areas of Behaviour and Areas of Concern in Unhelpful Behaviour From Critical Incident Reactions

Major areas of Unhelpful Behaviour	Areas of Concern in Unhelpful Behaviour
A. Demonstration of professionally unethical behaviour	1. Negative attitudes towards alcoholic persons
B. Denial of emotional support for patient	2. Negative behaviour towards alcoholic persons
C. Needs of nurse preventing awareness of patient's needs	3. A.A. not being contacted
D. Non-acceptance of drinking problem as a medical problem or illness	4. Hopelessness of the future
E. Evidence of insufficient education about alcoholism	5. Ignorance about alcoholism leading to inappropriate behaviour
	6. Treating alcoholics as non-persons

APPENDIX M

Copy of a Letter

Miss Jean Bramley
[redacted]

Dear Miss Bramley,

Thank you for your comments of "The Student and the Alcoholic Patient". I am happy to share a copy of my questionnaire with you and hope you find it helpful. Your mention of the low rate of referral of clients with alcohol-related health problems points up the fact that lack of recognition of alcoholism as a nursing concern is indeed an international problem. Our situation at East Orange General Hospital has improved to some extent in this regard following several changes, most of them very small, in our inpatient care system.

To begin, we drew up guidelines for medical and nursing care of medical-surgical patients who are alcoholics. The first nursing guideline is "Place a copy of the Medical Guidelines with the doctors' order sheet on the patient's chart". Other nursing guidelines include care of patients in acute withdrawal, teaching of patient and family, suggestions for realistic long and short term goals, referral of the patient to the clinical nurse specialist and/or alcoholism counselor and recommend giving each patient reading material on the nature and treatment of alcoholism as well as a list of available rehabilitation centers and A.A. meetings in their neighborhood.

Whenever I become aware of a nurse's having difficulty caring for an alcoholic in DT's, I assist with bathing, linen change, feeding and calming the patient. This role modeling has been the most effective single teaching strategy I have tried. At a time when the nurse welcomes my physical help, (s) he sees positive patient response to the interventions listed in the nursing guidelines and later uses them with other patients in similar situations. Nurses' identification of patients with drinking problems has increased since we added to our admission assessment form questions asking how much alcohol the patient usually drinks daily, in what form, how long since the patient's last drink and how much has been consumed during the 24 hours prior to admission. Finally, as part of our quality assessment program, we developed a form for assessing care of medical-surgical patients who are alcoholic. We commend nurses personally and in writing to their head nurse when we find nursing care appropriate to the patient's condition and situation. Likewise, we leave notes reminding nurses to include the recommended nursing measures in their planning and documentation of care. As nurses see their care and follow-up with alcoholic patients being evaluated and considered important, they take greater interest in such patients and are further encouraged when the patient response is positive.

I hope these comments have been helpful and I wish you great success in your efforts.

Sincerely , Ann Williams, M.S.N., R.N. Clinical Nurse Specialist

A P P E N D I X N

Critical Discussion

The author wishes the reader to be aware that in the following aspects the procedures used in compiling the B.R.A.M. Scale do not conform to those set out by Flanagan (1954) for the critical incident technique. Although noted in the main text, it is considered important to include this special section.

Statement of General Aim

It is recognized that the character of the incidents obtained may have been influenced by lack of clarity in instructions to the observers. Flanagan (1954) recommends continuing revision of the instructions in order to sharpen the meaning.

Sampling

Size

The size of the sample is small. There is a general problem relating to the number of incidents required to obtain validity, for which there is no simple answer.

However, as guidelines, Flanagan (1954) states that for a relatively simple activity it may be satisfactory to collect only 50-100 incidents, whereas for a skilled activity (such as a nursing activity) 1000-2000 incidents would seem to be adequate. In other cases 2000-4000 critical incidents are required.

In this study only one positive and one negative incident were requested of each respondent, resulting in only 22 of each category being obtained from the registered nurse subjects, and only 11 of each from the A.A. member subjects.

Nature

The nature of the sample in this study is such that the competence of the available observers is limited by failing to represent all the relevant groups involved.

While the registered nurse staff of a general hospital may not be particularly familiar with the activities specifically required in caring for problem drinkers, in both the hospitals used, at any time it is possible to have an alcoholic undergoing detoxication in practically any ward in either hospital, as such persons are admitted on a "scatter bed" system. Other persons are patients for other primary purposes, but with problem drinking as a secondary, or discovered, health problem.

The important point is that such registered nurses do not have specific training as observers for the purpose of the study, other than the written instructions (Appendix G) and explanation by the researcher.

Flanagan (1954) states that very useful observations can be contributed by consumers of the activity being studied.

It must be pointed out that A.A. members do not necessarily represent all such consumers, although some of them are detoxicated in the general wards in the hospitals used in the study.

Representation could be improved by the inclusion of nursing staff and clientele of alcohol assessment and treatment centres, and detoxication wards and centres. In this study some clientele of such a treatment centre were included through their attendance at an A.A. meeting: (In the local setting utilized there is but one specialist nurse employed in the small treatment centre.).

Analysis of Critical Incidents

In this study there is no confirmation of judgments by a number of persons. Although Flanagan (1954) states that there is no guarantee that results agreed on by several workers will be more useful than those obtained from a single worker, nevertheless such confirmation is usually reassuring.

Objectivity is thus reduced by a lack of independent judges in the analysis and categorizing of incident reactions.

Another weakness in methodology is the lack of a pretest in the form of a preliminary questionnaire being tried out with a small group of typical observers.

Thus the author wishes the reader to be aware that, due to deviation in procedures from those recommended by Flanagan (1954) conclusions drawn in Chapters 5, 6 and 7 may exceed what is warranted by the data.

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A P P E N D I X N

Critical Discussion

The author wishes the reader to be aware that in the following aspects the procedures used in compiling the B.R.A.M. Scale do not conform to those set out by Flanagan (1954) for the critical incident technique. Although noted in the main text, it is considered important to include this special section.

Statement of General Aim

It is recognized that the character of the incidents obtained may have been influenced by lack of clarity in instructions to the observers. Flanagan (1954) recommends continuing revision of the instructions in order to sharpen the meaning.

Sampling

Size

The size of the sample is small. There is a general problem relating to the number of incidents required to obtain validity, for which there is no simple answer.

However, as guidelines, Flanagan (1954) states that for a relatively simple activity it may be satisfactory to collect only 50-100 incidents, whereas for a skilled activity (such as a nursing activity) 1000-2000 incidents would seem to be adequate. In other cases 2000-4000 critical incidents are required.

In this study only one positive and one negative incident were requested of each respondent, resulting in only 22 of each category being obtained from the registered nurse subjects, and only 11 of each from the A.A. member subjects.

Nature

The nature of the sample in this study is such that the competence of the available observers is limited by failing to represent all the relevant groups involved.

While the registered nurse staff of a general hospital may not be particularly familiar with the activities specifically required in caring for problem drinkers, in both the hospitals used, at any time it is possible to have an alcoholic undergoing detoxication in practically any ward in either hospital, as such persons are admitted on a "scatter bed" system. Other persons are patients for other primary purposes, but with problem drinking as a secondary, or discovered, health problem.

The important point is that such registered nurses do not have specific training as observers for the purpose of the study, other than the written instructions (Appendix G) and explanation by the researcher.

Flanagan (1954) states that very useful observations can be contributed by consumers of the activity being studied.

It must be pointed out that A.A. members do not necessarily represent all such consumers, although some of them are detoxicated in the general wards in the hospitals used in the study.

Representation could be improved by the inclusion of nursing staff and clientele of alcohol assessment and treatment centres, and detoxication wards and centres. In this study some clientele of such a treatment centre were included through their attendance at an A.A. meeting: (In the local setting utilized there is but one specialist nurse employed in the small treatment centre.).

Analysis of Critical Incidents

In this study there is no confirmation of judgments by a number of persons. Although Flanagan (1954) states that there is no guarantee that results agreed on by several workers will be more useful than those obtained from a single worker, nevertheless such confirmation is usually reassuring.

Objectivity is thus reduced by a lack of independent judges in the analysis and categorizing of incident reactions.

Another weakness in methodology is the lack of a pretest in the form of a preliminary questionnaire being tried out with a small group of typical observers.

Thus the author wishes the reader to be aware that, due to deviation in procedures from those recommended by Flanagan (1954) conclusions drawn in Chapters 5, 6 and 7 may exceed what is warranted by the data.