The origins and evolution of the disease concept of treatment.

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Abstract:

The origins of treating alcohol as a disease were found to have originated in informal Alcoholics Anonymous meetings, published in AA literature and practiced in treatment programs. The disease concept of treatment (DCT) also evolved concurrently in state mental hospitals and detoxification units.

The disease concept of treatment (DCT) has been the dominant treatment model for alcoholism in the United States for the last 30 years (Hester and Miller, 1995; Institute of Medicine, 1990; Roman and Blum, 1991), however, remarkably little has been written about its nature. Writings have focused on its theoretical underpinning, the disease concept (Roman and Blum, 1991), rather than the treatment techniques and principles that seem to follow from it. Writings about DCT have been largely critical. Gordis (1987) states that it relies on unvalidated approaches. Fingarette (1988) claims that it depends on an untenable disease concept. Other authors have criticized the lack of innovation in DCT (Tournier, 1979) and its failure to use scientifically endorsed methods (Miller et al., 1995; Peele, 1984). Kalb and Propper (1976) and Pattison (1977) characterize alcoholism counselors, the primary treatment providers for DCT, as not open to new knowledge but rooted in the traditional and inviolate knowledge conveyed by Alcoholics Anonymous (AA). The aim of this article is to clarify the nature of DCT by tracing its historical origins and evolution in institutions. Brief descriptions of several representative facilities and interactions between professionals and alcoholism counselors are given as a demonstration of the processes that occurred.

AA, the Disease Concept and DCT

AA is a spiritual self-help fellowship based on the 12 Steps and the 12 Traditions, promising "recovery" from the "malady" of alcoholism. Bill Wilson, the co-founder of AA, wrote both the 12 Steps and the 12 Traditions (Alcoholics Anonymous, 1957), using as sources the practical experiences of early AA members and the teachings of the Oxford Group (Kurtz, 1979), a Christian reform movement (Pittman, 1988). Its principles, as viewed by its adherents, are spiritual (Alcoholics Anonymous, 1976, p. 45) and not scientific. AA is nonprofessional (Alcoholics Anonymous, 1976, 8th tradition) and is not a treatment program (Miller and Kurtz,

1994). A core belief of AA is that alcoholism is a "progressive illness" characterized by loss of control over drinking, which can never be regained (Alcoholics Anonymous, 1976, p. 30; Denzin, 1987; McCrady, 1994). The program for recovery (the model for change) includes attending AA meetings and "working" the steps (i.e., accepting and using them as a guide for living). AA suggests that the newcomer obtain a sponsor, an established AA member who can help him/her understand how AA works. The sponsor has no special training beyond his/her experience in recovery as an AA member. Each recovering alcoholic, however, develops his/her own recovery program. The philosophy and principles are spelled out in Alcoholics Anonymous (1976), an official publication of AA.

The disease concept, implicit in AA (Blume, 1983; Roman 1988; Schneider, 1978), was promoted by the National Council on Alcoholism (NCA) from its inception in 1944 (Keller, 1986). Mann (1958), the founder of NCA, included these elements in the disease concept of alcoholism: (1) Alcoholism is a disease. (2) Alcoholics gradually develop "loss of control" over drinking; once they begin drinking, they may be unable to stop. (3) Alcoholism is a permanent and irreversible condition; alcoholics can never drink safely. (4) Alcoholism is a progressive disease, which if untreated can lead to insanity or death. While this list conveys the general idea of the disease concept, there are variations (Laundergan, 1982; Milam and Ketcham, 1981; Pattison et al., 1977). The scientific validity of these postulates has been challenged for some time (Miller, 1993; Pattison et al., 1977; Wallace, 1993).

The basic features of DCT, as culled from several sources, are: (1) a didactic component, especially instruction on the disease concept; (2) abstinence as the only acceptable goal; (3) confrontation group therapy with the aim of acceptance of being an alcoholic; (4) indoctrination into the AA program; and (5) use of alcoholism counselors, supervised by professionals, as the primary treatment providers (Cook, 1988; Laundergan, 1982; Mann, 1991; Stuckey and Harrison, 1982).

A striking feature of the disease concept of treatment is that physicians are not mentioned nor are any medical procedures indicated (except for detoxification, discussed later). Another unusual feature is that only two of the five elements of DCT (1 and 2) are directly derived from the disease concept. DCT is compatible with AA principles, however. Other names for DCT are the medical model (Siegler et al., 1968), the Minnesota model (Spicer, 1993) and the 12-step facilitation model (Nowinski et al., 1992). Key to the development of the model were individuals, not professionally trained, hired to treat alcoholics in institutional settings and individuals in AA, usually recovering alcoholics, called variously lay counselors, AA counselors and paraprofessionals. In this article, the term alcoholism counselor will be used uniformly.

Institutional Alcoholism Treatment in the Early 20th Century and the Founding of AA

From the beginning of Prohibition in 1919 until the late 1940s, there was virtually no institutional treatment for the alcoholic (Lender and Martin, 1987; Pittman, 1988). There were a few private facilities that were mainly for the purpose of "drying out" alcoholics, an early term for detoxification. Most of these programs were unlicensed, however, and provided treatment of questionable merit (Corwin and Cunningham, 1944). Thus, AA, founded in 1935 (Alcoholics Anonymous, 1957), filled a large vacuum in the treatment system. From AA's inception, its

members offered help to other alcoholics, and this outreach became codified in AA's 12th step and 5th tradition (Alcoholics Anonymous, 1976). These early members formed clubhouses and AA homes, where they could bring newcomers and offer the AA program (Richeson, 1978). They also made themselves available to hospitals as volunteers (Alcoholics Anonymous, 1957; Smith, 1941).

In the early days, some recovering alcoholics became "professional alcoholics," as Taylor (1977) described them, dedicating their lives to helping alcoholics by offering their services as speakers on alcoholism and being available to help alcoholics in the community. For many, this activity started in a small way often on a volunteer basis and later led to a full-fledged occupational commitment, as for example running a halfway house. Bill Wilson and Dr. Bob Smith, the cofounders of AA, Pat Cronin, the first AA recovering alcoholic in Minnesota (Richeson, 1978), and Marty Mann, the first female alcoholic in AA (Johnson, B.H., 1973), are examples.

The Evolution of the Disease Concept of Treatment in Institutions

The evolution of DCT can be seen most clearly in the development of AA facilities. The model emerged, concurrently, in state mental hospitals and detoxification programs. The development of the model will be traced in these three types of institutions. Outpatient alcoholism clinics, which retained a traditional psychiatric model long after the other institutions had implemented DCT, will also be discussed.

The AA farm and the structured AA program

In the late 1930s and early 1940s, AA members developed informal facilities, called AA farms, recovery homes or retreats. The first, High Watch Farm, given to AA in 1939, was a retreat for recovering alcoholics wishing to embrace the AA lifestyle (Deutsch, 1992). There was no medically trained staff, no "treatment," just AA members helping newcomers (Alcoholics Anonymous, 1957; Committee on Public Health Relations of the New York Academy of Medicine, 1946-47; Robinson, 1989).

Many of these facilities, however, did begin to develop an informal treatment program centered around the steps of AA (Mann, 1991; Nace, 1993; Stuckey and Harrison, 1982), usually headed by a recovering alcoholic, and often begun in his house (Nace, 1993; Stuckey and Harrison, 1982). One of the first was Pioneer House opened in 1948. Its first director, Pat Cronin, developed 15 lectures on the 12 steps of AA (Richeson, 1978) and encouraged residents to do the 4th and 5th steps. Thus, AA principles were systematically presented in a didactic manner. These programs, which will be called Structured AA Programs, represent a midway point between the first informal AA facilities and DCT programs.

Halfway houses and alcoholism rehabilitation treatment centers

Two institutions developed from the informal AA facilities: the halfway house and the Alcoholism Rehabilitation Treatment Center (ARTC). At first, there was little distinction between the two, but eventually the halfway house developed a longer length of stay and work requirements, and formal treatment was shifted to affiliated outpatient alcoholism clinics, while

the ARTC developed an intensive, structured inpatient treatment with a shorter length of stay, often 30 days (Laundergan, 1982).

Halfway houses. Bill Wilson has been credited as the founder of the first prototype halfway house as he offered shelter and advice to alcoholics in 1935 (Kurtz, 1979), thus setting the tone for future programs (Richeson, 1978). One of the earliest halfway houses was the Fellowship Club established in 1953 to help homeless alcoholics (McElrath, 1987). It has been described as a home with an atmosphere of intimacy while it "provided a straight from the shoulder AA program" (McElrath, 1987, p. 62). The halfway house has been viewed as an extension of AA (Trice, 1966) since most halfway houses made extensive use of AA (Cahn, 1970) and often used AA principles as its sole treatment (Richards, 1968; Rubington, 1977). In halfway houses most of the paid workers were recovering alcoholics (Blacker and Kantor, 1968) and volunteers from AA were often present (Richards, 1968; Richeson, 1978). Staff and residents worked, ate and slept together, facilitating communication, minimizing professional status differences and emphasizing fellowship (Rubington, 1973). Requirements of abstinence (Blacker and Kantor, 1968; Cahn, 1970) and attendance at AA (Donahue, 1971; Rubington, 1977) reinforced AA principles. Since halfway houses, unlike the other facilities to be discussed, did not hire professionals, the exclusive adherence to AA principles remains largely intact today.

The ARTC. Other AA facilities developed into more structured and professional programs, known as ARTCs. Hazelden, whose history will be traced here, was founded in 1949 as an exclusively AA-oriented facility (Richeson, 1978, p. 189). The first director, Lynn Carroll, was an AA recovering-alcoholic layperson. "He developed a recovery course based on the straight AA program and process" (McElrath, 1987, p. 31), a Structured AA Program similar to that of Pioneer House.

In 1961, Dr. Daniel Anderson, hired from Willmar State Hospital, began to modify Hazelden's treatment program by hiring professionals and adding professional treatment elements. Even though Dr. Anderson was an advocate of AA principles (Anderson, 1981), the recovering-alcoholic staff became concerned about the changes (McElrath, 1987, p. 102; Richeson, 1978, p. 190). They felt that the hiring of professionals challenged the purity of the AA philosophy (McElrath, 1987, p. 103). They resented charting requirements, formal staff meetings and psychological testing of the patients (McElrath, 1987, p. 124). One counselor called the MMPI "reading the `tea leaves.'" (McElrath, 1987, p. 124). Several counselors became so unhappy that they left, including Lynn Carroll. However, the program continued to evolve and from 1966 to 1970 Hazelden's program solidified into an ARTC, utilizing the DCT approach (McElrath, 1987, p. 129). While professional standards were instituted, the important elements of the Structured AA Program remained, including instruction in the 12 steps, "working" the first five steps, and didactic lectures. Two added elements were the psychological. assessments, which helped the client realize problematic attitudes, and group sessions conducted by alcoholism counselors (Laundergan, 1982). Confrontation group sessions were developed at Hazelden in 1967 in a special program for repeaters (McElrath, 1987, p. 132). In these sessions, the patients were confronted with the evidence of their alcoholism and encouraged to accept it. The confrontation groups may have become necessary because of the time-limited nature of ARTC programs. It is likely that patients had to acknowledge their alcoholism early in the treatment in order to cycle through the program smoothly. Such groups are a departure from AA principles since there are

no time constraints nor requirement of admitting being an alcoholic in AA philosophy (Miller and Kurtz, 1994). Richeson (1978) attributes the invention of the confrontation group approach to Vernon Johnson in 1966. There is a detailed discussion of confrontation groups in Johnson's (Johnson, V.E., 1973) popular book, I'll Quit Tomorrow.

The state hospitals create specialized alcoholism units

In the late 1940s and the 1950s the state mental hospitals provided the bulk of institutional care for alcoholics (Cahn, 1970; National Institute on Alcohol Abuse and Alcoholism, 1973; Plaut, 1967), yet little treatment was provided (Blume, 1986; Chafetz and Yoerg, 1977; Glasscote et al., 1967; McCullough, 1952). AA members began to volunteer in state hospitals to help remedy this deficiency, first at Rockland State in New York (Alcoholics Anonymous, 1957;, Smith, 1941). AA members took patients to outside AA meetings, offered to talk to patients about their alcoholism and brought AA meetings to the hospital. By 1957, AA members had volunteered in 200 state mental hospitals (Alcoholics Anonymous, 1957).

Willmar State in Minnesota was the first state hospital to incorporate a special alcoholism unit. Before 1950, like other state hospitals, Willmar State had no treatment for alcoholics except for detoxification (Anderson, 1981). Nelson Bradley, the new director, and Daniel Anderson, the psychologist who later became director of Hazelden, took an interest in the treatment of alcoholism. As a first step, they brought in AA speakers and AA meetings. They sought advice of AA leaders and fostered communication between professionals and AA members (McElrath, 1987). They realized that, in order to fully incorporate the benefits of AA, they would have to, hire recovering alcoholics as alcoholism counselors, which they did in 1954 (Anderson, 1981, p. 18). At first, the interaction between the alcoholism counselors and the professional staff was characterized by challenge and crisis (McElrath, 1987, p. 69). McElrath reports, "It is difficult today to imagine how radical a change this was, to go from a physician-oriented, psychoanalytic hospital to a treatment program conducted by `drunks'" (McElrath, 1987, p. 74). Anderson stated that the AA philosophy of the alcoholism counselors quickly influenced the whole program (Anderson, 1981, p. 18). One such effect was that professionals became more relaxed, less distant and less formal, allowing first names to be exchanged among staff and patients on the unit (McElrath, 1987, p. 76). By 1960, there was genuine cooperation between the professionals and alcoholism counselors (Rossi and Bradley, 1960).

The 60-day program that was developed at Willmar State consisted of a didactic component of 28 lectures, including "Alcoholism as a Disease," "The AA Way of Life," "The 4th and 5th Steps," and group therapy conducted by the alcoholism counselors. Every evening there was an AA meeting or a discussion about AA (Rossi and Bradley, 1960). This program made alcoholism treatment distinctly separate from psychiatric treatment and facilitated the creation of separate units within hospitals. By the early 1960s, 45 state hospitals, of 171 responding to a survey conducted by Moore and Buchanan (1966), indicated that they had developed programs that incorporated many of the elements originated at Willmar State (Cahn, 1970; O'Neil, 1968; Plaut, 1967).

The creation of detoxification programs

In the 1940s, hospitals were reluctant to admit alcoholics in need of detoxification or other medical complications of alcoholism because of society's moralistic views of the disorder (Corwin and Cunningham, 1944). It was not until 1956 that the American Medical Association stated that alcoholics in medical need merited consideration for admission to hospitals (American Medical Association, 1956) and not until the 1970s that detoxification units became common (Moore, 1977). In these units, medical treatment for complications of withdrawal and alcoholism was followed by an introduction to AA by AA volunteers or an introduction to the disease concept by alcoholism counselors (Reed, 1978).

The origins of the modern detoxification unit can be traced back to Dr. Bob Smith's work at St. Thomas Hospital in Akron, Ohio. Dr. Smith, both physician and co-founder of AA, worked in St. Thomas Hospital from 1939 until his health failed in 1949. He was the first to import AA principles into a medical facility and probably the first to utilize several elements of DCT. Besides offering medical care, "Dr. Bob gave basic talks at the hospital emphasizing that alcoholics were chemically constituted different from average individuals, that alcoholics were allergic to alcohol" (Alcoholics Anonymous, 1980, p. 117). AA volunteers visited the unit continuously throughout the day and called the ward the basic-training grounds for AA (Alcoholics Anonymous, 1980, p. 192). Patients were helped through their 4th step (Alcoholics Anonymous, 1980, p. 196). Chronic recidivists were not readmitted so newcomers would not be negatively affected.

While some hospitals used St. Thomas Hospital as a model, like the Lincoln Avenue Plan in Ohio, where all the treatment staff were recovering alcoholics in AA (Reed, 1978), detoxification units did not become widespread until many years later. Two events sparked their broader acceptance. First, in 1955, experiments conducted at U.S. Public Health Service Hospital in Lexington, Ky., showed that delirium tremens was caused by withdrawal effects from alcohol (Isbell et al., 1955), lending credibility to the medical necessity of medical detoxification of alcoholics and medical treatment for alcoholism. Second, the 1971 Uniform Alcoholism and Intoxication Treatment Act encouraged the creation of treatment alternatives to arrest for public intoxication and the funding of detoxification facilities for public inebriates (Chafetz and Yoerg, 1977; Moore, 1977). St. Mary's Infirmary in St. Louis, established in 1966, is credited with being the first modern detoxification unit (St. Louis Metropolitan Police Department, 1970).

Regier (1979) has vividly demonstrated how DCT reevolved in two detoxification units created in response to the 1971 Act. At first a "medical" atmosphere was maintained in these facilities, guided by a naive belief that the aura of the hospital environment and medical treatment of withdrawal symptoms and related medical illnesses would cure the disease. Relapsed patients were readmitted with the understanding that they had an illness and were not responsible for their relapses. However, as most of the patients showed no improvement after repeated hospitalizations, the staff became discouraged. In the face of these repeated treatment failures, the professionals began to doubt the disease approach while the alcoholism counselors, deeply committed to it through AA, did not (Regier, 1979, p. 81).

The alcoholism counselors met several times and drew up a position paper to develop a better treatment model. They felt the continuous admission policy may have unwittingly contributed to the alcoholic's disease. They recommended refusing admission to repeaters, suggesting that it

was important that alcoholics experience the negative consequences of their drinking as this might better motivate them to become sober.

This position was presented at staff meetings, in which some lively exchanges occurred, as for example the following comments by an alcoholism counselor, "Say it's a guy's fifteenth admission here, and he's been out drinking for half a day. He's received here with open arms. He's brought in like it's his home. You are depriving that individual of feeling reality, and thus you are killing him (loudly, pointing finger at Director)" (Regier, 1979, p. 83).

At this stage an uneasy alliance developed between the professionals and the alcoholism counselors. The professional staff realized that they had no viable notion of how to proceed once the acute effects of withdrawal were medically treated. The alcoholism counselors, on the other hand, could offer the principles of AA to help the alcoholic seek and obtain sobriety. They were allowed to do this and, informally, they began to restrict admissions. Thus, it appears that Dr. Smith's treatment model had been re-embraced.

Outpatient alcoholism clinics

The Yale Plan Clinics, founded in 1944 (Jellinek, 1944-45), were the first "modern" alcoholism clinics. Keller describes the experimental nature of these programs: "Our idea was to use a variety of methods. We tried to fit treatments to types of patients. We treated with the classical Pavlovian conditioned-reflex method. We treated with disulfiram as soon as it became known. We treated with individual psychotherapy. We did not neglect religiotherapy and we did not overlook sociotherapy including vocational counseling, and we eagerly collaborated with Alcoholics Anonymous" (Keller, 1986, p. 35). From this description and a review of the transcripts of 11 group sessions conducted there (AA was prominent in only one discussion [McCarthy, 1949a,b,c, 1950a,b,c, 1951a,b, 1952]), it can be seen that AA was not the primary ingredient in their treatment model. Unlike the state hospitals, where the alcoholism programs were created in cooperation with AA members, alcoholism clinics through the late 1960s were developed from various psychiatric models, employing mental health professionals and utilizing individual psychotherapy as the primary modality (Cahn, 1970; Frazier, 1968). Cahn (1970) reports that there was antagonism between outpatient alcoholism clinics and local AA chapters, which may have hindered the adoption of DCT. According to Cahn, professionals in the outpatient clinics, viewing alcoholism as a symptom of a psychiatric disorder, objected to AA's view of alcoholism. Further, the professionals were often demoralized by and defensive about their lack of success in treating alcoholics (Gerard and Saenger, 1966), which may have made it difficult for them to accept AA members' help. For their part, AA members objected to the clinics' restrictive admission policies of admitting only the most motivated alcoholics (Gerard and Saenger, 1966), indifference to patients' medical problems and professionals' refusal to learn from AA (Cahn, 1970). Gradually, however, clinics came under the sway of DCT because newly created state alcoholism agencies began to regulate alcoholism facilities, often based on disease concept philosophy, as for example in New York State (New York State Office of Alcoholism and Substance Abuse Services, 1995, Cross-Training History Script, unpublished manuscript) and California (Wiener, 1981). In addition, the large numbers of private DCT inpatient programs newly created in the 1970s and 1980s often added outpatient clinics, which of course were governed by DCT principles (Sunshine and Wright, 1988). As the clinics began to embrace

DCT, the treatment elements became standardized to include didactic lectures, special types of group therapy, a standard length of stay (Cocores, 1991; Tatarksy and Washton, 1992) and use of alcoholism counselors as primary therapists (Banken and McGovern, 1992; Kolpack, 1992).

The proliferation of disease concept treatment programs

In the 1970s, DCT programs developed all over the country, and in 1978 a monograph (Groupe, 1978) celebrated their coming of age by giving accounts of 13 DCT programs. Boscarino's survey of alcoholism programs in the same year also indicated the prominence of this model (Boscarino, 1980). In 1979 Tournier wrote his famous article which claimed that AA had come to dominate alcoholism treatment as a philosophy and method. None of the published commentary in the Journal of Studies on Alcohol disagreed with his assertion (Demone, Goodwin, Madsen, Moore, Rosenberg, Shulman, and Sobell and Sobell, all 1979). Shulman (1970), however, did criticize Tournier for characterizing DCT programs as using only AA since these programs make use of professional treatment elements like group therapy and aftercare planning. By 1983 alcoholism counselors were the majority of the treatment providers in alcoholism treatment programs (Saxe et al., 1983). In the 1980s, the status of alcoholism counselors was raised by creating a competency-based credential for alcoholism counseling in most states (Banken and McGovern, 1992; Institute of Medicine, 1990).

Discussion

It is ironic that the debate about the scientific credibility of the disease concept raged for several years, when, in fact, the implementation of DCT was essentially the practical application of AA principles in institutions.

From the historical perspective developed here, it appears that DCT consists of the systematic and structured indoctrination of AA principles, with the addition of some other elements, especially the confrontation groups. The degree to which these changes make DCT meaningfully different from AA practice is unclear. A useful way to begin to determine such differences would be to compare the opinions and practices of alcoholism counselors with those of AA members. For example, Kurtz (1984) found differences between AA members' and professionals' ideological views of alcoholism. In surveying the views and practices of alcoholism counselors, alcoholism professionals and AA members, would we find that alcoholism counselors have more in common with the professionals or with AA members?

This historical review suggests that AA members in their efforts to help alcoholics created informal facilities that were the forerunners of all the current treatment facilities except the outpatient clinic. DCT programs evolved in AA facilities and in institutional settings. In AA facilities, Structured AA Programs represented a midway point between the first informal AA facilities and DCT programs. DCT was established when professionals were hired and some professional treatment elements were added. In institutional settings, AA members first volunteered and then were hired as alcoholism counselors, supplying a personal commitment to AA principles, which became formalized and structured into DCT. In some AA facilities like halfway houses, AA principles remained primary since professionals were never hired. The late

emergence of DCT in outpatient clinics may have been caused by the lack of cooperation between AA chapters and the clinics.

In both AA facilities and institutions, professionals and alcoholism counselors had to reconcile their differences concerning professional knowledge and experiential knowledge of alcoholism (Borkman, 1976). The alcoholism counselors relied on their personal experiences in AA to understand alcoholism while the professionals made use of knowledge learned in their professional schools. Regier's description of two detoxification programs and the history of Willmar States' alcoholism unit suggest that the experiential knowledge of AA became dominant. Even at Hazelden, where Dr. Anderson succeeded in introducing professional treatment elements, the resulting program is primarily based on the experiential knowledge of AA.

The depiction of this historical development is based on published accounts. Detailed archival research is required to show that the trends noted in the institutions described here are representative of the processes that occurred. Additional information on the interactions between alcoholism counselors and professionals would be useful to explore to what extent DCT represented a true collaboration between them. Did they create an emergent model of alcoholism treatment that incorporates both professional and experiential knowledge bases? Or, alternatively, did DCT simply provide a rationale for hiring alcoholism counselors and incorporate AA principles in institutions?

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