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.

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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.

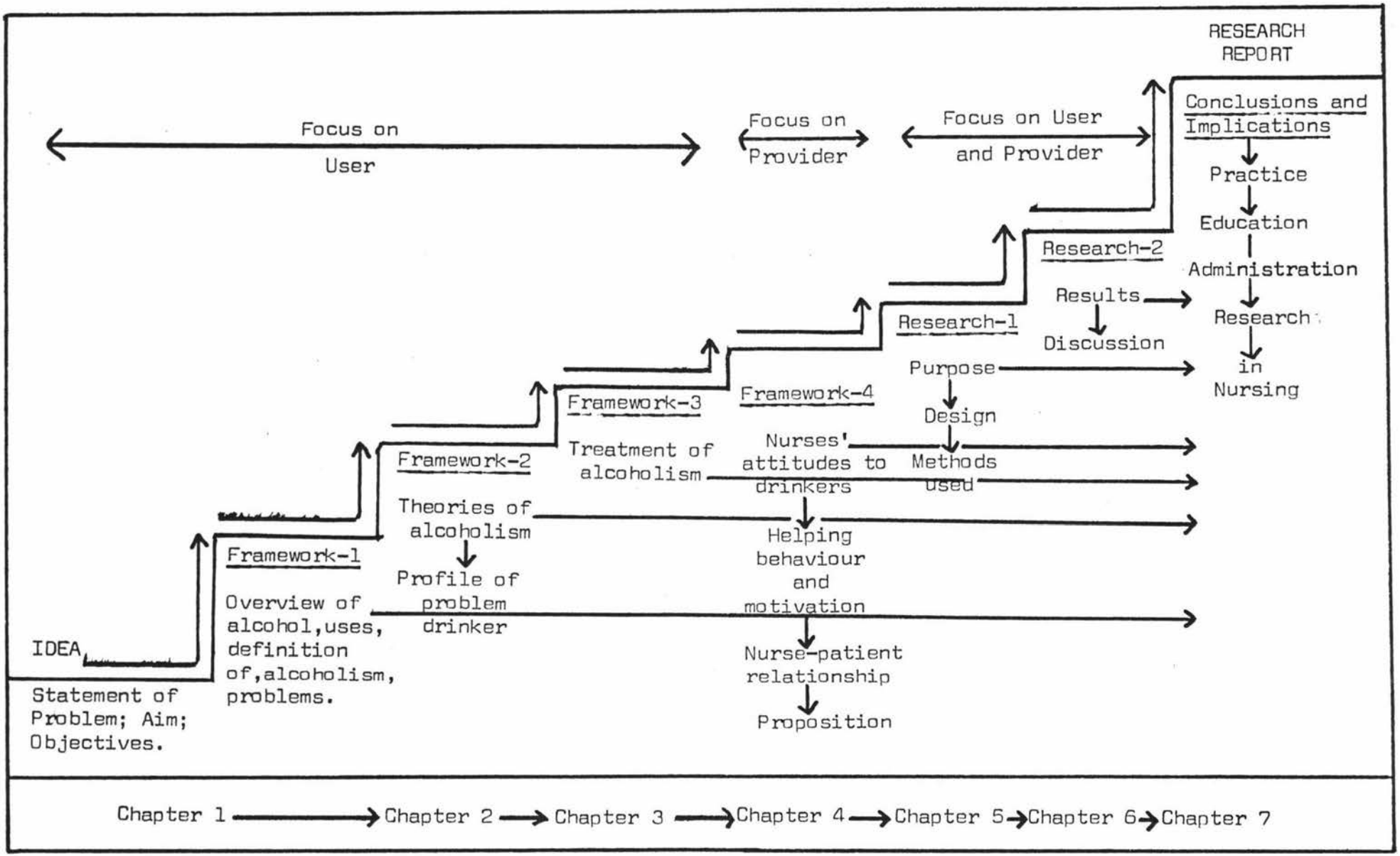

Figure 1.1: Plan of Thesis using Discovery Approach

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:

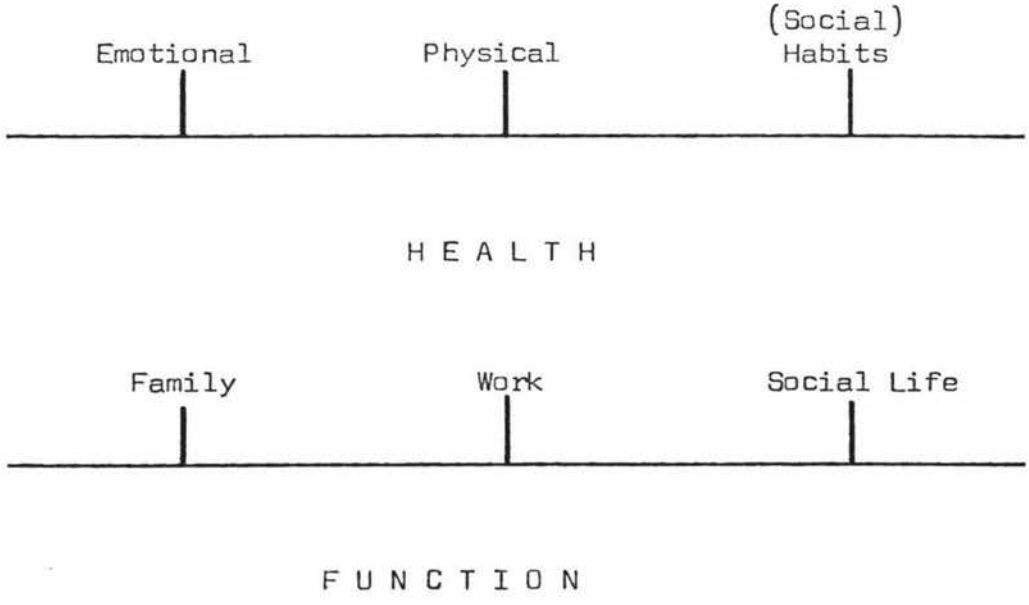

Figure 2.1: Areas of health and function in which alcohol causes harm. (Moon, 1979).

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.