

Attitudes of Clinical Social Workers Toward Alcoholis

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"The alcoholic experience is characterized by seemingly endless variety. The differences among alcoholics are so numerous that one hesitates to speak of a single unified "alcoholic experience". Alcoholics come in all shapes, Sizes, colors, sexes, occupations, levels of education, state of mental health, and income level. Contrary to all popular stereotypes, alcoholics do not even drink alike, nor do they share a single, common life history. Some alcoholics drink daily; others drink in episodic patterns, staying "dry" for intervals between drinking binges. Some drink enormous quantities of alcohol beverages; others consume relatively little. Certain alcoholics will drink only beer or wine; others only distilled spirits such as bourbon and Scotch. In terms of life careers, the patterning of the disease is equally variable, appearing very early in the lives of some people and later in the lives of others. There are persons who claim to have started drinking alcoholically from their very first drink; many others report that they drank for a number of years before crossing over the "invisible line" that separates "social drinking" from alcoholic drinking" (P.3).**John Wallace (1986)**

Introduction

The nature of alcoholism is a controversial subject in contemporary society. Alcoholism is a complex phenomenon which includes social, psychological, physiological, and political aspects. Many attempts have been made in the past to define alcoholism but none has received a universal recognition by all professional groups and among professionals within the same group (Anderson, 1987). The etiology of alcoholism is unknown yet, which leaves room for theoretical speculations (Schuckit, 1986).

There have been many studies on the biologic factors that attempted to establish the etiology of alcoholism. A review of all these studies is beyond

the scope of this work. Nonetheless, of all the variable studied, genetic factors were the easiest to investigate and have yielded findings of importance in establishing one element in particular of the many responsible for the final alcoholic picture (Schuckit, 1986). The fact that the concordance rate of identical twins for alcoholism never reached 100% suggests that other factors (social and psychological) are important in the development of alcoholism. It should be clear, however, that psychological and sociological variables are difficult to control, define, and measure, which probably explains the contradictory evidence and paucity of solid results from the etiological investigations on the social, psychological, and genetic factors.

The domination of the disease model on the alcoholism treatment industry along with the disease concept of alcoholism which is held by many practitioners and recovering alcoholics are major contributing factors to much of the confusion and controversy among professional groups (Lawson, Peterson, & Lawson, 1983).

When the questionnaire or interview design permits apparently contradictory responses to be made, the public's beliefs about alcoholism seem to be confused (Heather & Robertson, 1983). The confusion is not surprising when the lack of consensus among professionals is considered.

Although Bailey (1970) found 85% agreement with the statement "alcoholism is a disease" in a group of social caseworkers, reliance on percent as indicative of consensus is misleading since it offers no control over the agreement or disagreement that might occur by chance (Rapp, 1980). Knox (1971) found that only 35% of a group of 925 psychologists and psychiatrists endorsed the notion that alcoholism is a disease. Knox (1973) found a lack of consensus among social workers regarding the endorsement of the disease definition of alcoholism. These differences may be, in part, due to the way in which attitudes were measured (Heather and Robertson, 1983). Strong (1979), used a series of open-ended interviews with a number of general practitioners, and found that clearly medical conceptions of alcoholism were not held by most of them; rather these doctors held ambiguous attitudes centered around social and environmental pressures, simple personal choice, and the notion of "will - power".

This study focuses on whether or not there is a consensus among social workers with regard to the nature of alcoholism. Consensus means a general agreement among certain people regarding a position and/or a statement (Hornby, 1974). Two models were used in this study to examine consensus.

First, the disease model which views alcoholism as a disease. According to Jellinek (1960), alcoholism is a progressive illness and unless adequate treatment is provided, an alcoholic will eventually progress to death. Thus, the only hope for alcoholics is to abstain permanently from alcohol (Jellinek, 1952).

Second, the controlled drinking model, grounded in learning theory, emphasizes cognitive psychological factors in the etiology of alcoholism (Heather & Robertson, 1983). This model holds that alcoholism is a learned behavior; and therefore, it can be modified. controlled drinking is the treatment goal suggested by this model.

Social workers are heavily involved with alcoholics. Those who work in hospitals and/or treatment centers are likely to have a direct contact with the alcoholic population. Likewise, those who work in other settings are likely to encounter alcoholic clients in their practice occasionally. According to Bailey (1963), 15 - 20% of the cases seen at family agencies are alcohol related, and if the therapists were motivated to look further for symptoms of alcohol abuse, the figures could be higher. Social workers are in a unique position for prevention and early intervention with alcoholism (Anderson, 1987). Because of this close relationship between social workers and alcoholics, it is important to know how social workers view alcoholics and alcoholism.

Several studies have shown that social workers have negative attitudes toward alcoholics. Peyton, Chaddick, and Gorsuch (1980). found a strong bias against selecting alcoholics as clients by a group of graduate social work students. Wechsler and Rothman (1982), compared the attitudes of graduate students in four fields (medicine, nursing, social work, and counseling) and found that social work and counseling students were the least interested in treating clients with drinking problems.

Negative attitudes towards alcoholics are detrimental to the processes of diagnosis, relationship building, and ongoing treatment (Hanna, 1978). Professionals who respond negatively to alcoholics consider them poorly motivated, and consequently difficult to treat (Chafetz, 1968).

Research Problem:

The research problem can be stated as "investigating the kind of attitudes held by clinical social workers toward alcoholism".

The study was directed towards answering the following questions:

1. To what extent is there consensus about the nature of alcoholism among social workers?
2. What models do social workers use to describe alcoholism?

3. Is personal experience a factor that influences social workers towards favoring one model over another?

The reference to personal experience is to those of the subjects who are themselves recovering alcoholics and/or have an alcoholic family member.

4. Is there a relation between licensed clinical social workers' attitudes toward alcoholism and their demographic characteristics?

Sampling:

The population of this study is composed of licensed clinical social workers in the State of Illinois. The mailing list which contained the names and addresses of 4419 licensed clinical social workers was obtained from the Office of Professional Regulations in the State of Illinois located in Springfield, Illinois.

A sample was randomly selected from this population. The sampling procedure ensured that each licensed clinical social worker in the State of Illinois had the same probability of being selected to participate in this study. The randomization procedure included card shuffling by using the following steps: (1) a set of cards was prepared, each card carries a number corresponding to a page number of the mailing list. Since there was 246 pages in the mailing list, 246 cards carrying numbers from 1-to-246 were prepared; (2) each page in the mailing list contained 18 names, therefore, a set of 18 cards was prepared carrying numbers from 1-to-18 for the selection of subjects in each page in the mailing list; (3) the first set of cards was shuffled for the selection of the page number; (4) the second set of cards was shuffled for the selection of subjects from the page selected in the previous step; and, (5) for the purpose of simplifying this matter and saving time, a long sheet of paper was prepared that contained two categories, the page number and the number of the subject selected in each page. Thus, each time the selection was made, the page number and the number of the subject on that page was recorded immediately. These procedures were repeated until 200 subjects were selected.

This population was specifically selected from a wide range of social worker groups because most of its members have frequent close contact with alcoholics. Many of the clinical social workers work in hospitals and/or chemical dependency treatment centers where alcoholics are their primary clients. Other clinical social workers work in social work and/or social work-related settings where alcoholics and alcohol-related problems occasionally occur.

Research Methodology

Data for this study were collected by means of a 5-point, Likert-type scale questionnaire. The instrument contained forty statements which were followed by the alternative choices strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree. Each code has two points in the scale (see example # 1 below) except Neutral which has one point only.

Example 1

1. Alcoholism runs in the family.

SD		D		N		A		SA	
0	1	2	3	4	5	6	7	8	

Four weeks after the questionnaire was mailed, a follow-up letters was sent to non-respondent subjects urging them to respond.

Reliability:

The measure of internal consistency (reliability) was calculated by:

a. Cronbach's alpha.

$$\text{Alpha} = \left[\frac{K}{K-1} \right] \left[\frac{S_t^2 - S_i^2}{S_t^2} \right]$$

Where K = number of items

S_t^2 = the standard deviation of the total test.

S_i^2 = the standard deviation on item 1 of the test.

Alpha = r_{tt} = the reliability of the test.

b. The Spearman-Brown Prophecy Formula. The Spearman-Brown Prophecy formula, was used to calculate the reliability of the test that is twice the length of each half.

$$r_{tt} = \frac{2r_{12}}{1 + r_{12}}, \text{generally } r_{tt} = \frac{mr_{12}}{1 + (m-1)r_{12}}$$

where,

r_{12} = is the correlation between the two halves,

r_{tt} = is the reliability of the test, and m is the projected length divided by the length of the test which the correlation between the two halves was based.

Validity:

In establishing the Face validity of the instrument used in this study, the following steps were performed:

1. The instrument was reviewed by several faculty members in the School of Social Work at the University of Illinois.
2. The instrument was reviewed twice by the experts in the Research Lab affiliated to the University of Illinois.

Data Analysis

In determining the degree of consensus, the 9-point scale used in the questionnaire was reduced to 5-points. The reduction involves combining the two points in the scale for **Strongly Disagree, Disagree, Agree, and Strongly Agree** into one point. The **Neutral** category remained the same (one point on both scales). Since five categories were used, 20% agreement could occur by chance. Thus, to control for agreement that might occur by chance, Cohen's coefficient of agreement (K) was used to determine whether the respondents' most frequently selected category was selected more than could be expected by chance (Cohen, 1960). Cohen's coefficient of agreement has two useful properties:

1. It controls over levels of agreement that may occur by chance. and,
2. Its value ranges from 0.0 to 1.0 which permits comparison between studies.

where

$$K = \frac{Po - Pe}{1 - Pe}$$

Po = Proportion observed.

Pe = Proportion expected by chance.

Since this coefficient has a value ranging from 0.0 to 1.0, .21 was considered, in this study, the agreement above chance, indicating consensus. Cohen's coefficient of agreement can be computed as shown in the example below.

Example

If 55% of subjects agree with a statement, then Cohen's coefficient of agreement is:

$$K = \frac{55 - 20}{100 - 20} = \frac{35}{80} = .44$$

To illustrate the results better, the items included in the questionnaire were divided, according to their representation, into four subscales. These subscales are the etiology of alcoholism subscale, the disease model subscale, the controlled drinking model subscale, and the moralism subscale. Each of these subscales is presented in a separate table and includes only the items that represent it. In addition, items that do not belong to any of the subscales mentioned above were grouped and presented in a separate table called "residual items". Every table includes the item number, Cohen's coefficient of agreement, correlation with model preference variable, item nature, and the category which the largest proportion of subjects endorsed. Data were analyzed using SPSS/PC.

Research Findings

Response rate was 64.5%; 129 of the targeted 200 subjects responded to the questionnaire. Of the respondents, 23.1% were male and 76.9% were female. Only 3.8% of the subjects held the Ph.D. degree and the remaining 96.2% held the MSW degree. The respondents identified their areas of practice as predominately mental health (33.1%). In addition 16.2% reported working in social work schools, 14.6% in health, 13.8% in child welfare, 10% in family services, 3.1% in correction, 2.3% in gerontology, 1.5% in youth and community services, and 5.4% in other areas.

The vast majority of subjects (81.4%) reported having professional contact with alcoholic clients. This contact, however, varied from as low as 4% alcoholic clients to as high as 100% alcoholic clients, with a median of 43%. On the personal level, 73.6% of subjects reported having personal contact with alcoholics. Only 4.7% of subjects reported being recovering alcoholics. The reliability of the test (alpha) was .69 (corrected using the Spearman Brown formula).

Model Preference:

The original instrument doesn't offer any information about what model(s) social workers use to describe alcoholism. Thus, a new variable called "model preference" was developed. The development of the variable involved developing a scale called the "model preference scale". This scale was given seven points, each of which was assigned a value ranging from -3 to 3. The scale was based on items number 14 and 15. Subjects who scored 0 on item 14 and 8 on item 15 were assigned number - 3 and characterized as being strong supporters of the controlled drinking model (SSCDM). Those who scored, respectively 3-5, 2-5, 1-5, 0-5, 3-6, 2-6, 1-6, 0-6, 3-7, 2-7, 1-7, 0-7, 3-8, 2-8, or 1-8 were assigned a

value of -2 and characterized as being moderate supporters of the controlled drinking model (MSCDM). Those who scored 4-5, 4-6, 4-7, or 4-8 were assigned a value of -1 and characterized as being weak supporters of the controlled drinking (WSCDM). Those who agree with both items 14 and 15, disagree with both items, or scored 4 (neutral) on both items were assigned a value of 0 and characterized as being inconsistent or neutral subjects (N). Those who scored 8-4, 7-4, 6-4, or, 5-4 were assigned a value of 1 and characterized as being weak supporters of the disease model (WSDM). Those who scored, respectively 8-1, 8-2, 8-3, 7-0, 7-1, 7-2, 7-3, 6-0, 6-1, 6-2, 6-3, 5-0, 5-1, 5-2, or 5-3 were assigned a value of 2 and characterized as being moderate supporters, of the disease model (MSDM). Finally, subject who scored 8 on item 14 and 0 on item 15 were assigned a value of 3 and characterized as being strong supporters of the disease model (SSDM).

The frequencies of this variable presented in table 1 below show that over 86% of subjects are identified with the disease model and less than 7% of them are identified with the controlled drinking model.

Table 1
Frequencies of model preference variable

	Scale values	responses regarding female items	
group ^a		N ^b	% ^c
SSCDM ^d	-3	0	%
MSCDM ^e	-2	5	3.9%
WSCDM ^f	-1	4	3.2%
N ^g	0	8	6.2%
WSDM ^h	+1	7	5.5%
MSDM ⁱ	+2	46	35.9%
SSDM ^j	+3	58	45.3%
Total		128	100%

a Labels of subjects based on the model preference scale.

b Number of subjects.

c percent of subjects.

d Strong supporters of the controlled drinking model.

e Moderate supporters of the controlled drinking model.

f Weak supporters of the controlled drinking model.

g Neutral or inconsistent.

h Weak supporters of the disease model.

i Moderate supporters of the disease model.

j Strong supporters of the disease model.

Table 2 below shows that there was, in general, a consensus among social workers regarding the etiology of alcoholism. Lack of consensus,

however, was found regarding item 10 (alcoholic behavior is learned by watching other' drinking behavior), which represents one part of the learning theory of the etiology of alcoholism.

Table 2
Subscale table of the etiology of alcoholism

item	K ^a	r with model ^b preference	nature ^c of item	modal ^d category
1. Alcoholism runs in the family.	.38	.27	fact	A
2. Alcoholism is transmitted genetically from generation to generation.	.23	.22	hypothesis	A
3. Alcoholism is hereditary.	.28	.28	hypothesis	A
4. Prealcoholics are essentially different from nonalcoholics.	.42	.18	belief	A
5. The rate of alcoholism for relatives of alcoholics is as high as that for the general population.	.35	-.22	fact	D
6. Alcoholism characteristically occurs in persons who are easily frustrated.	.27	-.15	hypothesis	D
7. Attracting attention is the reason that alcoholics drink.	.53	-.19	hypothesis	SD
8. Alcohol initially reduces anxiety and tension, which is a rewarding experience for individuals.	.39	-.19	hypothesis	A
9. Alcohol serves to reduce the anxiety and create a false sense of power and control.	.68	.08	hypothesis	A
10. Alcoholic behavior is learned by watching others' drinking behavior.	.18	-.18	hypothesis	A
11. Alcoholics are products of their cultures.	.44	-.12	hypothesis	A
12. Persons who socialize with peers and friends who drink excessively are more likely to develop alcoholism than those who do not.	.38	-.05	belief	A
13. No one single factor is responsible for the occurrence of alcoholism.	.43	-.13	fact	SA

Note: The reliability (alpha) of the etiology of alcoholism subscale is .66 (corrected using the Spearman Brown Formula).

- Cohen's Coefficient of agreement or disagreement over and above that which is expected to occur by chance. In this study, a K of .21 or above is considered consensus.
- Values for model preference vary from -3 for strong support of the controlled drinking model to +3 for strong support of the disease model.
- The nature of "knowledge" featured in the item.
- The category which the largest proportion of subjects endorsed.

Findings presented in table 3 below show that there is a consensus among clinical social workers regarding the disease model items. Moderate to high positive correlations were found between subjects' responses to the disease model items and the model preference variable. The highest consensus and correlation was found in item 14 (in order to maintain sobriety, alcoholics must abstain completely and permanently).

Table 3
Subscale table of the disease model

item	K ^a	r with model ^b preference	nature ^c of item	modal ^d category
14. In order to maintain sobriety, alcoholics must abstain completely and permanently.	.48	.86	belief	SA
16. "One drink, one drunk" accurately describes an alcoholic's self control over his/her drinking.	.25	.51	belief	A
20. During the early stages of alcoholism, an individual must stop drinking immediately to prevent further deterioration.	.42	.40	belief	A
21. Alcoholism is a progressive disease that follows an inexorable development through a series of more or less distinctive phases.	.40	.32	belief	A
23. Alcoholism is incurable and the only way to deal with alcoholism is to arrest it.	.33	.43	belief	A
26. Alcoholism is a disease.	.30	.45	belief	A

Note: The reliability (alpha) of the disease model subscale is .88 (corrected using the Spearman Brown Formula).

- Cohen's Coefficient of agreement or disagreement over and above that which is expected to occur by chance. In this study, a K of .21 or above is considered consensus.
- Values for model preference vary from -3 for strong support of the controlled drinking model to +3 for strong support of the disease model.
- The nature of "knowledge" featured in the item.
- The category which the largest proportion of subjects endorsed.

A consensus was found regarding subjects' responses to the controlled drinking model items presented in table 4 below. Negative correlation was found between subjects' responses to the controlled drinking model and the model preference variable. The highest consensus and negative correlation was found in the responses to item 15 (alcoholics can learn how to control their drinking and become moderate drinkers).

Table 4
Subscale table of the controlled drinking model

item	K ^a	r with model ^b preference	nature ^c of item	modal ^d category
15. Alcoholics can learn how to control their drinking and become moderate drinkers.	.46	-.88	belief	SD
19. Individuals who are in the early stages of alcoholism can control their drinking.	.29	-.10	belief	D
36. Alcoholics should have the right to choose the treatment goal.	.41	-.19	belief	A

Note: The reliability (alpha) of the controlled drinking model subscale is .33 (corrected using the Spearman Brown Formula).

- Cohen's Coefficient of agreement or disagreement over and above that which is expected to occur by chance. In this study, a K of .21 or above is considered consensus.
- Values for model preference vary from -3 for strong support of the controlled drinking model to +3 for strong support of the disease model.
- The nature of "knowledge" featured in the item.
- The category which the largest proportion of subjects endorsed.

As shown in table 5 below, a consensus was found among subjects participating in this study regarding items testing attitudes held by social workers. The participant subjects held positive attitudes regarding alcoholics.

Table 5
Subscale table of the moralism

item	K ^a	r with model ^b preference	nature ^c of item	modal ^d category
18. Treatment is better than jail to get an alcoholic to stop drinking..	.34	.16	morality	SA
38. An alcoholic individual is harder to relate to than an individual whose illness is not self-inflicted.	.37	-.01	morality	D
39. Excessive drinking as an escape from social responsibility is evidence of lack of will power.	.30	-.07	morality	D
40. The alcoholic is responsible for the development of his/her alcoholism, since after all, s/ he is the one who does the drinking.	.23	-.04	morality	A

Note: The reliability (alpha) of the multivariate model subscale is .40 (corrected using the Spearman Brown Formula).

- Cohen's Coefficient of agreement or disagreement over and above that which is expected to occur by chance. In this study, a K of .21 or above is considered consensus.
- Values for model preference vary from -3 for strong support of the controlled drinking model to +3 for strong support of the disease model.
- The nature of "knowledge" featured in the item.
- The category which the largest proportion of subjects endorsed.

Table 6
Table of the residual items

item	K ^a	r with model ^b preference	nature ^c of item	modal ^d category
17. Alcoholism is a type of mental illness.	.14	-.22	belief	D
22. "Once an alcoholic, always an alcoholic".	.35	.43	belief	A
24. Active (as opposed to recovering) alcoholics experience an irresistible physical craving for alcohol.	.39	.26	belief	A
25. Active (as opposed to recovering) alcoholics experience an overwhelming psychological compulsion to drink.	.49	.25	belief	A
27. There are as many differences (social, personality, etc.,) among persons who are heavy drinkers as there are similarities.	.45	.11	belief	A
28. An individual's use of alcohol can be considered as a point on a continuum from nonuse, to nonproblem drinking, to various degrees of deleterious drinking.	.53	-.01	belief	A
29. The development of alcohol problems over time does not follow a universal pattern.	.28	-.14	belief	D
30. Abstinence in alcoholic individuals, bears no necessary relation to rehabilitation.	.14	-.29	belief	A
31. Psychological dependence and physical dependence of alcohol are separate and not necessarily related phenomena.	.25	-.17	belief	A
32. Continued drinking of large doses of alcohol over an extended period of time is likely to initiate a process of physical dependence.	.57	.17	belief	A
33. Alcohol problems are typically interrelated with other life problems, especially when alcohol dependence has been long established.	.46	.18	belief	SA
34. Because of the documented strong relationship between drinking behavior and environmental influences, emphasis should be placed on treatment procedures that relate to the drinking environment of the person.	.43	-.03	belief	A
35. Treatment and rehabilitation services should be designed to provide for continuity of care over an extended period of time.	.49	.20	belief	SA
37. The practitioner must be non-judgmental, if treatment is to be successful.	.31	-.08	belief	A

Note: The reliability (alpha) of the etiology of alcoholism subscale is .66 (corrected using the Spearman Brown Formula).

- Cohen's Coefficient of agreement or disagreement over and above that which is expected to occur by chance. In this study, a K of .21 or above is considered consensus.
- Values for model preference vary from -.3 for strong support of the controlled drinking model to +.3 for strong support of the disease model.
- The nature of "knowledge" featured in the item.
- The category which the largest proportion of subjects endorsed.

Personal experience: Personal experience was defined as those of the subjects who are themselves recovering alcoholics and/or have personal experience with alcoholics. To examine the influence of personal contact and being a recovering alcoholic on model preference, the following comparisons were made using one-way analysis of variance and using n (eta) as a measure of association (using .05 level of significance):

1. between subjects who were recovering alcoholics and those who were not. The results of these tests were:
 F ratio = 1.05 with degree of freedom of 125
 $n = .20$ (not significant)
2. between those subjects who have had personal contact with alcoholics and those who had none. The results of these tests were:
 F ratio = .36 with degree of freedom of 125
 $n = .12$ (not significant)

The results of this study showed that personal experience is not a factor that influences clinical social workers' preference of one model over another.

Demographic characteristics and model preference:

As shown in tables 7 and 8 below the results of this study showed that there is no relation between demographic characteristics of subjects and model preference.

Table 7
Table of demographic data and its effect on model Preference

Variable	Chi-Square	Degree of Freedom	Level of Significance	Cramer's V
Sex	.03	1	.85	.05
Degree Held	.00	1	1.00	.00
Area of Practice	2.20	8	.97	.13
Type of setting	6.95	7	.43	.24
Position Held	8.89	6	.18	.27
Professional Experience	.14	1	.70	.05

Table 8
Table of demographic data and its effect on model preference

Variable	one-way Analysis of Variance	Degree of Significance	n (eta)
Years of Experience	.71	125	.36
Date of Last Degree Obtained	1.40	125	.52
Percent of Alcoholic Clients	.97	114	.36

Implications of the Study

Results of this study contradicted what has been suggested by Pattison, Sobell & Sobell (1977) regarding the limitations of the controlled drinking model. They suggested that professional treatment providers (including social workers) in treatment centers were hesitant to implement the controlled drinking model due to the potential liability issue associated with it. Liability issues can occur, for instance, when alcoholic clients are advised to use controlled drinking treatment goal and fail to control their drinking and were involved in accidents. Such potential problems will not only make treatment providers liable, but it may also increase their insurance premiums. Thus, it was implied that social workers working in treatment centers believe in the controlled drinking model but cannot implement it.

It is clear from the results of this study that the controlled drinking model has little support among clinical social workers. Only 9 subjects (less than 7%) can be identified with the controlled drinking model.

Furthermore, none of these subjects was considered a strong supporter of the controlled drinking model; they ranged from moderate to weak supporters of the drinking model.

In support of most of the existing literature, the disease model was the most popular among clinical social workers. It is striking that not only over 86% of subjects were identified with the disease model, but over 50% of them (of the 86%) were considered strong supporters to that same model.

Results of this study showed that there is no statistically significant relationship between clinical social workers' model preference and personal experience. In addition, the demographic characteristics of subjects were not a factor that influenced model preference. However, in light of the fact that the department of Alcoholism and Substance Abuse in the state of Illinois primarily funds abstinence-based programs (T. Green,

personal communication, March 10, 1992), it is unclear from this study whether the support to the disease model is the cause or the effect of this policy.

Results of this study showed that there is a consensus among social workers regarding the etiology and nature of alcoholism. However, consensus does not mean consistency nor clarity in understanding the models under study. While the majority of subjects were identified with the disease model and endorsed the abstinence notion, a lack of consensus was found regarding items 30 (abstinence in alcoholic individuals bears no necessary relation to rehabilitation).

Besides, items included in the disease model subscale, only item 22 (once an alcoholic, always an alcoholic) had a positive and relatively high correlation with the model preference variable. This correlation (.43) suggests that the notion of irreversibility is strongly held by those of the subjects who believe in the disease model. The notion of irreversibility, however, has been proven to be inaccurate in the existing literature. For instance, Davies (1962), Sobell and Sobell (1973; 1976; 1978) found that some alcoholics who have been diagnosed as gamma alcoholics based on Jellinek's disease model formulation were able to regain control over alcohol consumption and become moderate social drinkers. In addition, the notion of irreversibility has never been a part of the disease model as presented by Jellinek (1960) (Heather & Robertson, 1983).

In view of the above discussion, one can infer the following from the results of this study:

1. Clinical social workers may have not been familiar with that line of research led by Pattison, Sobell and Sobell (1977), Sobell and Sobell (1973; 1976; 1978), Heather and Robertson (1983) which advocates an alternative to total abstinence treatment goal.

2. Clinical social workers might have seen high relapse rates among their alcoholic clients which led them to believe that alcoholism is irreversible.

As mentioned earlier, there was a lack of consensus regarding item 30 (abstinence in alcoholic individuals bears no necessary relation to rehabilitation). This suggests that despite subjects' belief in the total abstinence treatment goal, positive results have not been seen.

Thus far, two major conclusions have been presented. First, the majority of clinical social workers believe in the disease model of alcoholism and very few support the controlled drinking model. The relation between the policy adopted by the department of Alcoholism and Substance abuse and the model preference could not be established in

this study. Second, despite the continued implementation of the total abstinence treatment goal, clinical social workers dispute its usefulness. Clinical social workers might have little knowledge regarding alternatives to abstinence. Moreover, the support of the disease model of alcoholism is more or less based on traditional beliefs and not on empirical observations.

Despite the popularity of the disease model of alcoholism among clinical social workers, there appears to be a transition going on in the field of alcoholism. Clinical social workers have endorsed the environmental items included in the questionnaire (items 33 and 34), acknowledging the importance of environmental factors to explain the nature of alcoholism. It seems that clinical social workers do not think that the disease model is sufficient to explain the nature of alcoholism. In addition, clinical social workers do not seem to have a consistent alternative to the disease model.

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Attitudes of Clinical Social Workers Toward Alcoholism

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This study investigates whether or not there is consensus among clinical social workers regarding alcoholism. A sample of 200 clinical social workers were randomly selected to participate in the study. The method used in this composed of a 5-points Likert scale questionnaire which was mailed to participants. The results of this study revealed that; (a) there was consensus among clinical social workers regarding alcoholism; (b) the disease model of alcoholism is strongly held among clinical social workers, and; (c) there was no difference between attitudes toward alcoholic women and alcoholic men.