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An Effort to Sample Scientifically the Attitudes of Pastors Toward Alcholism in a Section of the Lutheran Church--Missouri Synod

James Hallerberg

AN EFFORT TO SAMPLE SCIENTIFICALLY THE ATTITUDES OF PASTORS TOWARD ALCOHOLISM IN A SECTION OF THE LUTHERAN CHURCH--MISSOURI SYNOD

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by

James W. Hallerberg

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Approved by: Martin Haendschke
Advisor

Fred P. Harms
Reader

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CHAPTER I

INTRODUCTION

What attitudes do pastors have toward alcoholics? Specifically, do parish pastors of the Lutheran Church--Missouri Synod have positive or negative attitudes in their ministry to alcoholics? Are the attitudes of pastors a significant factor in an effective ministry to alcoholics? What attitudinal factors can be specified as having particular significance? These are the fundamental questions which this study addresses.

Definition of Terms

The following terms are here briefly defined as they are used in the paper.

The word "pastor" in the paper has specific reference to parish pastors of the Lutheran Church--Missouri Synod (LC--MS), unless otherwise indicated by the context.

"Alcoholism" is a phenomenon characterized by a loss of control of the consumption of alcohol and a progressive decline in the life of a person. Alcoholism is a disease, and by definition alcoholics are ill. (Chapter II presents documentation and more precise wording for the definition of alcoholism.)

The definition of "attitude" is derived from descriptions of technical usage presented by Forrest P. Chisman in his book titled Attitude Psychology and the Study of Public Opinion[1] and is stated as follows: attitude is a relatively enduring system of feelings, beliefs, and action tendencies.

The words "recovery," "recovering," and "recovered" all refer to the alcoholic who has come to a place in his life where he is no longer consuming alcohol and is once again able to grow along productive lines. The nuances of present (recovering) and past (recovered) tenses are not generally observed in this study.

Importance of the Problem

Alcoholism is a major problem in America. Current research[2] confirms the statement made by the Department of Health, Education, and Welfare in 1971: "Alcohol is the most abused drug in the United States."[3] The National Institute of Alcohol Abuse and Alcoholism (NIAAA) estimated that in 1974 there were at least nine million American alcohol abusers and

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[1]Forrest P. Chisman, Attitude Psychology and the Study of Public Opinion (University Park, Pa.: The Pennsylvania State University Press, 1976), p. 26.

[2]Brent Q. Hafen, Alcohol: The Crutch that Cripples (St. Paul, Minn.: West Publishing Co., 1977), p. ix.

[3]U.S., Department of Health, Education, and Welfare, First Special Report to the U.S. Congress on Alcohol and Health (Washington, D.C.: U.S. Government Printing Office, 1971), p. vi.

alcoholics.[4] After heart disease and cancer, alcoholism is the country's major health problem.[5] Public records give evidence that one-third of all arrests are related to public intoxication.[6]

In a book published in 1977, Brent Hafen summarizes recent statistics which point to the immensity of alcohol related problems. Economic loss due to misuse of alcohol is conservatively estimated to be over $25 billion per year. Law enforcement statistics show that in one-half of all murders committed in the United States, either the killer or the victim had been drinking. One-fourth of all suicides have significant amounts of alcohol in the bloodstream. 50,000 Americans die in auto accidents each year. It is estimated that over one-half (28,000) of those killed involve drunk drivers or pedestrians. People who abuse alcohol are seven times more likely to be separated or divorced than are people of the general population.[7] "Of the approximately 95 to

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[4]U.S., Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, 2nd Special Report Updates Alcohol Knowledge: NIAAA Information and Feature Service, DHEW Pubn. (ADM) 74-29 (Rockville, Md.: National Clearinghouse for Alcohol Information, National Institute on Alcohol Abuse and Alcoholism, 1974), p. 2.

[5]Ibid., p. 7.

[6]U.S., DHEW, First Report to Congress, p. vi.

[7]Hafen, p. ix.

100 million Americans who drink, one in ten is now either a serious problem drinker or a full-fledged alcoholic."[8]

Alcoholism presents a problem for pastoral care. In spite of the belief held by many that the majority of alcoholics are to be found on skid row, and in spite of a view maintained by many people to think in terms of pastoral care to alcoholics as being only a very isolated and specialized form of ministry, the evidence points to a different situation. Only three to five percent of the alcoholic population lives on skid row;[9] most alcoholics live within the ordinary structures of society. They have families, report to their jobs, hold positions of high responsibility, go to church, and so forth. They have problems, to be sure. Ultimately, the problem revolves around their consumption of alcohol and its effect on them and the lives of those who surround them. People with problems are objects of pastoral care. Alcoholics qualify as objects of parish ministry.

When drinking patterns of Lutheran adults are compared in statistical studies to those of the national adult population, evidence emerges pointing to the conclusion that more Lutherans consume alcohol than do other people. A Gallup poll conducted in 1964 indicated that sixty-three percent of the

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[8]Ibid., p. x.

[9]U.S., DHEW, First Report to Congress, p. vi.

adult population drank alcohol.[10] Howard Clinebell lists some of the findings of a 1963 study by Harold Mulford, whose report of Lutheran drinking practices revealed the following: eighty-five percent in the category of those who drank; thirteen percent in the category of heavy drinker; five percent of those adult Lutherans who drank in the category of problem drinker.[11]

A later study reported by Don Calahan, Ira Cisin, and Helen Crossley reported that ninety percent of all adult Lutherans consume alcohol, and nineteen percent of them were classified as heavy drinkers.[12]

Karl Schneider, a Lutheran Church in America pastor who is employed full-time in the field of alcohol education, presented a paper at the Annual Meeting of the Alcohol and Drug Problem Association of North America in 1977. He cited Mulford's study, which showed that eighty-five percent of Lutheran adults consume alcoholic beverages. He also directed attention to the older and more conservative estimate (rather than the more current estimate quoted previously: one out

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[10]Don Calahan, Ira H. Cisin, and Helen M. Crossley, American Drinking Practices: A National Study of Drinking Behavior and Attitudes, Monographs of the Rutgers Center of Alcohol Studies, 6 (New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1969), p. 20.

[11]Howard J. Clinebell, Jr., Understanding and Counseling the Alcoholic through Religion and Psychology, rev. and enl. ed. (Nashville: Abingdon Press, 1968), p. 67.

[12]Calahan, Cisin, and Crossley, American Drinking Practices, p. 56.

of ten) that one out of twelve who drinks has a drinking problem. Schneider asked his audience to think along the following lines.

> Consider a hypothetical Lutheran congregation of 500 members, multiply the percentage who drink, or .85, and there are 425 drinking members. Divide 12 into 425, and there are 35 potential members with an alcohol problem. This is a statistical game at best, but it does cause any pastor to open his eyes and re-examine the possibility of alcohol problems and the neglected ministry. If you multiply the 35 potential members by 4 (4 or 5 family and friends are directly affected), a total of 140 persons are affected. What pastor can ill afford not to provide such a ministry?[13]

If one took into account different methods of gathering data and different standards of measurement which were applied in the three studies which have been briefly presented, one would have a reason for understanding discrepancies in the concluding statistics. There is general consensus, however, and the following can be stated as offering a profile derived from alcohol research about Lutherans.

There is evidence that from eighty-five (Mulford) to ninety (Calahan, Cisin, and Crossley) percent of Lutherans drink alcoholic beverages--a percentage higher than the national average. From thirteen (Mulford) to nineteen (Calahan, Cisin, and Crossley) percent of Lutherans can be classified as heavy drinkers. From five (Mulford) to eight

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[13]Karl A. Schneider, "Motivational Approaches in Training Clergy for Early Intervention in Addictive Problems in Parish and Community," paper presented at the 28th Annual Meeting of the Alcohol and Drug Problem Association of North America, Detroit, Mich., 25-29 September 1977, p. 3. (Mimeographed.)

(Schneider) percent have problems related to their consumption of alcohol, and at least four other people (general agreement) are affected in direct ways by the problem drinking.

The parish pastor is approached frequently by people who are affected by problems which result from heavy drinking and alcoholism. Whether they are people who are beginning to see the disastrous consequences of the use of alcohol for themselves, or whether they are people who are attempting to deal with the effect of someone else's drinking patterns on their lives, they are people who are looking for help. John Keller, a pastor of the American Lutheran Church who is currently director of Operation Cork, has stated in his book titled Ministering to Alcoholics that the pastor can be helpful and that he "should become involved, enlarge his understanding of and communicate his concern for the alcoholic."[14]

Reasons for Implicating Attitudes

Most pastors want to be effective in helping people with problems. As this desire is related to a ministry to alcoholics, it was reasoned that a pastor would generally want to help the person to deal with his drinking problems and with his recovery. Yet not all pastors seem to have

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[14]John E. Keller, Ministering to Alcoholics (Minneapolis: Augsburg Publishing House, 1966), p. vii.

interest in developing a relationship with a person with a drinking problem, and many pastors seem to avoid involvement with problems related to recovery.

Such a generalized picture of a pastor's ministry began to raise questions revolving around an apparent conflict between his desire and his behavior. Four different factors pointed to a study of pastors' attitudes about alcoholism.

First, it was observed (for example, in conversations among pastors at circuit and district conferences): pastors frequently expressed ambivalent feelings about ministry to alcoholics; pastors often did not think their ministry was effective; pastors were convinced that someone in the parish had a drinking problem, and they wondered aloud why he was not "doing something about it"--why the alcoholic had not contacted his pastor for help. It was reasoned that such conversations pointed to the pastors' attitudes about one part of their ministry, and it was considered that their attitudes about alcoholism might also be the subject matter of their conversations.

Second, the reading of a Ph.D. dissertation by LC--MS pastor Philip Stephan had implications for a study of attitudes. Stephan reported survey results of a random sampling of clergy in St. Louis and San Diego who were asked to rank in descending order from most (one) to least (twelve) the problems brought to them in which they felt most helpful.

Ranked twelfth (felt least helpful) was drugs. Ranked number eleven was alcohol.[15]

Third, there was consideration of the positive contributions of Alcoholics Anonymous (AA) to the recovery of alcoholics. William Madsen, recognized authority in the field of alcoholism, has stated that AA "remains the alcoholics' best hope for recovery."[16] Those who have attended AA meetings have emphasized that attitudinal factors--for example, those referred to by Madsen: acceptance, humility, patience, optimism, and confidence--make a contribution to the effectiveness of the AA fellowship.[17] It was thought that if attitudinal factors were important to the most successful recovery program--the one offered by AA--attitudes would also be of significance to parish pastors who want to be helpful for the recovery of the alcoholic.

Fourth, attitudes were found to receive great emphasis among those who work in the field of alcoholism. Marty Mann, long established as a recognized authority in the field,

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[15]Philip G. Stephan, "Clergymen as Counselors" (Ph.D. dissertation, United States International University, 1970), p. 86.

[16]William Madsen, "Alcoholics Anonymous as a Crisis Cult," in Proceedings of the Third Annual Alcoholism Conference of the National Institute on Alcohol Abuse and Alcoholism, ed. Morris E. Chafetz (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1973), p. 170.

[17]William Madsen, The American Alcoholic: The Nature-Nurture Controversy in Alcoholic Research and Therapy (Springfield, Ill.: Charles C. Thomas, 1974), pp. 168-176.

has called attitude "the key to successful treatment"[18] of alcoholics. Robert Sheldon, Harry Davis, and Ron Kohorn address the question of attitude not only to successful treatment but also to a therapist's ability to work with the alcoholic. They have written the following words.

> The therapist's views, prejudices, and real feelings about the patient govern his ability to work with the patient. He has to be able to accept him as a person worthy of the best help possible. He must view the patient as a total person, not just as an alcohol abuser, alcoholic, or "drunk."[19]

Howard Clinebell, whose book Understanding and Counseling the Alcoholic through Religion and Psychology has received wide acceptance by nearly all within the field, has stressed the significance of attitude. He says, "A minister's general attitude toward alcohol, alcoholics, and alcoholism seems to have a direct relationship to the number of alcoholics who come to him for help."[20]

Delimitations

The study did not deal with the personal attitudes of pastors toward alcohol itself, nor was it concerned with

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[18]Marty Mann, "Attitude: Key to Successful Treatment," in The Para-professional in the Treatment of Alcoholism, ed. George E. Staub and Leona M. Kent (Springfield, Ill.: Charles C. Thomas, 1973), p. 4.

[19]Robert B. Sheldon, Harry G. Davis, and Ron L. Kohorn, "Individual Counseling and Therapy with the Alcoholic Abuser," in Alcohol Abuse and Rehabilitation Approaches, ed. John G. Cull and Richard E. Hardy (Springfield, Ill.: Charles C. Thomas, 1974), p. 141.

[20]Clinebell, p. 50.

determining attitudes of pastors toward simple use or abuse of alcohol. It did not investigate attitudes about the pastoral care of the family of the alcoholic.

The study was limited to six areas for investigation. The areas of attitude, together with two questions which gave specific focus to the study of each attitudinal factor, were limited for the study and were specified as follows:

(1) Disease Concept: Does the pastor have a positive or a negative attitude toward a disease concept of alcoholism? Do pastors believe that alcoholism is appropriately defined as a disease, and do pastors view the alcoholic as a person with an illness?

(2) Stereotyping: Does the pastor believe that the skid-row-drunk stereotype is representative of what an alcoholic is like? Do pastors have a narrow and negative image of an alcoholic?

(3) Acceptance: Does the pastor accept the alcoholic as a person? Do pastors have an attitude expressive of genuine positive regard for the alcoholic?

(4) Moralism: Does the pastor approach the alcoholic with a moralistic attitude, believing that the primary problem for the alcoholic is his lack of will power or moral strength? Do pastors approach alcoholics having already judged the case rather than being open to listening to the story of life as told by the alcoholic himself?

(5) View of AA: In view of AA's potential for being a symbol of positive attitudes toward alcoholics, does the pastor have positive or negative feelings about the program and fellowship of AA? Do pastors believe that AA is helpful to the alcoholic's recovery?

(6) Pastor's Role: Does the pastor believe that he has a significant role to play in helping alcoholics? Do pastors have negative or positive attitudes about their ministry to alcoholics?

Additional limiting factors of the study are stated below in the discussion of method.

Method and Approach

A survey instrument was designed in order to pursue the effort to determine pastors' attitudes toward alcoholism. The instrument (appendix 2) consisted of fifty-six opinions related to the six areas to which the study was limited. Such opinions were perceived to give verbal expression of attitudes, and they were the means used for measuring attitudes, according to the school of scientific investigation which holds that attitudes can be measured by the expression of acceptance or rejection of opinions and statements. The items for the survey were not selected out of consideration for their cognitive content but rather as they were carriers or symbols of attitude. A Likert-type scale was used, so that the subjects could respond with varying degrees of

intensity on a scale ranging between the extremes of strongly agree to strongly disagree.[21] The scale contained five positions: (1) strongly agree; (2) agree; (3) agree somewhat; (4) disagree somewhat; (5) strongly disagree.

The survey instrument also included a set of six different statements dealing specifically with the question of the relationship of sin and alcoholism. The six statements were derived from a discussion by Clinebell, which suggested that most conceptions of this relationship fall into one of the categories represented by the six statements.[22] It was reasoned that Clinebell's statements dealt with attitudinal factors, and the notion that there might be a correlation between attitudes measured by the Likert-type scaling and one of the six statements led to inclusion of them. Respondents were instructed to choose one of the six as expressive of the view with which they most agreed.

At the end of the survey form, subjects were asked to supply information. The concluding questions sought data about the following areas: age of respondent; year and place of graduation from seminary; the district to which he belonged; number of confirmed communicant members; percentage

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[21]Stephen Isaac (in collaboration with William B. Michael), Handbook in Research and Evaluation: A Collection of Principles, Methods, and Strategies Useful in the Planning, Design, and Evaluation of Studies in Education and the Behavioral Sciences (San Diego: Robert R. Knapp, 1971), p. 100.

[22]Clinebell, pp. 168-170.

of his parish estimated to be alcoholic; number of alcoholics he ministered to during the past twelve months; indication of his interest in a report of results of the survey.

Use of the instrument was limited to pastors of three western LC--MS districts: Southern California District (SC), California-Nevada-Hawaii District (CNH), and Northwest District (NW). The survey was administered in two different ways.

In SC, parish pastors attending the 1979 Spring Pastor-Teacher Conference were asked to complete and return the forms during the conference. It was specifically stated that only parish pastors were to participate, and the letter (appendix 1) prepared for mailing was read verbatim. No additional instruction was given; questions raised by pastors were not answered.

The survey (appendix 2) was sent by mail to pastors of CNH and NW (with the cover letter). Names of pastors and addresses of churches were selected at random from The Lutheran Annual (1979 edition).[23] An addressed and stamped envelope was included in each mailing for return of the survey. It was recognized that, with the exception of explicit

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[23]The Lutheran Annual 1979 of the Lutheran Church--Missouri Synod, comp. Department of Personnel and Statistics (St. Louis: Concordia Publishing House, 1978).

instructions stated on the survey instrument, control factors were lacking in the administration of the survey.

Responses of the returned survey forms were entered on a Fortran Program Sheet. Aztec Computer Services in San Diego, California, included a verification factor for the key punch operation which transferred the data to standard IBM program cards for computer analysis. Dr. Clifford Weedman, systems and statistics specialist at the California School of Professional Psychologists, was consultant for the final phase dealing with the collection of data, which included programing and computer analysis. A detailed accounting of data and analysis will be presented in part II of the paper

The paper is divided into two parts. Part I includes background and rationale for the study and a selective review of the literature pertaining to the study. It examines the problem of definition of alcoholism, the pastor's role in ministry to alcoholics, and the significance of attitude. Part II reports the findings of the study and discusses implications.

Significance of the Study

Though the literature of the field of alcoholism pointed to the significance of attitude, no study, scientifically constructed, was discovered which dealt with the attitudinal factors of parish pastors which were investigated

in the immediate study. It was reasoned that such investigation--scientifically constructed--would provide new data in the field of research into alcoholism. It was thought that the effort reported in the paper could provide data useful for education within the academic setting. Operating within the discipline of Practical Theology, it was reasoned that the study could find use, particularly within the context of seminary education and continuing education programs for parish pastors. It was hoped that the study would provide insight into one aspect of pastoral care and that the data would contribute to a more effective ministry to people with the problem of alcoholism.

Chapter Summary

At the beginning, basic questions for the study of attitudes of pastors toward alcoholism were raised. Four terms which find frequent use in the paper were briefly defined. It was observed that alcoholism is a major problem for Americans and that parish pastors are called upon to help people with the problem. Statistical data pertaining to drinking patterns of Lutherans were examined. Four factors which pointed to approaching a study of attitudes were discussed. The limits of the study were set by specifying areas of study, and two questions were addressed with reference to attitudinal factors to each of the six areas. The manner of approaching the project was presented in detail,

and the scientific nature of the study was described. Original research into the matter of pastors' attitudes toward alcoholism would provide new data for the field of alcoholism in general and for the ministry of the church in particular.

PART I

BACKGROUND AND RATIONALE:

A SELECTIVE REVIEW OF LITERATURE

CHAPTER II

ALCOHOLISM: PROBLEM OF DEFINITION

What is alcoholism? Who is an alcoholic? A survey of the literature reveals that there is a problem in definition. There are a great number of definitions and a wide difference of opinion; there are also points of similarity and convergence.

The purpose of this chapter is not to report all definitions, nor is it the purpose of this chapter to provide an extended discussion of the various approaches[1] which are available in attempting to define alcoholism. The purpose here is to demonstrate by quoting and citing selected definitions that there is a problem in defining alcoholism and to provide a background for a precisely worded definition for the study. (In preparing to report various definitions, there was recognition of what William Madsen calls a

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[1]For a relatively complete but concise description of approaches to alcoholism see, Ralph E. Tater and Dorothea U. Schneider, "Models and Theories of Alcoholism," in Alcoholism: Interdisciplinary Approaches to an Enduring Problem, ed. Ralph E. Tater and A. Arthur Sugerman (Reading, Mass: Addison Wesley Publishing Co., 1976), pp. 82-102.

"disciplinary provincialism"[2] which is generally peculiar to a particular approach in the formation of definitions.)

Selected Definitions

Due to the fact that much of current literature continues to make reference to E. M. Jellinek's classic work, The Disease Concept of Alcoholism, the first definition to be presented is that one by Jellinek which states that alcoholism is "any use of alcoholic beverages that causes damage to the individual or society or both."[3] Jellinek calls this "an operational definition"[4] and elaborates his definition with a discussion of five "species" or categories of classification, noted according to letters of the Greek alphabet.

"Alpha alcoholism represents a purely psychological continual dependence or reliance upon the effect of alcohol to relieve bodily or emotional pain."[5] There is no real loss of control or physiological addiction, nor is there evidence of a progressive process. There is excessive consumption of alcohol which is frequently spoken of as problem drinking.

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[2]William Madsen, The American Alcoholic: The Nature-Nurture Controversy in Alcoholic Research and Therapy (Springfield, Ill.: Charles C. Thomas, 1974), p. 18.

[3]E. M. Jellinek, The Disease Concept of Alcoholism (New Haven, Conn.: College and University Press, 1960), p. 35.

[4]Ibid.

[5]Ibid., p. 36.

Beta alcoholism is characterized by nutritional deficiency diseases such as gastritis and cirrhosis of the liver. According to Jellinek's classification, people in this category do not show signs of loss of control, withdrawal, or other addictive symptoms. The damage is primarily physiological and attributed to heavy consumption of alcohol.[6]

> Gamma alcoholism means that species of alcoholism in which (1) acquired increased tissue tolerance to alcohol, (2) adaptive cell metabolism . . . , (3) withdrawal symptoms and "craving," i.e., physical dependence, and (4) loss of control are involved. In gamma alcoholism there is a definite progression from psychological to physical dependence . . . .[7]

Delta alcoholism gives evidence of the first three characteristics found in gamma alcoholism, but rather than loss of control "there is inability to abstain."[8] One continues to consume alcoholic beverages to maintain a certain minimum level of inebriation most of the time rather than to seek maximum impact of alcohol. Those who drink alcohol in this manner are often described as "nipping" in order to maintain an "all-day glow."

Epsilon alcoholism describes one who is "periodic" in his drinking pattern and who is usually abstinent between binges. He may begin a drinking binge when he feels the onset of a painful depression.[9]

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[6] Ibid., p. 37.

[7] Ibid.

[8] Ibid., p. 38.

[9] Ibid., p. 39.

Though there have been many adjustments both to Jellinek's formulation of a definition of alcoholism and to his classification system, and though there are critics of his medical model and a disease concept of alcoholism,[10] Jellinek provided a working model which makes a disease concept of alcoholism not only respectable but also a basic referent for most definitions since his time.

With reference to the disease concept of alcoholism, it is generally recognized that Jellinek made allowance for excluding alpha and beta categories from a disease definition. An article in the July 1976 issue of the Journal of Studies on Alcohol suggests that Jellinek himself intended the gamma and delta categories specifically to apply to the disease definition. The article argues that gamma and delta categories are especially useful for the disease concept of alcoholism because they have in common (1) increased tolerance, (2) withdrawal systems, (3) inability to abstain, and (4) loss of control. It is further suggested that these

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[10]The following quotation from an NIAAA publication represents the view of many critics who are disturbed by a disease concept of alcoholism.

> "The medical model of alcoholism places causation 'inside-the-man,' thereby taking inadequate account of socio-cultural factors that may play a causal role. Furthermore, the disease model directs the responsibility for treatment toward medical practioners who perpetuate the doctor-patient relationship, encouraging the latter to assume a passive role . . . ." (U.S., Department of Health, Education, and Welfare, Alcoholism and Treatment, ed. David J. Armor, J. Michael Polich, and Harriet B. Stambul [Santa Monica, Calif.: Rand Corp., 1976], p. 9.)

two categories exhibit addiction to alcohol and a drinking behavior which can be regarded as a disease process.[11]

Jellinek was not alone in defining alcoholism as a disease. Marty Mann wrote two years before publication of Jellinek's major work, offering the following definition.

> Alcoholism is a disease which manifests itself chiefly by the uncontrolled drinking of the victim, who is known as an alcoholic. It is a progressive disease, which, if left untreated, grows more virulent year by year, driving its victims further and further from the normal world, and deeper and deeper into an abyss which has only two outlets: insanity or death.[12]

Howard Clinebell, suggesting that a nontechnical definition has advantages, favorably quotes Marty Mann as follows: "'An alcoholic is someone whose drinking causes a continuing problem in any department of his life.'"[13] The significant point of this definition is that though nontechnical, it does distinguish alcoholism from simple inebriation.

In a different context, Clinebell offers the following definition: "An alcoholic is anyone whose drinking interferes frequently or continuously with any of his

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[11]Ovide Pomerlau, Michael Pertschuk, and James Stinnett, "A Critical Examination of Some Current Assumptions in the Treatment of Alcoholism," Journal of Studies on Alcohol 39 (July 1976):851.

[12]Marty Mann, Marty Mann's New Primer on Alcoholism (New York: Holt, Rinehart, and Winston, 1958), p. 3.

[13]Howard J. Clinebell, Jr., "Some Religious Approaches to the Problem of Alcoholism" (Ph.D. dissertation, Columbia University, 1954), p. 9.

important life adjustments and interpersonal relationships."[14] This broad definition points to the significance of observing consequences of alcohol consumption.

Simplicity of definition has its merits, claims Max Hayman in a 1956 journal article. He says that "the simplest definition is: Loss of the power of choice. There is an inability to stop drinking even though this is consciously willed."[15]

Karl Menninger, in a book discussing the church's ministry to alcoholics, states that he believes alcoholism to be "a form of mental illness"[16] rather than a simple addiction to a drug. His definition in that context takes the form of a way of thinking about alcoholism, as follows:

> I would suggest that you think of alcoholism as a kind of perversion, as it were, of the instinct to grow and to live and to love, an instinct we assume pervades us all. Many individuals seem to be at war with themselves.[17]

Menninger's way of describing alcoholism takes into account the dynamics of personality.

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[14]Howard J. Clinebell, Jr., Understanding and Counseling the Alcoholic through Religion and Psychology, rev. and enl. ed. (Nashville: Abingdon Press, 1968), p. 19.

[15]Max Hayman, "Current Attitudes to Alcoholism of Psychiatrists in Southern California," American Journal of Psychiatry 112 (January 1956):485.

[16]Karl Menninger, "The Psychoanalytic Approach to Alcoholism," in Alcoholism, Source Book for the Priest: An Anthology (Indianapolis, Ind.: National Clergy Conference on Alcoholism, 1960), p. 373.

[17]Ibid., p. 377.

Many definitions pick up the theme of compulsive drinking patterns and alcohol dependency. A representative of such definitions is Harry Milt, who defines alcoholism as "a condition in which the individual drinks compulsively to the point of intoxication, does so repetitively, and continues to do so chronically."[18] Similiarly, David Davies says that "alcoholism is intermittent or continual use of alcohol associated with dependency (psychological or physical) or harm in the sphere of mental, physical, or social activity."[19]

Brent Hafen suggests that there are three factors present in alcoholism: (1) loss of control of alcohol intake; (2) functional or structural damage to areas of life--for example, those described as physiological, psychological, domestic, economic, or social; and (3) use of alcohol as a self-administered drug to keep life from disintegrating.[20] Some of these factors may be present in the lives of problem drinkers who damage themselves, their families, or their communities because of their drinking patterns.

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[18]Harry Milt, Alcoholism: Its Cause and Cure, A New Handbook (New York: Charles Scribner's Sons, 1976), p. 15.

[19]David L. Davies, "Definitional Issues in Alcoholism," in Alcoholism: Interdisciplinary Approaches to an Enduring Problem, ed. Ralph E. Tater and A. Arthur Sugerman (Reading, Mass.: Addison Wesley Publishing Co., 1976), p. 69.

[20]Brent Q. Hafen, Alcohol: The Crutch that Cripples (St. Paul, Minn.: West Publishing Co., 1977), p. 53.

But Hafen notes that there is a difference between problem drinkers and alcoholics. Some of those in the problem drinker classification "are clearly addictive [italics mine] drinkers or alcoholics. They are those who are not only psychologically dependent, but also physically dependent and have developed some degree of tolerance."[21]

Hafen states that the definition which is most widely considered to be authoritative is the one given by Mark Keller of the Center of Alcohol Studies at Rutgers University. That widely accepted definition reads as follows:

> Alcoholism is a chronic disease or disorder of behavior characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use, or ordinary compliance with the social drinking customs of the community and which interferes with the drinker's health, interpersonal relations, or economic functioning.[22]

This definition by Keller includes the disease concept of alcoholism and also points to behavior. But others disassociate themselves from a disease definition, arguing that alcoholism is better described in terms of learning and behavior than it is in medical (disease) terms. Two representative definitions offered by those who take issue with a disease concept follow.

Claude Steiner, writing from the approach of transactional analysis, says that alcoholism is best defined as follows:

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[21] Ibid., p. 48.

[22] Ibid., p. 53.

> . . . [a] behavior disturbance characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication. . . . The real or ulterior motive of alcoholic behavior is the production of certain interpersonal payoffs, and . . . alcohol is incidental to this activity.[23]

Donald Goodwin reports that a behavioral approach defines alcoholism as follows: "Alcoholism is a behavioral disorder. The specific behavior that causes problems is the consumption of large quantities on repeated occasions."[24]

According to many authorities it is important to give consideration to many factors when attempting to define alcoholism. William Madsen is among those who would take issue with those definitions which have a single-minded orientation (for example, behaviorists) which leads to an unnecessary exclusion of other factors. Anthropologist Madsen argues for a multi-dimensional approach and understanding of alcoholism. In The American Alcoholic, which deals with the "nature-nurture" controversy about the causes of alcoholism, Madsen offers a definition which takes into account various factors which may contribute to a person's being considered alcoholic. (In the quotation which follows, hereditary

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[23]Claude M. Steiner, "The Alcoholic Game," Quarterly Journal of Studies on Alcohol 30 (December 1969):922.

[24]Donald W. Goodwin, "Psychiatric Description and Evaluation of the Alcoholic," in Alcoholism: Interdisciplinary Approaches to an Enduring Problem, ed. Ralph E. Tater and A. Arthur Sugerman (Reading, Mass.: Addison Wesley Publishing Co., 1976), p. 208.

factors which may contribute to alcoholism are referred to by using the word "biological.") Madsen's definition is as follows:

> Accepting both psychological and biological correlates, then, alcoholism may be defined as a stress disease. The alcoholic lacks both the psychocultural and biological means of maintaining homeostasis.[25]

In his article titled "The Disease Concept of Alcoholism Revisited," Mark Keller reviews the positive and the negative responses to the disease concept. Within the context of the review, he states:

> Alcoholism is a dysbehaviorism, manifested as a repeated ingestion of sufficiently large amounts of alcohol-containing beverage (a) to allow an inference (or to arouse a suspicion) that the behavior is bizarre, abnormal, or deviant, and (b) to cause harm to the ingestor's health or social or economic functioning. It is the same as alcohol addiction and classified as a chronic disease of uncertain etiology and undetermined site.[26]

Keller says what is meant by a disease, as follows:

> One of the most reliable criteria of the presence of a disease is that the condition constitutes a physical or mental disablement of the person. The key word is disablement. For example, no one would dispute that a person who is paralyzed has a disease. One might wish to know what the nature of the disease is, but from the condition of disablement we infer that there is a disease.[27]

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[25]Madsen, p. 62.

[26]Mark Keller, "The Disease Concept of Alcoholism Revisited," Journal of Studies on Alcohol 37 (November 1976):1695.

[27]Ibid., p. 1696.

There are a number of factors about Keller's definition which point to its significance. It comes from one who works within the academic community and who has established an excellent reputation in scientific research into alcoholism. It offers criteria for diagnosis which are useful for research, for helping professions, and for the alcoholic himself. It is more rather than less technical in nature. At the same time, it is practical and does not forsake a "common sense" approach by suggesting that one observe behavior related to the consumption of alcohol, and it asks the observer not to discount what he has seen.

Keller's definition has pointed to alcoholism as a chronic disease. Does the medical community concur with such terminology? A response to this question is given in the Manual on Alcoholism, published by the American Medical Association (AMA). The AMA publication appears to prefer to use the word "illness"; at the same time, the AMA does concur with the use of the word "disease." "Is alcoholism really an illness?" is the question raised in the Manual, and the answer is given, as follows:

> There is still debate over this question, but the preponderance of evidence points to the conclusion that alcoholism is an illness. The American Medical Association, the World Health Organization, and many other professional groups regard it as a specific disease entity.
>
> Some authorities continue to consider alcoholism as essentially a manifestation of underlying psychopathology. Certainly it can be seen at times as primarily a complication to other conditions, both physical and

> mental. It has also been described as basically a symptom, which increases and eventually attains such magnitude as to become an illness. For practical purposes, however, and in view of evidence presently available, it seems most logically classified as a highly complex illness, . . .[28]

John Keller finds the disease concept to be useful within the context of pastoral care. He stresses the importance of understanding alcoholism as a spiritual sickness. The spiritual dimension of sickness has significance for Christians, and Keller addresses this matter, as follows:

> Alcoholism is a "total sickness." The alcoholic is often physically sick, suffering from malnutrition because of eating improperly while drinking excessively. But as we try to understand the alcoholic within our Christian faith, we see him as a person who is also spiritually sick. The recovery program of A.A. makes it clear that this is the way many alcoholics feel about themselves, too.[29]

Many definitions of alcoholism have been examined. It appears that the problem of definition is less a matter of variety and number and more a matter of approach to the subject of alcoholism.

To summarize: there is a problem encountered in attempting to define alcoholism; there are points of similarity as well as areas of disagreement in the definitions which have been cited; there is still debate about the precise way to address a disease concept of alcoholism, but

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[28] Manual on Alcoholism, 3d ed. (Chicago: American Medical Association, 1977), p. 3.

[29] John E. Keller, Ministering to Alcoholics (Minneapolis: Augsburg Publishing House, 1966), p. 12.

most of those working with alcoholics and writing about alcoholism agree that a disease concept is useful for the definition of alcoholism.

A Working Definition

One involved in a study of pastors' attitudes toward alcoholism finds it necessary to have a definition of alcoholism. One is confronted by three basic alternatives: (1) to adopt one of the definitions offered in the available literature; (2) to adopt one, making deletions or additions as deemed necessary; (3) to develop one for the immediate use of the study. Each of the three alternatives has its own advantage and liability. The alternative chosen is the third. The brief definition initially presented in chapter I is useful in general, but a more precise definition offers potential for a more exact understanding of the study.

This section of the chapter addresses itself to the development of a more precise definition of alcoholism, and it contains background and rationale for a working definition. The approach was recognized as eclectic, but it was reasoned that the material about the definition of alcoholism which has been presented could have creative application to the field of alcoholism in general and to pastoral care in particular.

E. M. Jellinek provides a point of departure for ingredients of a working definition in making the comment

that "it comes to this, that a disease is what the medical profession recognizes as such."[30] Jellinek's principle is reasonable. For those involved in pastoral care, the health of members of the parish is significant. Pastoral care has as one of its specific concerns a ministry to those who are ill. And if one is to know who is sick, it is appropriate to look to the medical profession for a diagnosis. The AMA has been shown to be on record as regarding alcoholism as a disease or highly complex illness. It is important to include the disease concept in the working definition.

A review of the selection of definitions offered previously reveals that other medical terms appear. The disease can be described as progressive, chronic, and terminal (if not arrested).

John Keller is representative of those who stress the definition's including factors other than those covered by medical terms. It was reasoned that a working definition should include descriptive words which point to consequences or areas of life damaged for the person who is alcoholic. All areas of life are affected: physical, emotional, mental, social, economic, and spiritual. These areas of life are observable. The concern of those who emphasize behavior is taken into account by pointing to these areas as places where behavior can be observed. If it be granted that common

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[30]Jellinek, p. 12.

sense is also of importance to diagnosis and treatment, these would be areas where it could be in operation with a common sense approach of trusting the observation itself.

It is also important that loss of control be included in the working definition. The significance of this phrase is that it describes that which is either precipitating or resulting factor in alcoholism. It is useful for describing an alcoholic who is either drinking or recovering. It was reasoned that loss of control is observed not only when alcohol is consumed; loss of control is also affirmed by many who have recovered. This latter point is central to the story of recovery repeated at meetings of the AA fellowship. For people in AA, the loss of control of consumption of alcohol is understood to be a significant factor both when the disease of alcoholism is progressing and when the alcoholic is recovering.

With the background of the previous pages in mind, the working definition for the study takes form and is precisely stated, as follows: Alcoholism is a progressive, chronic, and terminal (if not arrested) disease precipitated by and resulting in loss of control of consumption of alcohol which affects the following areas of life: physical, emotional, mental, social, economic, and spiritual. A person with this disease is called an alcoholic.

Chapter Summary

The chapter dealt with the problem of defining alcoholism. A number of definitions selected from the literature of the field of alcoholism were presented, and points of similarity and difference were evident. The chapter concluded with the formulation of a new definition.

CHAPTER III

ASPECTS OF PASTORAL CARE RELATED TO ALCOHOLISM

The target for research of this study is the attitude of pastors toward alcoholism. The focus of this chapter is on the pastor. The purpose of the chapter is to discuss aspects of pastoral care within the specific context of ministry to alcoholics. Significant questions for such a discussion can be stated as follows: Is there anything unique about the pastor's role which allows him to be particularly helpful to the alcoholic? Are there any unique contributions which the pastor may make as a member of one of the helping professions?

Assumptions about Pastoral Care

It is not the purpose of the chapter to attempt to review all literature about the pastor's role nor to deal with all aspects of pastoral care. However, pastoral care is a major focus of attention in ministry to alcoholics. It was therefore reasoned that some assumptions about pastoral care in general should be observed before proceeding to its specific application to concerns about alcoholism.

It was assumed that the primary focus of pastoral care has to do with the Gospel and the Sacraments. It was

assumed that pastoral care is implemented within the context of "the relationship between man and God by conveying the Word of God concerning Jesus Christ to man," and that "the pastor's special sphere of service is in relation to the individual's spiritual welfare."[1] It was assumed that one of the functions of pastoral care has to do with helping people in distress and with counseling those who have problems. William Hulme states: "Pastoral counseling centers in problem solving. It is a relationship-centered function in which the person and his problem occupy the point of focus."[2] It was reasoned that alcoholism does offer a matter for problem solving, with the alcoholic as the focus of attention.

There was also recognition of an assumption which operates under the generalization that pastoral care is care for the "whole man." In the previous chapter, the working definition of alcoholism included the point that all areas of life--physical, emotional, mental, social, economic, and spiritual--are affected by the disease. Though there was recognition of the fact that the spiritual is of special concern for the pastor, it was thought that a ministry to the whole man has concern for the other areas listed also.

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[1]Harold J. Haas, Pastoral Counseling with People in Distress (St. Louis: Concordia Publishing House, 1970), p. 55.

[2]William E. Hulme, The Pastoral Care of Families: Its Theology and Practice (Nashville: Abingdon Press, 1962), p. 12.

It is also important to state that Clinebell's revised model for pastoral counseling had strong influence in considering a ministry to alcoholics. Clinebell says that this model can be referred to as "relationship-centered counseling" and that it is based "on relational, supportive, ego-adaptive, reality-oriented approaches to therapy."[3]

Position and Availability

In making the point that ministers need to learn to be more effective in the treatment of alcoholism, Joseph Kellermann emphasizes that clergymen are in a unique position for helping alcoholics, as follows:

> The minister has more to offer in preventing alcoholism or helping in recovery than any professional in the community. . . . The role of the minister provides him with a position of attack on alcoholism which no other person in the community has.[4]

The pastor does occupy a unique position in almost any given community. Both people within and outside the Christian Community identify him as a person who, by definition of his profession and role, is available to help people. He may not be seen as one who is competent to deal with all problems in a specialized manner, but he is generally

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[3]Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (Nashville: Abingdon Press, 1966), p. 23.

[4]Joseph L. Kellermann, "The Clergyman's Role in Recovery," in World Dialogue on Alcohol and Drug Dependence, ed. Elizabeth D. Whitney (Boston: Beacon Press, 1970), p. 199.

recognized as one person--and often as the person--who is readily available to people who have problems. Kellermann does not argue that because people recognize the pastor as an available resource for help they will come to his office to deal with their problem. He does argue that the pastor still today occupies a unique position of availability for relating to and helping those with alcohol problems.

Karl Schneider, the Lutheran Church in America pastor who is Director of Education at Eagleville Hospital and Rehabilitation Center in Pennsylvania, cites a survey by the Joint Commission on Health which pointed to the pastor's unique position to be of assistance to people seeking help. The study also showed that the pastor is more likely to be approached for help than are other professional people. According to Schneider, the Joint Commission on Health survey demonstrated the pastor's unique position in statistical terms, as follows:

> Among those who sought help for some kind of personal problems, 42% consulted clergymen, 29% physicians in general, 18% psychiatrists or psychologists, and 10% social agencies or marriage clinics. . . . Churches are still the only social institution with regular contact with the whole family.[5]

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[5]Karl A. Schneider, "Motivational Approaches in Training Clergy for Early Intervention in Addictive Problems in Parish and Community," paper presented at the 28th Annual Meeting of the Alcohol and Drug Problem Association of North America, Detroit, Mich., 25-29 September 1977, p. 2. (Mimeographed.)

Addressing the topic of "The Clergy and Alcoholism," Eugene Verdery points to five factors which contribute to a unique role for the pastor in his ministry to people with alcohol problems. First, he suggests that there is evidence that the pastor is often the first person the alcoholic or the family approaches for help. Second, the pastor is usually "free," that is, he is the one person who has professional standing in a community who does not generally charge a fee for his services to individuals. Third, Verdery says that people often approach a pastor due to the feelings they have that he is one who can be trusted. In a sense, a distrust of other people leads to the trust in a clergyman. Fourth, he points to the fellowship of the church, making the point that there is a unique context within which people may feel at liberty to approach the pastor. Finally, working with the assumption that alcoholism does have a spiritual dimension, he points to the pastor as one uniquely qualified for helping with insight into the religious experience.[6]

While noting that the clergyman cannot be effective in helping the alcoholic if he attempts to work alone rather than as part of a team, Kellermann offers a similar listing which points to the pastor's unique position for helping the

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[6]Eugene A. Verdery, "The Clergy and Alcoholism," in Alcoholism: Behavioral Research, Therapeutic Approaches, ed. Ruth Fox (New York: Springer Publishing Co., 1967), pp. 280,281.

alcoholic, because (1) he is able to enter the home of members in a way not available to others; (2) the health of people in his parish is one recognized aspect of his responsibilities; (3) he is frequently the first professional approached by the family with problems; and (4) he is readily available.[7]

The National Council on Alcoholism considers pastors to be of such significance in helping alcoholics and their families that it has published A Guide for Clergy. There is recognition of the unique role of the clergy in this document (which was written by Joseph Kellermann). A statement on ministry to alcoholics, adopted by the General Board of the National Council of Churches and pointing to the need for the pastor's involvement in helping alcoholics, appears on the first page. This significant statement in the National Council on Alcoholism's Guide reads as follows:

> The churches share a pastoral concern for alcoholics, problem drinkers and their families. . . .
> Alcoholics are persons in need of diagnosis, understanding, guidance and treatment. They are especially in need of pastoral care and the divine love which the church can bring them. . . . Ministers and churches should not be content merely to direct alcoholics to treatment centers.[8]

The Guide points to some unique pastoral functions to help alcoholics. The pastor's job description permits

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[7] Kellermann, p. 200.

[8] Joseph L. Kellerman, Alcoholism: A Guide for the Clergy, ed. Yvelin Gardner (New York: The National Council on Alcoholism, n.d.).

uninvited contact with people in their homes. In person or by letter he is in a position to address the problem as no one else is able to do. Due to the fact that alcoholism frequently creates a crisis situation, the pastor is again in a unique position since he is trained to deal with crises and he is likely to be called upon when they arise. The Guide also points to his ability to call upon parish members who belong to AA for helping him in his ministry to alcoholics.[9]

A number of factors which point to the pastor's being in a unique position for helping alcoholics have been presented. Those who work in the field of alcoholism emphasize the need for the pastor to draw upon the aspects of his position and availability in his pastoral care of alcoholics.

The "God Question"

The pastor has a unique contribution to make in helping alcoholics due to the spiritual dimensions of alcoholism. As the "religious man" in a community, the pastor is able to assist alcoholics in their spiritual struggles, which take special shape in the disease of alcoholism.

Martin Luther points to what might be called the "god question" when in his Large Catechism he says:

> What is it to have a god? What is God?
> Answer: A god is that to which we look for all good and in which we find refuge in every time of need. To

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[9] Ibid., pp. 7,8.

> have a god is nothing else than to trust and believe him with our whole heart.[10]

One way of understanding alcoholism is to recognize that "in the bottle" the alcoholic looks for all good and turns to alcohol to find refuge in every time of need. If "God" represents the center of life--a point of departure and a place to go, the beginning and the end--then it is not inappropriate to designate alcohol as the god for the alcoholic. His life revolves around his drinking.

In many respects, this concept lies behind the Twelve Steps of AA. The way to recovery, AA believes, includes dealing with the "god question," both as it relates to continued addiction and to recovery.[11]

Doman Lum, writing in the Journal of Religion and Health, addresses the "god question" in a direct manner, pointing to the alcoholic's lack of a vital faith and to his substituting the bottle for God. He writes as follows:

> The alcoholic is a person without a vital faith who is searching for a religious experience. He substitutes the bottle as a god and finally hits bottom when he realizes that his false god is an idol.[12]

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[10]Martin Luther, "The Large Catechism," in The Book of Concord, ed. Theodore G. Tappert, trans. Robert H. Fisher (Philadelphia: Muhlenberg Press, 1959), p. 365.

[11]In what is generally called "The Big Book," the Twelve Steps are discussed in Chapter 5 and agnostics are addressed in Chapter 2. Alcoholics Anonymous, 3d ed., new and rev. (New York: Alcoholics Anonymous World Services, 1976), pp. 59-60, 44-57.

[12]Doman Lum, "The Church and the Prevention of Alcoholism," Journal of Religion and Health 9 (April 1970):197.

Howard Clinebell also suggests that the alcoholic looks for a religious experience in his use of alcohol, and he states the following:

> An understanding of any religious approach to alcoholism must include the recognition that, for the alcoholic, religion and alcohol often are functionally interchangeable.[13]

The pastor is uniquely qualified by his training to relate to questions about God. It is reasonable to assume that he is qualified to deal with the dynamics of faith. Clinebell, Lum, and AA all stress the importance of faith and the religious experience for the alcoholic. If he is to recover, there is need for a change in his faith object.

It was reasoned that the pastor can be of special assistance to the alcoholic in his dealing with the "god question." It is suggested that the significance of the pastor's ministry to alcoholics does not lie simply in some theoretical approach to an understanding of the spiritual aspects of alcoholism nor only in his having solutions to the alcoholic's quest for God. It is suggested that of special significance is that he and the alcoholic have a common point of departure, a kind of functional principle of understanding and appreciation of the way in which the object of faith (God or alcohol) has consequence for living. One does live by faith. The pastor may be of special use in

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[13]Howard J. Clinebell, Jr., Understanding and Counseling the Alcoholic through Religion and Psychology, rev. and enl. ed. (Nashville: Abingdon Press, 1968), p. 154.

helping the alcoholic understand how true this is as he examines the progress of the disease and how significant this is as the alcoholic is enabled to move toward recovery. On the one hand, the pastor need not lay exclusive claim to an understanding of faith and the "god question." On the other hand, the pastor does have a unique concern for and appreciation of these matters, and consciously or unconsciously the alcoholic does as well.

Anxiety, Estrangement and Grace

> Among the diverse feelings which characterize the alcoholic, the minister may relate especially to his sense of isolation, to his dependency needs, to his guilt, and to his sense of purposelessness in life. [14]

There is an assumption in these words of Eugene Verdery which points to another aspect of the pastor's unique place in relating to the alcoholic; that is, the pastor is especially prepared to deal with feelings of isolation and dependency, with guilt and purposelessness. There would be little debate among pastors about such areas as being of great concern for their ministry.

But what clinical evidence is there which would point to such problems? What theological concepts are available which would relate specifically to such problems? What unique factors for ministry to alcoholics emerge when

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[14] Verdery, p. 275.

clinical observation and theological orientation are brought together for investigation?

Howard Clinebell offers a summary of scientific investigation into and clinical observation of the alcoholic which is useful in responding to the first question, as follows:

> The following have been mentioned repeatedly in reports of psychological studies of alcoholics: (1) a high level of anxiety in interpersonal relationships, (2) emotional immaturity, (3) ambivalence toward authority, (4) low frustration tolerance, (5) grandiosity, (6) low self-esteem, (7) feelings of isolation, (8) perfectionism, (9) guilt, (10) compulsiveness. These psychological attributes are often present in enlarged proportions when the person is in the nightmare of active alcoholism.[15]

All of these factors tend to cause the alcoholic pain. Alcohol becomes the solution for relieving the pain--and this is of such great significance that Clinebell says, "One will not fully understand alcohol as a problem until one sees it as a 'solution.'"[16] Pain causes anxiety; the alcoholic uses alcohol as a solution to both the pain and the anxiety. And with his use of alcohol, he becomes more and more estranged--from himself and from others. It is a tragic circle--moving from problem to "solution," and from solution back to problem. Clinebell quotes anthropologist Donald Horton, who, after studying many cultures, said, "'The primary function of alcoholic beverages in all societies is the reduction of anxiety.'"[17]

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[15]Clinebell, p. 53. [16]Ibid., p. 57. [17]Ibid., p. 58.

The Johnson Institute, a Minneapolis-based treatment program for alcoholics which claims high success in helping them to recover, has developed a therapy which is designed to assist the alcoholic to come back to a realistic way of living. In the book which discusses this approach titled I'll Quit Tomorrow, Vernon Johnson traces the progressive nature of alcoholism, pointing to the alcoholic's attempt to achieve euphoria (which includes reduction of pain) as that which is eventually "characterized by harmful dependency and a rising emotional cost."[18] He loses touch with reality as he continues to use alcohol, and alienates himself from others as he projects his feelings of self-hate to those around him.[19] Johnson stresses the importance of presenting reality to the alcoholic in "a receivable fashion,"[20] but of significance at this point is his stress on the fact that the alcoholic has lost touch with reality and lives in estrangement. As alienation and estrangement increase, so does his drinking--and vice versa. The scientific investigation into alcoholism of the Johnson Institute demonstrates how closely anxiety and estrangement are linked together.

Is there a theological perspective from which to approach the problems of anxiety and estrangement which

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[18]Vernon E. Johnson, I'll Quit Tomorrow (New York: Harper & Row, Publishers, 1973), p. 14.

[19]Ibid., p. 28.

[20]Ibid., p. 48.

might be significant not only in understanding the human predicament in general but the alcoholic's problem in particular? John Keller points to a theological approach to this question, centering on a Christian understanding of the nature of man. He concentrates upon anxiety and estrangement as concepts expressive of the concern within the framework of a Christian anthropology. In the course of his presentation he offers insight into unique potential for the pastor's involvement with the alcoholic and his problems.

Keller begins with an understanding of man as a unique creation of God. "God created man so that there might be life in and with relationship. Only persons can live in relationship."[21] It is important to take into account not only man as created by God; one needs also to take into account fallen humanity and that one of the consequences of the Fall is estrangement and anxiety. St. Augustine's statement about man's soul being restless until it rests again in God points to an understanding of humanity which takes into account anxiety and estrangement. "The anxiety of estrangement in this ultimate relationship in life may not be man's most conscious anxiety. But theologically it is man's most basic anxiety."[22]

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[21]John E. Keller, Ministering to Alcoholics (Minneapolis: Augsburg Publishing House, 1966), p. 4.

[22]Ibid., p. 5.

What may be common to all people takes special form in the life of an alcoholic. According to Keller, the alcoholic appears to cope with anxiety and estrangement by using alcohol. In the process of making this point, Keller provides a link in relating observed behavior to theological concerns, as follows:

> Anxiety over the unresolved estrangement in his human to human relationships was a consciously felt, not understood, powerfully destructive force. Alcohol temporarily removed the anxiety of this inner conflict. . . . He experienced that alcohol worked in a way that nothing or no one else ever had.[23]

At this point, it may be useful to suggest that whether one takes a scientific approach to attempt to "name the problem," or a theological approach in order to "name the sin," the end result is similar: anxiety and estrangement. According to the definition of alcoholism offered in the previous chapter (which emphasizes loss of control of consumption of alcohol), both approaches could--at least in theory--agree that anxiety and estrangement are either precipitating or resulting factors which revolve around alcohol. Whether scientific diagnosis or theological judgment is rendered, anxiety and estrangement emerge as a common factor related to loss of control of the consumption of alcohol. To the extent that there is such agreement and consensus, one could argue that the pastor working with a theological perspective does not have a unique contribution

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[23]Ibid., p. 11.

to make in this area. Such an argument is not offered in order to exclude the Law (defined in this instance as that which accuses and diagnoses) as something of great use for the pastor in relating to the alcoholic but in order to point to the possibility that his unique offering may be more clear and evident in another aspect of his ministry. It is a way to begin to suggest that the pastor is in a unique position to be of significant help to the alcoholic because of the pastor's understanding of the Gospel and due to his appreciation and experience of grace.

In the following two quotations, John Keller points to an understanding of the need for grace as a matter of extreme importance for the pastor's role vis-a-vis the alcoholic, and he stresses the need for the Gospel.

> Those of us who are not alcoholic are just as sinful as we would be if we were alcoholic. We are all in need of God's grace. And there are no degrees of need for grace. . . . When we realize and truly accept this truth, we see that the alcoholic is not someone unlike ourselves but our brother in sinfulness and need. He is one of us.[24]

> The Gospel makes clear that only the person who has by grace experienced the resolution of estrangement with God, himself, and others is free to live as a responsible person, in humility of spirit in meaningful relationships that find expression in service to God and man.[25]

Grace has to do with acceptance. Grace and acceptance are of great concern to one living in anxiety and

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[24] Ibid., p. 13.

[25] Ibid., p. 22.

estrangement. Keller's point is that when the pastor is able to offer the Good Word--in the form of words and actions which express gracious acceptance of the alcoholic--he is able to make a unique contribution for the alcoholic's progress toward recovery. Though there is no need for the pastor to lay exclusive claim to the grace of God, it is important for the pastor to approach himself and alcoholics as equally in need of and reliant upon the grace of God.

With considerable sensitivity, Keller points to the pastor as having potential for a unique contribution for the recovery of the alcoholic, especially when he recognizes a kind of mutual sharing of anxiety and estrangement in relationship to grace and acceptance. The pastor is able to see himself and the alcoholic as estranged persons equally in need of grace. Keller says:

> It is this kind of attitude and understanding about ourselves that makes possible understanding and acceptance in relationship with the alcoholic. Unconsciously he is looking for this in others in their relationships with him. He doesn't expect to find it and experience it. And when he finds it in a pastor, strangely enough in many cases the last person he expected to have it, this can be a delightful surprise and readily result in the lowering of his defenses and the beginning of a meaningful helping relationship in which the alcoholic can begin to face the reality of his problem responsibly.[26]

In summary, Keller is suggesting that the "gracious activity" of the pastoral office offers a gift not readily available to the alcoholic at other places in society.

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[26]Ibid., p. 23.

Living within the Fellowship of Redeemed Sinners

The parish pastor consciously lives within the fellowship of redeemed sinners. This context of his life gives potential for another unique aspect of his offering help to the alcoholic.

Clinebell discusses evidence of unrealistic expectations and of perfectionism operative in alcoholics. Rather than dealing with realities and imperfections, there is the tendency for the alcoholic to turn to the bottle.[27] Pastor and parish together proclaim their realistic view of the nature of things in divine terms: perfection is not possible on our part, for we are sinners; God offers redemption in Jesus Christ, so there is hope. In a sense, pastor and parish offer the opportunity for a kind of Christian realism which appears to be of particular importance to the alcoholic who lives with unrealistic estimates of himself and with a disastrous kind of perfectionism.

In developing a treatment program for alcoholics involving a therapy focusing on bringing the patient back to reality (with the implicit suggestion that by definition alcoholism leads to or results in a loss of being in touch with reality), Vernon Johnson talks about what he calls a "startling observation" which may be of special importance in this discussion. He says, "Our most startling

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[27]Clinebell, pp. 51,53,55.

observation has been that alcoholism cannot exist unless there is a conflict between the values and the behavior of the drinker."[28] In many respects, the therapeutic approach of the Johnson Institute is based on this observation.

With no intention of depreciating either that observation or the usefulness of Johnson's approach, there is need to point to the fact that one who works within the framework of the fellowship of redeemed sinners would not find such an observation startling. In fact, especially within the Lutheran tradition, one would expect to observe a conflict between values and behavior--on the part of the alcoholic or the non-alcoholic.

The pastor's way of looking at things with an expectation of observing a conflict between values and behavior could be of significance in relating to the alcoholic if Johnson's startling observation can be something of a catalyst in developing a treatment model which is especially useful to the alcoholic's recovery process. A theology which emphasizes realism--which takes shape not only in words of teaching like simul justus et peccator but also in the living fellowship of redeemed sinners called the church--has potential for providing a helpful approach to the alcoholic, who appears to be desperately in need of realism and of a way to deal with his imperfection. Such a theology may

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[28]Johnson, p. 2.

frequently be taken for granted by pastors or may not be seen as offering great potential for helping people deal realistically with life or conflicts. But it is suggested that precisely within the framework of such a working theology one discovers that which is especially helpful to the recovery of the alcoholic.

Member of a Team

The parish pastor is a person of professional standing in a community. As such he has opportunity to offer his unique forms of service to the alcoholic and his family. It is not unlikely that when the alcoholic and his family move in the direction of dealing with the problem that they will draw upon various resources of the community. Due to the complexity of the disease, there is general agreement among those who work in the field of alcoholism that a multi-disciplinary approach and treatment program is most likely to succeed. There are at least two implications which flow from such reasoning.

On the one hand, the pastor can approach his ministry to the alcoholic and his family as a member of a team. Ministers who have attempted to "go it alone" frequently find that they are less than effective in helping the alcoholic. On the other hand, the minister does have a significant role to play as one of the members of a team. Clinebell suggests that a minimum team would include a physician, a member of

AA, the alcoholic, and the pastor himself. In making this point, Clinebell states the following:

> The pastor should think of himself as a team member with important functions. . . . He should see himself as the coordinator [emphasis mine] of the team in providing help for those alcoholics who come to him, unless there is some other person or agency which can fulfill this function more efficiently.[29]

It is important for the pastor to recognize that there are professional people in the community who are available for helping the alcoholic and his family. Frequently he will refer alcoholics to such community resources. At the same time, it is Clinebell's point that the pastor also recognize that, as a professional person, he himself has much to contribute. One way of his participating in such a team effort would be as coordinator of the team.

There is also need for the alcoholic to have a person who gives a sense of continuity to his recovery. It is the experience of many alcoholics that nearly everything in life seems to fall apart. Even as recovery is begun, there may be many relationships which have already been destroyed. Frequently the alcoholic begins to feel that he is less than a person and that nearly all points of continuity in his life have been destroyed. The pastor can continue to relate to him as a person, and with that kind of action provide a needed sense of continuity in at least one relationship.

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[29]Clinebell, p. 191.

There is certainly no need for the pastor to assume a posture which might be described as protective or paternalistic as the alcoholic is in recovery. But there is great potential for the good of the alcoholic and his family if the pastor can relate to the alcoholic--during his active stage of the disease or after recovery--with a constant concern for his growth as a person. It is probable that some of the other members of the recovery team--for example, his physician--may cease their participating in the life of the recovered alcoholic. The pastor is able to maintain his relationship with the recovered person, and in the process he is able to assist in a unique way so that the recovery is maintained. With the exception of the fellowship of AA, it is likely that the pastor may be the only professional person in a community to offer such concerned continuity. Max Glatt suggests that there is the possibility that the pastor has a more important role for the alcoholic after he has found sobriety than he has during the active phase of the disease, particularly as the pastor provides spiritual guidance and helps to teach the alcoholic to pray.[30]

If it be granted that recovery is most likely within the context of a team effort--and there is really no debate about this--then it follows that the pastor's involvement in

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[30]Max Glatt, The Alcoholic and the Help He Needs (New York: Taplinger Publishing Co., 1969), p. 137.

the effort as one member of the team has significance. The uniqueness of his role as a member of the team is precisely at the point where he functions in his pastoral role. This role may take shape as coordinator or spiritual guide. But without his participation the team limps, in that it does not have one functioning as pastor. The pastor cannot "go it alone," but he is certainly needed--before, during, and after the alcoholic's recovery.

Chapter Summary

This chapter has dealt with the pastor's role and pastoral care as related specifically to alcoholism. After a discussion of working assumptions, it dealt with some factors of the pastoral office and the pastor's role which offer unique potential for helping the alcoholic toward recovery.

A review of the literature pointed to the pastor's occupying a unique position of availability which is of importance to the alcoholic. The "God Question" was pointed to as one of those areas where the pastor can be of special help to the addict whose life revolves around alcohol. The significance of faith as related both to continued addiction and to recovery was discussed. It was suggested that the pastor's understanding and application of grace in view of the alcoholic's anxiety and estrangement are of great significance. The pastor who lives within the fellowship of redeemed sinners operates with a kind of hopeful Christian

realism which is of great importance to an alcoholic who tends to have great difficulty in dealing with reality and imperfections. Finally, the chapter dealt with the pastor as one significant member of a team of professionals who can be helpful to the alcoholic, both before and after his recovery, with an emphasis upon the uniqueness of his role as coordinator of the team and as one who may provide concerned continuity as the alcoholic recovers and grows.

CHAPTER IV

THE SIGNIFICANCE OF ATTITUDES

What evidence in the literature of the field of alcoholism points to attitude as a significant factor for effective treatment of the alcoholic? What kinds of attitudes are of importance? What significance does attitude have for a ministry to alcoholics? These are the questions to be addressed in this chapter.

After a brief discussion of the concept of attitude, attention will be directed to the importance of attitude for people who work in helping professions. A number of examples of attitudinal factors which are of significance in the treatment of alcoholism will be examined. The particular importance of a pastor's having positive attitudes in his ministry to alcoholics will be demonstrated.

Several assumptions were made in the examination of attitude. It was assumed that there would be a point of contact between the pastor and other professional people--what is significant for a member of one helping profession is likely to be important to someone who is in a different profession. It was also assumed that it is important to attempt to determine what positive attitudes may be more helpful and what negative attitudes may be less helpful in

effective ministry to the alcoholic. Finally, it was assumed that the views about attitudes of recovered alcoholics themselves need to be taken into account in the attempt to determine what may be more or less helpful.

If there was to be developed an instrument which attempted to investigate attitudes of pastors toward alcoholics, it was necessary to examine what is meant by attitude. If there was to be an effort to determine scientifically attitudes of LC--MS pastors toward alcoholics, there was need not only to establish that attitudes are significant but also to examine what is important about attitudes for the pastor's ministry to alcoholics. The focus of this chapter is on attitudes.

The Concept of Attitude

In Attitude Psychology and the Study of Public Opinion, Forrest Chisman takes account of the highly complex nature of the concept of attitude. There are, however, aspects of the concept which are generally accepted in studies within an academic setting. He offers a general description of the factors involved in a more technical understanding of attitude, as follows:

> Psychologists generally define an attitude as an "enduring evaluative disposition" toward some object or class of objects and often say that attitudes are

comprised of "cognitive, affective, and behavioral components" which are "consistent" with each other.[1]

Chisman also gives a short summary of different approaches to the definition of attitude. There follows a number of definitions of attitude which he gives in summary fashion, presented in the manner of his listing (with the name of the one formulating the definition followed by a summary of his definition).

> Irving Sarnoff: a disposition to react favorably or unfavorably.
> Isidor Chein: a disposition to evaluate certain objects, actions, and situations in certain ways.
> Theodore Newcome: viewing with some degree of favour or disfavour.
> Milton Rokeach: a relatively enduring organization of beliefs around an object or situation predisposing one to respond in some preferential manner.
> Krech, Cruchfield, and Ballachey: a system of feelings, cognitions, and beliefs.
> Thomas and Znanecki: a tendency to action.[2]

In summary, Chisman places focus on feelings, beliefs, and action tendencies, as follows:

> Feelings, beliefs, and action tendencies are . . . components of attitudes in the sense that an individual's attitudes are comprised of these three different sorts of reactions to objects.[3]

The following quotations from Scales for the Measurement of Attitudes by Marvin Shaw and Jack Wright take into account theories of learning and give emphasis upon attitudes as a consequence of the socialization process.

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[1]Forrest P. Chisman, Attitude Psychology and the Study of Public Opinion (University Park, Pa.: The Pennsylvania State University Press, 1976), p. 23.

[2]Ibid.

[3]Ibid., p. 26.

> Attitudes, the end products of the socialization process, significantly influence man's response to cultural products, to other persons, and to groups of persons.[4]

Attitudes are significant for behavior, as is indicated by the following:

> Attitude entails an existing predisposition to respond to social objects which, in interaction with situational and other dispositional variables, guides and directs the overt behavior of the individual.[5]

Shaw and Wright offer their own definition, as follows:

> [Attitude is] a relatively enduring system of evaluative, affective reactions based upon and reflecting the evaluative concepts or beliefs which have been learned about the characteristics of a social object or class of social objects.[6]

A final definition of attitude for consideration is the one offered by L. L. Thurstone. It was originally published in the American Journal of Sociology (January, 1928) and more recently reprinted in Attitude Measurement. Thurstone's description of attitude has particular significance, due to the fact that it was written within the context of establishing a basis on which to measure attitudes, and his work in the field is considered a classic study. In establishing a basis for the investigation and measurement of attitudes, Thurstone stated the following:

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[4]Marvin E. Shaw and Jack M. Wright, Scales for the Measurement of Attitudes (New York: McGraw-Hill Co., 1967), p. 1.

[5]Ibid., p. 2.

[6]Ibid., p. 3.

> The concept "attitude" will be used here to denote the sum total of a man's inclinations and feelings, prejudice or bias, preconceived notions, ideas, fears, threats, and convictions about any specified topic.[7]

Though different words are used in defininig attitudes by those experts in the field who have been cited or quoted, there is general agreement that attitudes have to do with feelings, beliefs, and action tendencies. Chapter I offered a brief definition of attitude which took into account the various emphases of those which have been discussed. That definition is here restated, as follows: attitude is a relatively enduring system of feelings, beliefs, and action tendencies.

Positive Attitudes Needed

Richard Mackey, in an article titled "Views of Care-giving and Mental-Health Groups about Alcoholics," points to the need for positive attitudes on the part of those who are involved in a helping profession by directing attention to attitudes as a determining factor for people involved in work with alcoholics. He says:

> The psychological predisposition of one person to another plays a highly significant role in determining how each one behaves toward the other. Feelings about or attitudes toward other persons and groups may either enhance or destroy the potential for relating to them

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[7]L. L. Thurstone, "Attitudes Can Be Measured," in Attitude Measurement, ed. Gene F. Summers (Chicago: Rand McNally & Co., 1970), p. 128.

as separate human beings rather than as the embodiment of one's own prejudices and stereotypes.[8]

In addressing the counseling process and emphasizing the need of the counselor to view the alcoholic as a person (and not simply as a drunk) Robert Sheldon, Harry Davis, and Ron Kohorn make a similar point. "The therapist's views, prejudices, and real feelings about the patient govern his ability to work with the patient."[9]

Such statements as these two here offered are representative of those who work in the field of alcohol counseling, and they emphasize that attitudes determine and govern approaches to people. It is evident that positive rather than negative attitudes are needed to be of effective help to the alcoholic. But before pointing to positive attitudes, it is useful to examine some studies of negative ones and their effect on treatment.

Examples of Negative Attitudes

Patricia Sowa and Henry Cutter report the results of a study of attitudes of therapists which showed that those who had "moralistic attitudes" toward alcoholism were less optimistic about the alcoholic's recovery than those who

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[8]Richard A. Mackey, "Views of Caregiving and Mental-Health Groups about Alcoholics," Quarterly Journal of Studies on Alcohol 30 (September 1969):665.

[9]Robert B. Sheldon, Harry G. Davis, and Ron L. Kohorn, "Individual Counseling and Therapy with the Alcoholic Abuser," in Alcohol Abuse and Rehabilitation Approaches, ed. John G. Cull and Richard E. Hardy (Springfield, Ill.: Charles C. Thomas, Publishers, 1974), p. 141.

expressed an "illness-oriented attitude." They conclude: "Thus, perceived patient treatment potential is related to the attitude of the person treating the patient."[10] In support of this point, they report that the study showed that psychiatrists had less favorable attitudes toward alcoholics than did low-status staff (for example, clerical and housekeeping persons) who tended to be more optimistic about recovery.[11]

In an article published in 1965 in the Quarterly Journal of Studies on Alcohol there is reported an example of the way in which attitudes affect diagnosis and treatment of alcoholics. The article reports interviews with physicians in which it was discovered that even though they stated that alcoholism was a "disorder" which could occur among any social group, they tended in their diagnosis of patients to behave as though it were primarily and almost exclusively a disorder of derelicts. They would diagnose derelicts as alcoholic; but even when they recognized alcoholism in a middle class person, they hesitated to make that

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[10]Patricia A. Sowa and Henry S. Cutter, "Attitudes of Hospital Staff Toward Alcoholics and Drug Addicts," Quarterly Journal of Studies on Alcohol 35 (March 1974): 210.

[11]Ibid., p. 218.

diagnosis, and they tended to look to other symptoms to name the problem.[12]

Robert Straus reports a study conducted in 1971 by James W. Middleton, Jr., which demonstrated that negative attitudes tend to surface when treatment personnel are involved in working with alcoholics. This study, which took place in a general medical hospital, revealed that it made no difference which floor or service of the hospital the alcoholic patient was on--after the patient was identified as having a drinking problem, staff members frequently took a negative approach toward the patient. The study cites examples of such negative attitudes, as follows:

> Although sympathy for the patient was almost always expressed, negative attitudes were revealed by such statements as "T.W.S.T." (trash will survive and thrive); "the poor degenerate"; or "Is he really worth the effort?" Other defeatist attitudes frequently expressed by the staff were illustrated by such statements as "he will probably be back in a year's time"; "basically nothing can be done to cure alcoholism"; "alcoholism is a sad situation--there isn't a thing we can do for it." Although such opinions were not universal, they were expressed a substantial number of times.[13]

In spite of the fact that there has been a concentrated effort on the part of many involved in the treatment

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[12]Irving Wolf, Morris E. Chafetz, Howard T. Blane, and Marjorie J. Hill, "Social Factors in the Diagnosis of Alcoholism: Attitudes of Physicians," Quarterly Journal of Studies on Alcohol 26 (March 1965):79.

[13]Robert T. Straus, "Problem Drinking in the Perspective of Social Change, 1940-1973," in Alcohol and Alcohol Problems: New Thinking and New Directions, ed. William J. Filstead, Jean J. Rossi, and Mark Keller (Cambridge, Mass.: Ballinger Publishing Co., 1976), p. 34.

of alcoholism to remove stigmatization and stereotyping of alcoholics, there is evidence that professional people still have negative attitudes. Straus makes the point that a medical model for the treatment of alcoholism was drawn upon partly to help alleviate stigmatization and to assist alcoholics in feeling more comfortable in reaching out for help. Even though there is some evidence that there has been some change in the attitude of the general public toward alcoholics since the medical model has gained wider acceptance (since the early 1940's), Straus concludes his study by saying that three decades later there is evidence "that a negative image of alcoholics still prevails among the very people, who because of their professional training and roles, are assumed to be the best equipped to offer help."[14]

Doman Lum, Th.D., points to a similar conclusion, that negative attitudes are operative among many who work with alcoholics. He agrees with Pittman and Stern, whom he quotes as follows: "'Many treatment personnel are marked by ambivalence, moralism, and pessimism regarding the alcoholic and his treatability.'"[15] Such attitudes are detrimental rather than helpful in the treatment of alcoholism.

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[14]Ibid., p. 33.

[15]Doman Lum, "The Church and the Prevention of Alcoholism," Journal of Religion and Health 9 (April 1970): 143.

Marty Mann, recognized authority in the field of alcoholism, makes the point that many people do not have helpful, accepting attitudes and that their negative attitudes are betrayed in their approach to the alcoholic. Mann describes such people and the consequence of their negative attitudes as follows:

> They are condemning, and therefore often hostile. They are quick to blame the alcoholic for his condition and to see the horrors of the condition as the man. They unwittingly treat him as less than human because he is not as they are. They are contemptuous of his weakness, his failure to stand up to life. They are sometimes punitive, believing that what he really needs is to be taught a lesson. They do not understand him and they do not really like him. And he knows it.[16]

In the context of discussing the need for accepting a disease concept of alcoholism, Howard Clinebell approaches the moralistic viewpoint (which believes that the major problem for the alcoholic is his lack of will power or lack of moral strength) and points to a moralistic attitude as that which is actually harmful to the alcoholic--there are negative consequences resulting from holding a moralistic attitude. Clinebell assumes the position of the alcoholic person in making his point, and he says,

> As long as the alcoholic thinks of his trouble as essentially a matter of willpower, he will tend not to seek help. To do so would be an admission that he is weak or morally corrupt. But as soon as he accepts the

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[16]Marty Mann, "Attitude: Key to Successful Treatment," in The Para-professional in the Treatment of Alcoholism, ed. George E. Staub and Leona M. Kent (Springfield, Ill.: Charles C. Thomas, 1974), p. 4.

> the sickness conception and applies it to himself, he will tend to take action appropriate to a sickness--get help. Those whose attitudes help perpetuate the moralistic conception of alcoholism are thus unwittingly responsible for pushing alcoholics deeper into the dark morass.[17]

Negative attitudes frequently take shape in a kind of mythology which does not correspond to facts about alcoholics. Brent Hafen points to the way in which attitudes which are stereotyping and judgmental take the form of common myths about alcoholism. He lists the following six myths about alcoholism.

> Nothing can be done unless the alcoholic "wants to stop drinking."
>
> The alcoholic must hit "rock bottom" (i.e., lose job, family, home, health) before he will want to get well.
>
> It is hopeless to treat alcoholism in any case. A patient may reform for a while but always slips back.
>
> Alcohol itself is the only cause of alcoholism. If it were removed, there would be no alcoholism.
>
> Most alcoholics are found on skid row.
>
> Only the "psychological cripples" will become problem drinkers and develop into alcoholics.[18]

Karl Schneider, who is consultant for the Alcohol and Drug Services for the Southeastern Pennsylvania Synod of the Lutheran Church in America, has a concern--both as a pastor and as one who works full-time in the field of alcoholism--about attitudes of pastors toward alcoholics

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[17]Howard J. Clinebell, Jr., Understanding and Counseling the Alcoholic through Religion and Psychology, rev. and enl. ed. (Nashville: Abingdon Press, 1968), p. 308.

[18]Brent Q. Hafen, Alcohol: The Crutch that Cripples (St. Paul, Minn.: West Publishing Co., 1977), pp. 80-82.

and the effect of attitudes on the pastor's ministry. While one might suggest that his approach relies on a kind of argument from silence, his way of using statistics to get at attitudes is of interest and merits consideration. (Chapter I previously drew upon this study by Schneider, but in this present instance a more complete report of his reasoning is given.)

Schneider points to evidence that clergymen are the professional persons most likely to be contacted by people in a time of need or crisis. He draws upon the statistic that one out of every twelve Americans who drinks has a problem with alcohol. He also uses the figure determined by Harold Mulford's study which indicated that eighty-five percent of Lutherans consume alcoholic beverages. He also cites the figure of three percent as the number of those people who indicated in a study that they had come to an agency due to their pastor's referral. His point is to suggest that if a national study showed that forty-two percent of people surveyed indicated that they had gone to their pastor for help and yet only three percent of those with alcoholic problems indicate that they have seen their pastor, then perhaps the great difference between the two figures is to be accounted for by looking to attitudinal factors on the part of the clergy. The following extended quotation presents Schneider's reasoning.

> Consider a hypothetical Lutheran congregation of 500 members, multiply the percentage who drink, or .85, and there are 425 drinking members. Divide 12 into 425, and there are 35 potential members with an alcohol problem. This is a statistical game at best, but it does cause any pastor to open his eyes and re-examine the possibility of alcohol problems and the neglected ministry. If you multiply the 35 potential members by 4 (4-5 family and friends are directly affected) a total of 140 persons are affected. What pastor can ill afford not to provide such a ministry?
>
> This is a sample of the potential of the local congregation in a ministry to persons with alcohol problems.
>
> Though the potential statistics may raise eyebrows of awareness, there is a natural question--where are the problem drinkers?
>
> Why the gap between the potential of the clergy and the response of only 3% to treatment referral centers? For me, the gap is due to attitudinal stumbling blocks.[19]

Howard Clinebell, who drew upon samples of attitudes of pastors involved in alcohol studies at Yale University at the beginning and at the end of an educational process, reports a conclusion similar to the one suggested by Schneider's (in the last paragraph of the above quotation). However, Clinebell's approach was in a more controlled setting and his conclusions are scientifically more verifiable and of greater validity. The evidence of Clinebell's study led him to conclude: "A minister's general attitude toward alcoholics, and alcoholism seems to have a direct

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[19]Karl A. Schneider, "Motivational Approaches in Training Clergy for Early Intervention in Addictive Problems in Parish and Community," paper presented at the 28th Annual Meeting of the Alcohol and Drug Problem Association of North America, Detroit, Mich., 25-29 September 1977, pp. 4,5. (Mimeographed.)

relationship to the number of alcoholics who come to him for help."[20] Clinebell's conclusion appears to offer support for Schneider's explanation: attitudinal stumbling blocks and negative attitudes on the part of a pastor appear to contribute to his not being approached for help by alcoholics and/or to his being less than effective in his ministry to them.

At the beginning of this section dealing with negative attitudes, it was pointed out that attitudes affect the counseling relationship. Laura Root, who addresses the topic of training of para-professional people, points to the significance of attitudinal factors when she says that without positive beliefs and attitudes there is a resulting therapeutic relationship which is less than effective.[21] The examples cited appear to support her claim.

In summary: Some examples of negative attitudes have been reported--in a hospital setting, among medical doctors, in the form of common myths and stereotyping, among pastors in a parish setting. Consistently the evidence is in support of concluding that negative attitudes toward

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[20]Clinebell, p. 183.

[21]Laura Root, "In-service Training of the Para-professional in the Field of Alcoholism," in The Para-professional in the Treatment of Alcoholism, ed. George E. Staub and Leona M. Kent (Springfield, Ill.: Charles C. Thomas, 1973), p. 46.

alcoholics tend to be detrimental rather than helpful, that negative attitudes tend to be acted out in various non-helpful ways, that negative attitudes are stumbling blocks to effective ministry to alcoholics.

Examples of Positive Attitudes

In the process of reporting an attitude study describing the relationship between social workers and alcoholic clients, A. T. Winckler makes a statement which reflects a kind of working hypothesis about alcoholics which frequently is accepted by those who work in the field of alcoholism. He makes the point that attitude often proves to be the decisive factor in treatment because, he says, "Alcoholics are sensitive people with a low self-esteem. Consequently they often feel rejected."[22] Positive attitudes are therefore of crucial importance in the treatment of and ministry to alcoholics.

Joseph Kellerman is very direct about one positive attitude which is needed by the pastor. That attitude is one which takes the shape of accepting a disease concept of alcoholism. Kellermann says, "Accepting the disease

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[22]A. T. Winckler, "The Social Worker and the Alcoholic Client--An Attitude Study," in Proceedings of 31st International Congress on Alcoholism and Drug Dependence 3, 23rd-28th February 1975 (Lausanne, Switzerland: International Council on Alcohol and Addictions, 1975), p. 717.

concept of alcoholism ia a prerequisite to helping as a pastor."[23]

In an earlier paragraph, he links together attitude and acceptance of a disese concept, as follows:

> The clergyman's own attitude is inevitably shaped by the experience and conditioning of his life. When discussing the use of alcohol, the clergyman may exhibit more prejudice than knowledge. It is imperative that the clergy understand the disease concept of alcoholism, for the use of alcohol alone does not cause alcoholism. . . . Effective treatment and rehabilitation begin with an understanding of the illness and acceptance of the alcoholic as a sick person--physically, emotionally, and socially.[24]

Howard Clinebell also emphasizes the importance of an attitude which accepts the alcoholic as a sick person. He points to a conflict which may exist for some pastors, whose attitude takes the shape of a belief system which generally views alcoholism as a sin and as something which has ethical consequences. The following quotation provides a specific call for an attitude which accepts a disease concept, while at the same time recognizing ethical concerns. Clinebell writes as follows:

> To counsel effectively with alcoholics the minister need to have done business with any problems he may have in accepting alcoholism as a sickness. To see that it is a sickness does not require denying that there are complex ethical issues involved in it, as in many

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[23]Joseph L. Kellermann, "The Clergyman's Role in Recovery from Alcoholism," in World Dialogue on Alcohol and Drug Dependence, ed. Elizabeth D. Whitney (Boston: Beacon Press, 1970), p. 205.

[24]Ibid., pp. 203,204.

> personality illnesses. Rather, the sickness conception refocuses the ethical issues, putting the emphasis on the person's responsibility for obtaining treatment. This is the redemptive place to put it. The alcoholic's condition, like yours and mine, involves an incredibly complex mixture of sin and sickness, compulsion and accountability. To moralize with him, however subtly, is the height of counseling futility, driving him away from help and deeper into the dark morass of alienation from himself, others, and God.[25]

In a particularly significant portion of the same chapter which is titled "Pastoral Counseling of the Alcoholic and His Family," Clinebell deals with another attitude which is positive in nature--and which he says is crucial. It is the one which accepts another person as a fellow human being, and it is more significant than counseling techniques. He refers to it as a "therapeutic attitude." In describing such an attitude, he gives expression to what it involves, as follows:

> Deep inside himself, the minister must be aware that the alcoholic is not essentially an alcoholic. He is essentially a <u>human being</u> with alcoholism. Far more important than <u>particular</u> counseling techniques is the presence of the "therapeutic attitude." This attitude is based on an awareness of one's own inner conflicts, anxieties, and compulsions, and on an acceptance of oneself as a child of God. Out of self-acceptance grows ability to accept others. The therapeutic attitude is present to some degree when, in relating to an alcoholic, one rediscovers the truth expressed in St. Augustine's familiar words: "There but for the grace of God go I." It is present more fully when, at another level of awareness, one suddenly realizes: "There go I!" Seen

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[25]Howard J. Clinebell, Jr., "Pastoral Counseling of the Alcoholic and His Family," in <u>Alcoholism--The Total Treatment Approach</u>, ed. Ronald J. Catazaro (Springfield, Ill.: Charles C. Thomas, Publisher, 1968), p. 206.

> as a fellow human being, the alcoholic is recognized by the minister as being much more like himself than different from him. To the degree that the therapeutic attitude is present in the counselor, his relationships will be channels of healing--channels for the working of that Power which is the source of all healing.[26]

In his book Understanding and Counseling the Alcoholic, Clinebell draws upon three components of Carl Rogers' work to describe the therapeutic attitude, as follows: Congruence, empathic understanding and unconditional positive regard."[27] These components are at the same time expressions of positive attitudes as well as prerequisite factors for an effective counseling situation. Clinebell describes the different components of this positive attitude, as follows:

> Congruence means genuineness as a person. . . . Congruence involves knowing one's feelings and owning them. The most important thing a person brings to any helping or teaching relationship is himself--unhidden and real. Congruence is particularly important in working with alcoholics. They are hypersensitive to its absence--"being a phoney" or "putting on an act."
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> Empathic understanding means being able to "tune in" on the inner world of feelings and meanings of another person. . . . In relating to an alcoholic, empathic understanding means that one is able to understand, to an appreciable degree, the chaotic complexity of his fears, guilt, despair, and hopes. This understanding, which is a thing of the heart as well as the head, is crucially important because of the alcoholic's feeling of haunting aloneness in a bizarre world and his belief that others could not possibly comprehend.
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> Unconditional positive regard means warm, human regard for the individual as a person of unconditional worth. With his fragile self-esteem (hidden by his

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[26] Ibid., pp. 206,207.

[27] Clinebell, Understanding and Counseling the Alcoholic, p. 323.

> defensive grandiosity), the alcoholic desperately needs positive regard. He hungers like a starving man for the acceptance he cannot give himself.[28]

Marty Mann makes a similar point about the great need for positive attitudes in her writing about "Attitude: Key to Successful Treatment." The point is made that the attitudes and beliefs held by one who works with alcoholics are crucial and determining factors. Mann points to four aspects of a positive attitude, as follows:

> What is this attitude that I call the key to successful treatment? First, it is accepting of the other person just as he is, for exactly what he is. Second, it accords him the dignity of his humanity quite apart from his illness which may have buried that humanity deep out of sight. He is regarded as a person, in great trouble to be sure, but not a non-person for all that. Third, it offers him understanding and, as a result of that, compassion, or as many recovered alcoholics flatly put it, <u>love</u>. Finally, and perhaps most important of all, it exhibits faith, a belief that he too, this alcoholic whoever he may be, can and will recover.[29]

J. B. Kendis lists a number of positive attitudes needed by those who work with alcoholics, whether they be specialists in the field or act as para-professionals. Each of the attitudes in his listing is of extreme importance for the one who would be helpful to the alcoholic. His listing is of particular significance because he points to some of the things which are going on in the alcoholic's life to which the positive attitudes respond in a helpful manner. These attitudes are listed by Kendis as follows:

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[28]Ibid., p. 323.

[29]Mann, p. 3.

Honesty--particularly in view of the fact that the alcoholic has fooled himself so frequently, has manipulated others, and with a denial system has lost touch with reality in many areas of his life, honesty on the part of the helping person is of extreme importance.

Kindness--the alcoholic is frequently a person who has been met by rejection. Kindness expressed as a love which reaches out to help is one of his great needs. When he finds one with an attitude of kindness, he is more open to help. In Kendis' terms, kindness implies an acceptance of the alcoholic as a person, and it helps to keep the door open.

Firmness--this is an attitude which enables the helping person to communicate something like, "The problem is yours, and you must do the job; I cannot do it for you." It is a kind of tough love, which is concerned about the alcoholic's living with the consequences of his drinking patterns, while at the same time it grants him the right to responsibility for his dealing with his problem.

Humbleness--that kind of attitude on the part of the helping person which includes at a feeling level the idea, "It could happen to me." Due to the fact that many alcoholics have received a message of superiority from other people ("I could never be like that!"), such an attitude of humility, when it is genuine, may be something of a new experience for him.

Empathy--the helping person can risk understanding and feeling what is going on in the life of the alcoholic. The alcoholic generally has a feeling of being rejected by other people. When confronted by a person who is willing to accept and to understand him, the alcoholic is frequently enabled to deal with feelings he has long repressed.

Granting of dignity--this attitude on the part of the helping person has to do with an approach to other people which expresses a feeling of the worthiness of another person. It implies a respect of the person. The alcoholic has little respect for himself as a person, and such granting of dignity is thus helpful for him.

Optimism--this attitude includes the ability not to be discouraged about working with alcoholics. In many respects, the alcoholic is not only helpless but also hopeless. His continued use of alcohol is a way to bury his helpless and hopeless feelings while it is also a concrete expression of his helplessness and his hopelessness. His feelings have frequently been reinforced by other people who consider his situation hopeless as well. An optimistic attitude on the part of the counselor assists the alcoholic to be in touch with reality (the reality being, "There is hope"), while at the same time it offers the counselor increased ability to continue patiently working with the alcoholic.[30]

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[30]J. B. Kendis, "Does It Take a Specialist to Treat the Alcoholic?," in Proceedings 31st International Congress on Alcoholism and Drug Dependence, p. 187.

Sheldon, Davis, and Kohorn offer a similar listing. They recommend attitudes for a therapist which include the following: empathy, optimism, objectivity, knowledge of the patient's language, warmth, sincerity, and patience.[31]

Due to the agreement of recognized authorities in the field of alcoholism that positive attitudes are of such crucial significance in effective treatment of alcoholism, it was reasoned that not only a summary of the literature reported in this section would be useful, but that it would also be appropriate to draw implications related specifically to a ministry to alcoholics in the course of a summary of the section. There follows a number of implications for the parish pastor's ministry as realted to positive attitudes on his part.

(1) All the positive attitudes which have been suggested as useful and necessary for those who work with alcoholics are useful and necessary for pastors who work with alcoholics. While it is granted that the positive attitudes which have been presented are generally applicable and significant for pastoral care in its broadest concerns, it has been suggested that they are particularly and specifically significant for the pastor's ministry to alcoholics, due to the alcoholic's particular needs and problems.

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[31]Sheldon, Davis, and Kohorn, p. 141.

(2) There is need for recognition of the fact that the positive attitudes which have been discussed have significance for working with alcoholics not only during the active stage of the disease, but also for ministering to alcoholics who are in the process of recovery.

(3) It is suggested that within the fellowship of AA one discovers that most of the positive attitudes which have been discussed are evident. It is possible that one of the reasons AA is able to report success in helping alcoholics to recover is precisely because within that fellowship such positive attitudes are recognized as having great significance. This point about AA is made in order to point to two factors. First, AA itself offers evidence of the importance of positive attitudes, and one who attends AA meetings can observe that they are operative within that fellowship. It can also be observed that alcoholics themselves appear to respond favorably to such positive attitudes. Secondly, pastors (and other professional people) frequently refer alcoholics to AA, and such referral may at times be motivated by an awareness of the significance of an accepting attitude which is evident within that fellowship.

(4) Finally, it is suggested that the positive attitudes which have been presented are compatable with a theological concern. On the one hand, there is recognition of the danger of making the theological task into a mere

anthropological system, so that God and his relationship with people take a distorted form of discounting the divine and taking only the human into consideration. On the other hand, it is suggested that, if one takes into account such doctrines at the Incarnation and the Vicarious Atonement, one discovers that there are at least points of reference in raising theological questions about the matter of attitude. For example, the Incarnation can be seen as an expression of God's attitude of love for his people. The Cross can be seen as a symbol of God's so completely identifying with his people that Jesus himself dies our death. Other Biblical teachings--for example, Jesus' teachings about love of neighbor and St. Paul's plea for Christians to have the mind of Christ--may appropriately be considered as having implications for a Christian approach to attitude.

It is beyond the scope of this paper to attempt to develop a comprehensive concept of attitude theologically approached or understood, but the suggestions above have been offered in order to indicate a recognition of the probability that Lutheran pastors would tend to have theological concerns about the matter of attitude. It is merely suggested that such concerns could be approached and that there is the possibility that the positive attitudes which have been discussed could find strong rooting in God's relationship with people and in the Christian life with the

neighbor. Christianly understood, the alcoholic is a neighbor in need. Those with negative attitudes too easily pass him by; those with positive attitudes are more likely to stop to help him.

Chapter Summary

A general description of attitude in its more technical meaning was presented. Examples of negative and positive attitudes which are relevant to the field of alcoholism were discussed. The literature demonstrated that all experts in the field of alcoholism were in agreement that positive attitudes are a key to successful treatment of alcoholics, and the significance of positive attitudes for the pastor in his ministry to alcoholics was discussed.

PART II

SURVEY AND IMPLICATIONS

CHAPTER V

ATTITUDE SURVEY AND RESULTS

Part I of this paper has presented a background and rationale for the study of pastors' attitudes toward alcoholism and their ministry to alcoholics. This second part of the paper is devoted to the study itself. This chapter will report in detail how the effort to determine pastors' attitudes in their ministry to alcoholics was given shape and carried out, and it will submit the data collected for the study.

Chapter I discussed the method and approach used in the study. For the sake of completeness, major portions of that discussion will be repeated in the present chapter; however, more details will be specified here, in order that a full account of the study may be available. (Documentation of sources presented in chapter I will not be repeated here; new material presented in this chapter will be documented.)

Developing a Survey Instrument

A number of questions were raised at the beginning of the effort to develop a survey instrument. What aspects of ministry to alcoholics would provide useful information about

a pastor's attitude. What attitudes of pastors would merit investigation? Where should one focus attention in an effort to determine the attitudes of pastors toward alcoholism? How could one investigate pastors' feelings, beliefs, and action tendencies in the area of their ministry to alcoholics?

In response to such questions, research in the field of alcoholism was continued. As stated in chapter I, the areas for investigation were limited to six, as follows: (1) disease concept; (2) stereotyping; (3) acceptance; (4) moralism; (5) view of AA; (6) pastor's role.

The manner of approaching the six areas in the development of the survey instrument was as follows:

(1) Two questions were raised which related the matter of attitude to the specific area of concern

(2) A summary statement reflecting research in the literature applicable specifically to each area was made

(3) An appraisal of positive or negative factors relating to the attitude for investigation was formulated

(4) A concluding question was formulated which would give shape to development of statements for the survey.

This outline was followed in the initial stages of instrument development, and the following gives account of the process of reasoning which was involved (with the previous paragraph's outline being followed below).

Disease Concept.

Does the pastor have a positive or a negative attitude toward a disease concept of alcoholism? Do pastors believe that alcoholism is appropriately defined as a disease, and do pastors view the alcoholic as a person with an illness?

The literature reveals that it is appropriate to define alcoholism as a disease (both in common usage and in medically technical language), and various experts in the field of alcoholism make the point that an attitude which accepts a disease concept of alcoholism is prerequisite to effective work with alcoholics.

It was reasoned that a pastor who accepts a disease concept of alcoholism would reveal such a belief, and consideration was given to the thought that a positive attitude toward a disease concept of alcoholism might indicate a more positive and less negative attitude toward the alcoholic.

The concluding question was: Do pastors tend to be positive or negative in their attitude toward a disease concept of alcoholism?

Stereogyping.

Does the pastor believe that the skid-row drunk stereotype is representative of what an alcoholic is like? Do pastors have a narrow and negative image of an alcoholic?

The literature reveals that some professionals--among whom are those who have had specialized training--continue to have a negative image of the alcoholic and continue to express stereotyping concepts in spite of the fact that less than ten percent of the alcoholic population could be classified as living on skid row, and various experts in the field of alcoholism make the point that stereotyping has disastrous consequences and that working with a mythological system about alcoholics is a hindrance rather than a help to them.

It was reasoned that a pastor who believes a distorted mythology of what an alcoholic is like or who stereotypes alcoholics would tend to have a negative attitude toward the alcoholic.

The concluding question for investigation was: Do pastors tend to accept stereotyped images of the alcoholic or to have a narrow view of what an alcoholic is like?

Acceptance.

Does the pastor truly accept the alcoholic as a person? Do pastors have a therapeutic attitude--an attitude expressive of genuine positive regard for the person who is an alcoholic?

The literature reveals that a therapeutic attitude is necessary for a working relationship with alcoholics, and various experts in the field of alcoholism make the point

that a positive attitude of acceptance of the alcoholic as a person is a crucial and determining factor for effective work with alcoholics.

It was reasoned that pastors who genuinely accept the alcoholic as a person and who have a therapeutic attitude would be likely to have a favorable disposition toward the alcoholic.

The concluding question for investigation was: Do pastors tend to be more or less accepting of the alcoholic?

Moralism.

Does the pastor approach the alcoholic with a moralistic attitude, believing that the primary problem for the alcoholic is his lack of will power? Do pastors approach alcoholics having already judged the case rather than being open to listening to the story of life as told by the alcoholic?

The literature reveals that many people have a moralistic attitude toward alcoholics which judges the problem of the alcoholic to be lack of will power or weakness of moral character, and various experts in the field point to such an attitude as being not only a gross misunderstanding of the nature of the problem but also as being detrimental to establishing a relationship with the alcoholic so that he can receive the help he needs.

It was reasoned that a pastor who has a moralistic attitude would be less than effective and helpful and

consideration was given to the thought that a moralistic attitude would be a negative characteristic in a ministry to alcoholics.

The concluding question for investigation was: Do pastors tend to be more or less moralistic in attitude as they approach their ministry to alcoholics?

View of AA.

In view of the fact that AA exists as a resource for referral, does the pastor believe that AA is more or less helpful to the alcoholic's recovery? Do pastors have positive or negative feelings about the program and fellowship of AA?

The literature reveals that the program and fellowship of AA are particularly helpful for the recovery of many alcoholics, and various experts in the field of alcoholism point to AA as the best resource available for a pastor in making a referral.

It was reasoned that a pastor who has a favorable disposition toward AA is more likely to draw upon its program as a resource for helping an alcoholic, and consideration was given to the thought that a positive attitude toward AA would tend to be more rather than less helpful in a ministry to alcoholics.

The concluding question for investigation was: Do pastors have a positive or negative attitude toward AA?

Pastor's role.

Does the pastor believe that he has a significant role to play in helping alcoholics? Do pastors have negative or positive feelings about their ministry to alcoholics?

The literature reveals that many people in the helping professions feel negative about their work with alcoholics, and experts in the field of alcoholism point to the pastor as having a significant role to play in helping alcoholics and as being in a unique position of availability within a community for helping alcoholics to recover.

It was reasoned that a pastor who views his role as significant for helping alcoholics would be more likely to have an effective ministry to them, and consideration was given to the thought that a favorable disposition toward his pastoral care of alcoholics would indicate a more rather than a less positive attitude about his ministry to alcoholics and toward the alcoholic in this aspect of ministry.

The concluding question for investigation was: Do pastors tend to be more or less positive about their role in ministering to alcoholics?

A survey instrument was then designed in order to pursue the effort to determine pastors' attitudes toward alcoholism. The instrument (appendix 2) consisted of fifty-six opinions related to the six areas to which the study was

limited. Such opinions were perceived to give verbal expression of attitudes, and they were the means to be used for measuring attitudes, according to the school of scientific investigation which holds that attitudes can be measured by the expression of acceptance or rejection of opinions or statements. The items for the survey were not selected out of consideration for their cognitive content but rather as they were carriers or symbols of attitude. A Likert-type scale was used, so that the subjects could respond with varying degrees of intensity on a scale ranging between the extremes of strongly agree to strongly disagree. The scale contained five positions: (1) strongly agree; (2) agree; (3) agree somewhat; (4) disagree somewhat; (5) strongly disagree.

Nine of the opinions (or statements) in the survey instrument were designed to tap pastors' attitudes about a disease concept of alcoholism (items numbered 4, 7, 10, 11, 16, 22, 28, 46, 52). Nine opinions dealt with stereotyping (items numbered 3, 9, 15, 21, 27, 33, 39, 45, 51). Eight statements in the survey dealt with the matter of acceptance (items numbered 5, 17, 23, 29, 35, 41, 47, 53). Ten items dealt with moralism (numbered 2, 8, 13, 14, 20, 26, 32, 38, 44, 50). Eight opinions were used in order to determine the pastors' views of AA (items numbered 6, 12, 18, 24, 30, 36, 42, 48). Nine of the items appearing in the survey

sought to tap the pastors' attitudes toward their role in ministering to alcoholics (numbered 1, 19, 25, 31, 37, 43, 49, 55, 56). Items numbered 40 and 54 were judged not to apply to any of the areas.

Four of the items appearing in the survey were taken from an attitude scale as reported by Margaret Bailey in an issue of the Quarterly Journal of Studies on Alcohol.[1] (These were items numbered 4, 8, 10, 46.) Nine of the items were drawn from a scale used to study attitude changes of Public Health Nurses and their care of alcoholics.[2] (These items are numbered 2, 3, 15, 17, 21, 23, 33, 35, 50.) One item (numbered 11) was taken from "Project Cork Global Survey."[3] The remaining forty-two items were original.

Previous to the time when the fifty-six opinions were put in the precise wording which is found in the survey, one person and two groups were asked to evaluate opinions which were considered for the survey. A time for consultation with Herbert Albrecht, an LC--MS pastor whose Ph.D.

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[1]Margaret Bailey, "Attitudes Toward Alcoholism before and after a Training Program for Social Caseworkers," Quarterly Journal of Studies on Alcohol 31 (1969):672,673.

[2]Morris E. Chafetz, Howard T. Blane, and Marjorie Hill, ed., Frontiers of Alcoholism (New York: Science House, 1970), pp. 346,347.

[3]"Project Cork Global Survey," p. 1. (Mimeographed.) [No other information appears on the document; however, it was learned from John Keller, Director of Operation Cork, that the survey was designed for use in medical schools.]

dissertation is titled "Alcoholism and Personal Values: An Investigation of Relationships,"[4] was arranged. Albrecht made suggestions about changing some of the originally considered opinions so that the attitudes to be investigated might be more accurately reflected by the statements to appear in the survey. A second evaluation of the opinions was made by twelve people who attended the "Wednesday Evening Speaker's Meeting" of AA in Coronado, California. These recovering alcoholics were asked to react to the opinions, stating if they thought that the statements were appropriate for investigating the attitudes under consideration. Some opinions which had been considered for the survey were criticized, and they were either discarded or changed according to the suggestions which the people made. A third evaluation of the opinions which had emerged for use in the survey as a result of the previous consultations was made by eight people who were in attendance at the "Friday Evening Discussion Group" of AA in Coronado, California. There was general consensus by this group that the opinions at this stage were appropriate for use in investigating attitudes about alcoholism.

In addition to the Likert-type scaling to determine attitudes according to the six areas for investigation, the

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[4]Herbert Carl Albrecht, "Alcoholism and Personal Values: An Investigation of Relationships" (Ph.D. dissertation, United States International University, 1975).

survey instrument also included a set of six different statements dealing specifically with the question of the relationship of sin and alcoholism. The six statements were derived from the discussion by Howard Clinebell (documented in chapter I) which suggested that most conceptions of this relationship fall into one of the six categories represented by the six statements in the survey. It was reasoned that Clinebell's statements dealt with attitudinal factors and they were included in the instrument as a provision for an additional way of investigating attitudes. Respondents were instructed to choose one of the six as expressive of the view with which they most agreed.

At the end of the survey form, subjects were asked to supply information. The concluding questions sought data about the following areas: age of respondent; year and place of graduation from seminary; the district to which he belonged; number of confirmed communicant members; percentage of his parish estimated to be alcoholic; number of alcoholics he ministered to during the past twelve months; and indication of his interest in a report of the results of the survey.

Administration of Survey

Use of the instrument was limited to pastors of three western LC--MS districts: Southern California District (SC), California-Nevada-Hawaii District (CNH), and

Northwest District (NW). The survey was administered in two different ways.

In the SC, parish pastors attending the Spring Pastor-Teacher Conference (Arrowhead, California, 29 April to 1 May 1979) were directed to complete and return the forms during the conference. It was specifically stated that only parish pastors were to participate, and the letter (appendix 1) prepared for mailing was read verbatim. No additional instruction was given; questions raised by pastors about the survey were not answered. It was estimated that approximately one hundred parish pastors were present in the room when the request was made and the instructions given.

The survey, together with the cover letter, was sent by mail to pastors of CNH and NW. One-hundred-eighteen survey forms were sent to pastors of CNH, and one-hundred-forty survey forms were sent to pastors of NW. Names of pastors and addresses of churches were selected from The Lutheran Annual, 1979 edition. Care was taken so that no pastor received more than one survey (for example, pastors serving a dual parish received one form at only one of the two parish addresses). In order to limit expenditures for postage expense, most of the surveys were sent by bulk-rate postage. An addressed and stamped envelope was included in each mailing for return of the survey. It was noted that--with the exception of explicit instructions stated in the

cover letter and on the survey form itself--control factors (such as amount of time spent or environmental factors) were lacking in the administration of the survey.

Recording Results

The individual responses found on each returned survey form were recorded on a Fortran Program Sheet. Aztec Computer Services in San Diego, California, included a verification factor for the key punch operation which transferred the data to standard IBM program cards for computer analysis. Both the program sheets and the program cards were spot-checked for accuracy. Arrangements were made for consultation with Clifford Weedman--Ph.D., systems and statistics specialist at the California School of Professional Psychologists--for the final phase dealing with the collection of the data. Such consultation resulted in determination of which factors would receive attention specifically relating to the fifty-six attitudinal opinions of the survey which had been included according to the Likert-type scaling. Using the facilities of the Computer Center at the University of California-San Diego, Weedman did the programing. Other parts of the survey (for example, the part which asked for statistical information) were scored by hand.

Resulting Statistical Data

This section of the paper gives an account of resulting statistical data. The purpose of such an account is to

provide information gathered about the respondents and their returned surveys. Each part of this report will consist of a verbal description of the data followed by a table which will present detailed information. (As is fitting for scientific reporting, arabic numerals are used in this section and in the remainder of the paper.)

A total of 358 survey forms were administered as previously described. Of the approximately 100 pastors in SC who were present when the request was made to participate in the survey, 54 returned the forms. 118 surveys were mailed to CNH and 140 surveys were mailed to NW, with 62 from CNH and 77 from NW returning the forms. Table 1 presents a summary of the surveys sent and returned by districts. The percentage of the total number returned by each district is expressed in decimals (consistently carried to nearest hundredth).

Table 1--Surveys Sent and Returned According to Districts (N=193)

	SC	CHN	NW
Number sent	100	118	140
Number returned	54	62	77
Percentage returned	.540	.525	.550

The first question which appeared on the last page of the survey form sought to determine the place of

graduation. The question read as follows: "From which Seminary did you graduate?" (This question was missing on the forms used in SC, but upon request some completing the form included the information.) Table 2 presents the information provided in response to the question.

Table 2--Place of Graduation
(N=193)

	SC	CNH	NW
St. Louis	22	34	43
Springfield (Ft. Wayne)	10	20	28
No response	22	8	6

Information about the age of the respondents was sought by the question, "How old are you?" The answers were tabulated in this instance to provide information about the total sample and placed into categories representing five-year age factors. Table 3 describes the age of the respondents according to five-year intervals. The percentage figure which is expressed in decimals represents the percent of the total falling in the specified age category.

Table 3--Age of Respondents
(N=193)

	under 30 yrs.	30-34 yrs.	35-39 yrs.	40-44 yrs.	45-49 yrs.
Number of responses	5	20	33	36	27
Percentage of total	.026	.104	.171	.186	.140

(Table 3--continued)

	50-54 yrs.	55-59 yrs.	60-64 yrs.	65 yrs. and over
Number of responses	25	24	18	5
Percentage of total	.130	.124	.093	.026

Information about the size of the parish was sought with the question," How many confirmed communicant members in your parish?" The results were tabulated by categories to represent smaller and larger parishes and are so described in table 4. The percentage number expressed in decimals represents the percent of the total number.

Table 4--Parish Size
(N=193)

	under 100 members	100-149 members	150-199 members	200-299 members	300-399 members
Number of responses	17	18	27	42	19
Percentage of total	.088	.093	.140	.218	.098

	400-499 members	500-799 members	800-999 members	over 1000 members	no response
Number of responses	29	30	7	2	1
Percentage of total	.150	.155	.036	.010	.005

"What percentage of your parish do you estimate to be alcoholic?" was the next question appearing in the survey. Responses to the question were tabulated to reflect the percentage estimated by the pastors, and the percentage (expressed in decimals) of their total responses was also figured. Table 5 presents in summary fashion how pastors estimated the percentage of their parish which they thought to be alcoholic.

Table 5--Percentage of Parish Estimated To Be Alcoholic (N=193)

	under 1%	1%	2%	3%	4%	5%
Number of responses	22	42	42	19	9	32
Percentage of total	.114	.218	.218	.098	.047	.166

	6%	7%	8%	9% or more	no response
Number of responses	2	2	2	17	4
Percentage of total	.010	.010	.010	.088	.021

"How many alcoholics did you minister to, relating specifically to their alcoholic problem, during the past year (12 months)?" was the next question on the survey. The results were tabulated by listing the number of alcoholics ministered to as indicated by the responses from "none" through "nine or more" (the number of alcoholics ministered to is

designated by numbers expressed in words in the following table), and the percentage of the total responses in each category (expressed in decimals) was also tabulated. Table 6 presents a summary of the results.

Table 6--Number of Alcoholics Ministered to During Past 12 Months (N=193)

	None	One	Two	Three	Four
Number of responses	47	42	49	19	16
Percentage of total	.244	.218	.254	.098	.083

	Five	Six	Seven	Eight	Nine or more
Number of responses	12	2	1	0	5
Percentage of total	.062	.010	.005	- -	.026

The final question in the survey asked, "Are you interested in a report of the results of this survey?" A high percentage of the responses indicated "Yes." Table 7 offers a summary of the indication of interest on the part of the pastors to receive a report of the survey.

Table 7--Interested in Report of Survey (N=193)

	Yes	No	No response
Number of responses	160	31	2
Percentage of total	.829	.161	.010

Survey Results About Six Attitudes

This section of the paper reports the findings about the attitudes of pastors as expressed by their circling one of the five responses appearing under each opinion on the survey according to the Likert-type scaling. The process of reporting the results for each of the six attitudinal factors which were investigated is similar. Due to the fact that each of the six areas had a different number of items, such individualized reporting was reasoned to be necessary, in order that an accurate account could be given for each attitudinal factor investigated. Each part of this section contains a table which presents the data gathered in a clear and precise manner.

Disease Concept

There were nine items which comprised the disease concept scale. Each item was assigned a numerical value for scoring purposes, as follows: Strongly agree=1; Agree=2; Agree somewhat=3; Disagree somewhat=4; Strongly disagree=5 (such numerical values remained constant for tabulation). Those items which had been reversed to avoid response set were programed with an opposite numerical value (this step in the computer analysis was consistently taken, and it will not be reported for each category). The range of results was therefore from 9 (9 items X 1=Strongly agree) to 45 (9 X 5=Strongly disagree), with 18 representing Agree,

27 representing Agree somewhat, and 36 representing Disagree somewhat. A 9 would thus indicate strong agreement with those opinions which were favorable to a disease concept of alcoholism, and a 45 would indicate strong disagreement.

The age variables were bifurcated into two groups: those respondents who were 44 years old and younger, and those who were 45 years of age or older. Each district was programed individually. Thus SC 44 years and younger and SC 45 years of age and older were considered separately, and CNH and NW were programed in identical fashion. Mean disease-concept-scores were developed for each of the six subgroups. Table 8 presents a summary of such scoring, and the results of the survey by districts can be described individually as follows:

Table 8--Disease Concept
(Numbers=mean scores)

	SC	CNH	NW
Less than or equal to 44 years old	22.55	22.17	23.25
More than or equal to 45 years old	21.72	23.24	22.80

Table 8 shows that the range for responses was between 21.72 to 23.25, the mean response thus falling between Agree=18 and Agree somewhat=27. There was a tendency of the respondents to agree, but not strongly. The results may indicate some ambivalent feelings about full acceptance of a disease concept of alcoholism.

Stereotyping

There were nine items which comprised the stereotyping scale. Each item was assigned the numerical value as previously reported (Strongly agree=1, etc.). The range of results was therefore from 9 (9 items X 1=Strongly agree) to 45 (9 X 5=Strongly disagree), with 18 representing Agree, 27 representing Agree somewhat, and 36 representing Disagree somewhat. A 9 would indicate strong agreement with those opinions which stereotyped alcoholics or presented a narrow image of them. Thus in this instance a lower mean score represents a tendency not to stereotype alcoholics, and a higher mean score would represent a tendency to do so.

The age variables were bifurcated into two groups: those respondents who were 44 years old and younger, and those who were 45 years of age or older. Each district was programed individually. Mean stereotyping-scores were developed for each of the six subgroups. Table 9 presents a summary of such scoring, and the results of the survey by districts can be described individually as follows:

Table 9--Stereotyping
(Numbers=mean scores)

	SC	CNH	NW
Less than or equal to 44 years old	15.72	15.93	16.06
More than or equal to 45 years old	15.40	15.82	16.56

Table 9 shows that the range for responses was between 15.40 and 16.56, the mean response thus falling between Strongly Agree=9 and Agree=18. In this instance, a lower mean score would represent a tendency not to stereotype alcoholics. The results indicate a relatively strong tendency not to agree with opinions which describe alcoholics in negatively stereotyped ways.

Acceptance

There were eight items which comprised the acceptance scale. Each item was assigned the numerical value as previously reported (Strongly agree=1, etc.). The range of results was therefore from 8 (8 items X 1=Strongly agree) to 40 (8 X 5=Strongly disagree), with 16 representing Agree, 24 representing Agree somewhat, and 32 representing Disagree somewhat. An 8 would thus indicate strong agreement with those opinions which were expressive of accepting the alcoholic as a person, and a 40 would indicate strong disagreement.

The age variables were bifurcated into two groups: those respondents who were 44 years old and younger and those respondents who were 45 years of age and older. Each district was programmed individually. Mean acceptance-scores were developed for each of the six subgroups. Table 10 presents a summary of such scoring, and the results of the survey by districts can be described individually as follows:

Table 10--Acceptance
(Numbers=mean scores)

	SC	CNH	NW
Less than or equal to 44 years old	17.62	18.38	18.00
More than or equal to 45 years old	18.20	17.94	18.20

Table 10 shows that the range for responses was between 17.62 and 18.38, the mean score responses thus falling between Agree=16 and Agree somewhat=24. There was a tendency of the respondents to agree, but not strongly. The results may indicate some ambivalent feelings about fully accepting the alcoholic as a person or may indicate a disposition toward the alcoholic which could be interpreted as less than an unconditional positive regard for the alcoholic as a person.

Moralism

There were ten items which comprised the moralism scale. Each item was assigned the numerical value as previously reported (Strongly agree=1, etc). The range of results was therefore from 10 (10 items X 1=Strongly agree) to 50 (10 X 5=Strongly disagree), with 20 representing Agree, 30 representing Agree somewhat, and 40 representing Disagree somewhat. A 10 would thus indicate strong agreement with those opinions which were expressive of a moralistic attitude toward alcoholics, and a 50 would indicate strong disagreement with such opinions.

The age variables were bifurcated into two groups: those respondents who were 44 years old and younger and those respondents who were 45 years of age and older. Each district was programed individually. Mean moralism-scores were developed for each of the six subgroups. Table 11 presents a summary of such scoring, and the results of the survey by districts can be described individually as follows:

Table 11--Moralism
(Numbers=mean scores)

	SC	CNH	NW
Less than or equal to 44 years old	15.69	15.72	16.78
More than or equal to 45 years old	15.76	17.03	17.12

Table 11 shows that the range for responses was between 15.69 and 17.12, the mean score responses thus falling between Strongly agree=10 and Agree=20. In this instance, a lower mean score would represent a tendency not to agree with those opinions which were expressive of a moralistic attitude (due to the reversal of numerical factors in the computer analysis which was programed for the moralistic items). The results indicate a relatively strong tendency not to agree with opinions which point to the alcoholic's problems being described merely in terms of a lack of will power or of a weakness in moral character.

View of AA

There were eight items which comprised the scale to determine pastors' attitudes toward AA. Each item was assigned the numerical value as previously reported (Strongly agree=1, etc.). The range of results was therefore from 8 (8 items X 1=Strongly agree) to 40 (8 X 5=Strongly disagree), with 16 representing Agree, 24 representing Agree somewhat, and 32 representing Disagree somewhat. An 8 would thus indicate strong agreement with those opinions which were expressive of a favorable view of or disposition toward AA, and a 40 would indicate strong disagreement with such opinions.

The age variables were bifurcated into two groups: those respondents who were 44 years old and younger, and those who were 45 years of age or older. Each district was programed individually. Mean view-of-AA-scores were developed for each of the six subgroups. Table 12 presents a summary of such scoring, and the results of the survey by districts can be described individually as follows:

Table 12--View of Alcoholics Anonymous
(Numbers=mean scores)

	SC	CNH	NW
Less than or equal to 44 years old	20.10	19.79	20.19
More than or equal to 45 years old	20.04	19.94	21.22

Table 12 shows that the range for responses was between 19.79 and 21.22, the mean responses thus falling between Agree=16 and Agree somewhat=24. There was a tendency of the respondents to agree, but not strongly. The results may indicate some ambivalent feelings about agreeing with those opinions which were favorable to the program and fellowship of AA.

Pastor's Role

There were nine items which comprised the scale to determine pastors' attitudes toward their pastoral role in a ministry to alcoholics. Each item was assigned the numerical value as previously reported (Strongly agree=1, etc.). The range of results was therefore from 9 (9 items X 1= Strongly agree) to 45 (9 X 5=Strongly disagree), with 18 representing Agree, 27 representing Agree somewhat, and 36 representing Disagree somewhat. A 9 would indicate strong agreement with those opinions which were expressive of positive attitudes about the pastor's role in his ministry to alcoholics, and a 45 would indicate strong disagreement.

The age variables were bifurcated into two groups: those respondents who were 44 years old and younger, and those who were 45 years of age or older. Each district was programed individually. Mean pastor's-role-scores were developed for each of the six subgroups. Table 13 presents

a summary of such scoring, and the results of the survey by districts can be described individually as follows:

Table 13--Pastor's Role
(Numbers=mean scores)

	SC	CNH	NW
Less than or equal to 44 years old	24.48	23.17	23.42
More than or equal to 45 years old	26.08	23.70	23.07

Table 13 shows that the range for responses was between 23.07 and 26.08, the mean responses thus falling between Agree=18 and Agree somewhat=27. There was a tendency to agree, but not strongly. The highest mean response (26.08) in this instance was closest to the Agree somewhat category. The results may indicate some ambivalent feelings about those opinions which were positive in nature in describing the pastor's role and ministry to alcoholics, and there may be an indication that the pastors tended to choose the more neutral response when they reacted to the opinions which indicated that the pastor's role has great significance in the treatment of alcoholism.

Alcoholism: Sin and/or Sickness?

As reported previously, six additional statements appeared on the last page of the survey which offered opinions about alcoholism as a sin and/or a sickness. Pastors were instructed to circle only one of the six statements--

that one with which they could most agree. The opinions were derived from a discussion by Howard Clinebell about the relationship between sin and sickness conceptions of alcoholism. There follows a quotation of each statement by number as it appears on the survey (see appendix 2), and each statement is commented upon according to Clinebell's remarks which are made in connection with his discussion of the conceptions represented.

1. Alcoholism is a sin and not a sickness from start to finish. Clinebell says, "According to this conception, alcoholism begins as the sin of drinking and ends as a sinful habit. It is entirely a matter of immoral behavior."[5]

2. Alcoholism begins as a personal sin and ends as a sickness. Clinebell comments about this view, as follows:

> Briefly put, this is the view: Drinking alcohol is, per se, a sin for a variety of reasons. . . . Once the drinking has passed a certain point and is out of volitional control, it becomes a sickness. Although the person is no longer responsible for drinking . . . he is responsible for having caught the compulsion or illness.[6]

3. Alcoholism is a sickness which involves the sin of abuse. Clinebell points to this view as the one held by the Roman Catholic Church, and he makes the point that such a viewpoint--while emphasizing that it is abuse rather than

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[5]Howard J. Clinebell, Jr., Understanding and Counseling the Alcoholic through Religion and Psychology, rev. and enl. ed. (Nashville: Abingdon Press, 1968), p. 168.

[6]Ibid.

use of alcohol which involves sin--"has the practical difficulty of making it necessary to establish a degree of responsibility or to find a line of demarcation beyond which a person is not responsible."[7] Clinebell believes that such an attempt is "utterly impossible."

4. Alcoholism is a sickness which is caused by a combination of factors involving both sin and sickness. Clinebell suggests that this viewpoint is expressive of the one held by AA.[8]

5. Alcoholism involves sin in the sense that it has destructive consequences. Clinebell suggests that this is a "nonjudgmental" conception of sin applied to alcoholism. He offers explanation of what is meant by this by quoting a minister who wrote as follows: "'Alcoholism is a sin in that it hinders the person from abundant living and true happiness. It is not a sin insofar as morals are concerned.'"[9]

6. If one speaks of sin in relationship to alcoholism, then only the society (and not the alcoholic) is responsible for that sin. This wording is different from Clinebell's original statement ("Alcoholism is a social sin"[10]), and moves the focus of responsibility from the person of the alcoholic to the society.

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[7] Ibid., p. 169.

[8] Ibid., pp. 169,170.

[8] Ibid., p. 169.

[10] Ibid., p. 170.

The majority of LC--MS pastors who returned the survey indicated that they could most agree with statement number 4. They appear to have an attitude about alcoholism similar to the one held by AA. This majority (60%) tended to have an attitude toward alcoholism which held the belief that alcoholism is both sin and sickness. Table 14 presents a summary of the response of pastors and their choice of one of the six opinions which was most expressive of their own.

Table 14--Sin and/or Sickness
(N=193)

	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
Number responding	4	13	34	117	20	1
Percentage of total	.021	.067	.176	.606	.104	.005

Validity and Reliability

Was the survey instrument valid? The question of validity asks if the study measured what it intended to measure. As applied to the present study, did the items present opinions which were expressive of attitudes? It is suggested that the opinions presented according to the Likert-type scaling for responses did express conceptions about alcoholism in a valid manner. The consultations with other people which were reported previously tend to indicate that the opinions were expressive of attitudes about alcoholism. The data which have been reported also appear to

suggest validity, in that they do represent what was to be measured--the attitudes of pastors about alcoholism and alcoholics.

Was the survey reliable? Were there consistent readings of the items in each of the six areas? A response to the question of reliability was arrived at by a split-half correlation method (split-half correlations are indications of the reliability of the scale). Consultant Clifford Weedman did a computer run on each of the six categories. Split-half correlations were computed on an odd-versus-even items within each of the six scales of the fifty-six opinions. The split-half correlations were adjusted for test length and are as follows:

Disease Concept:	.57
Stereotyping:	.67
Acceptance:	.62
Moralism:	.56
View of AA:	.63
Pastor's Role:	.55

All correlations are acceptable--above .5, which is an acceptable and adequate index of reliability.

Chapter Summary

The chapter began with a detailed account of the manner of developing a survey instrument which would investigate pastors' attitudes about alcoholism. The survey was

administered to parish pastors--in SC at a conference, and in CNH and NW by mail. After describing the manner of recording the results, a detailed account of the resulting statistical data was given. By verbal reporting and by use of tables each of the six categories for investigation was described in detail. An additional way of tapping attitudes of pastors was described in the attempt to address the question if pastors tend to believe that alcoholism is a sickness or a sin, and the results of this part of the survey revealed that the majority of pastors believed alcoholism to be both sin and sickness. Questions were raised about validity and reliability of the survey, and reasons were offered which pointed to adequate reliability and validity.

CHAPTER VI

IMPLICATIONS OF THE STUDY

Part I of the paper provided material useful in developing a survey to investigate pastors' attitudes toward alcoholism. The material there presented can also be drawn upon in order to interpret the data provided in the returned surveys. The purpose of this chapter is to offer some ways of interpreting the data and to examine some implications of the study of pastors' attitudes about alcoholism. The manner of approaching these matters will be to comment about the data and to make some suggestions about areas which could merit further investigation.

But before proceeding with such matters, it was considered necessary to make a few general comments about the study. The following two paragraphs present a perspective from which the implications of the study were approached.

On the one hand--within the context of scientific research--it was reasoned that the most significant items of the study have already been reported. The statistical data yielded by the survey contain new information about the attitudes of pastors in their ministry to alcoholics. The effort to sample scientifically the attitudes of pastors toward alcoholism in a section of the LC--MS has, within the limits

originally set, been completed with the administration and return of the surveys, with the recording and analyzing of the resulting data, and with the report which has been made about the results in the previous chapter.

On the other hand, within the discipline of Practical Theology, it was considered necessary to discuss some implications of the study for the pastoral ministry. If attitude has to do not only with feelings and beliefs but also with action tendencies, then the attitudes of pastors about alcoholism and toward alcoholics are likely to affect their practice and their style of ministry. With such reasoning it was thought that a discussion of implications of the study and for further research could also suggest ways of approaching a more effective ministry to alcoholics.

Some Implications Drawn from Attitudinal Data

In previous sections of the paper, there was a consistently similar order of listing the six attitudinal factors which were investigated. In this discussion the order of listing the general areas for the study--which were investigated by the fifty-six opinions--is determined by an apparent correlation of some factors with others.

The previously reported statistical data point to the tendency of pastors not to agree with opinions which were expressive of moralistic or stereotyping attitudes. Especially in view of the reports that many professional people

do have these negative attitudes which are seen to be a hindrance to effective treatment of alcoholics, the relatively strong rejection of moralistic and stereotyping opinions would seem to imply that what is a hindrance to effective treatment of alcoholism for some other professional people is less of a hindrance to the pastors who returned the survey. It is suggested that such a lack of hindering and negative factors would point to a significant and good potential for a pastor's helping alcoholics in an effective manner. If this be true, a significant item for further study and research would be an attempt to determine if pastors from other geographical areas of the LC--MS would also tend rather strongly to reject moralistic and stereotyping opinions.

The results of the survey expressed in mean scores showed a tendency for pastors to agree with opinions expressive of accepting the alcoholic as a person, but there was not a strong agreement. It was previously suggested that the mean scores may be interpreted as revealing an ambivalence on the part of pastors in this area of acceptance. It is suggested that if there were ambivalence about accepting the alcoholic as a person--with the pastor at times giving a double message to the alcoholic like the following: "Sometimes I accept you, and sometimes I do not"--such ambivalence would hamper effective ministry to alcoholics. If the alcoholic receives two conflicting messages, he is likely to

tune in to the negative one and go elsewhere. He is particularly sensitive to negative feelings and frequently experiences rejection. An area for further study would be a concentrated attempt to determine if pastors are aware of their ambivalence. There would also be significance to a study which would attempt to determine if recovered Lutheran alcoholics tend to view their pastors as expressing ambivalence about accepting them as persons or if recovered alcoholics believe their pastors to be genuinely and consistently accepting of them as persons.

There was a similar tendency of pastors to have ambivalent feelings about the acceptance of a disease concept of alcoholism. It is possible that there is a close relationship between less than a strong acceptance of the alcoholic as a person and one's not being certain that the primary problem facing the alcoholic is a disease. One implication for further study would be to attempt to determine if there is a correlation between a pastor's belief that a person has a particular disease (such as cancer or diabetes) and his higher or lower acceptance of people with different diseases.

One could suggest that one reason that the pastors who returned the survey tended not to affirm a disease concept strongly may be due to their tendency to see the abuse of alcohol as a sin and to believe that alcoholism has to do primarily with abuse and is therefore more sin than sickness.

While there is recognition that the majority (60%) of pastors did choose the opinion which defined alcoholism in terms of sin and sickness, it is suggested that there would be significance to a future study which would shed some light on the way in which pastors--both in theory and in practice--tend to deal theologically with sin and sickness, and with sin and sick people.

It was reported that the pastors surveyed agreed (though not strongly) with those opinions favorable to AA. This may indicate a generally positive attitude toward AA as helpful for recovery, but it appears to be with some reservations. It would be significant to attempt to determine what the reservations about AA are, and it is suggested that it would be important to attempt to determine if the pastor tries to help the alcoholic find those things important for recovery which he feels are lacking in AA.

The pastors surveyed appear to have been least positive about agreeing with those opinions which placed stress on the pastor's role as significant for helping alcoholics to recovery, which suggested that the pastor was competent and effective in his ministry to alcoholics, or which emphasized positive feelings on his part about his ministry to alcoholics. The results may be interpreted as indicating a considerable amount of uncertainty on the part of pastors about their role and effectiveness in a ministry to alcoholics. Have pastors decided that alcoholism is too

difficult to deal with, and do alcoholics receive less pastoral care than other (sick) people? An answer to the question is not supplied by the present study, but the results do imply reasons for raising the question.

All people who work in the field of alcoholism would agree that treatment of the disease is a risky and frequently discouraging business--if one judges himself or his effectiveness by the measure of success (the success apparent only if the alcoholic recovers). Bluntly stated, more alcoholics die from the disease than recover from it. It would be significant for further investigation to examine success orientation of pastors in connection with their attitudes about their pastoral role in a ministry to alcoholics. Would there be a correlation between high success orientation and more negative attitudes toward their ministry to alcoholics?

Some Implications Drawn from Statistical Data

It is possible to draw some implications about the statistical data reported by the pastors who returned the survey. Table 6 shows that 24% of the pastors indicated that they did not minister to any alcoholics during the year past. Table 5 shows that 33% of the pastors estimated that 1% or less than 1% of the parish was alcoholic.

Are pastors aware of studies in the field of alcoholism which point to a figure of from 5% to 8% of those who drink--and who are Lutheran--as having serious problems in

their lives due to their drinking? How do one-fourth of the pastors who returned the survey feel about their not ministering to any alcoholics during a year's time? One cannot appropriately predict that one-fourth of all pastors in the geographical section which was studied would report a similar lack of ministry to alcoholics. But the present sample does suggest that it would be significant to attempt to determine how many pastors in the entire LC--MS would report no ministry to alcoholics over a twelve month period.

Statistics reported in table 7 show that 83% of the pastors who returned the survey indicated an interest in receiving a report of the findings. It is suggested that such a statistic may be interpreted as indicating that the pastors have a desire to learn more about alcoholism. If such an interpretation has validity, it could be reasoned that 83% represents a strong desire. People who are involved in continuing education programs for pastors could conclude that pastors have a desire for a course dealing specifically with pastoral care for alcoholics.

Concluding Remarks

In conclusion, it can be stated that the effort to sample scientifically the attitudes of pastors toward alcoholism in a section of the LC--MS revealed that the pastors who returned the survey tended to have positive rather than negative attitudes about the pastoral care of alcoholics.

The results of the effort may indicate, however, that the pastors did not have strongly positive attitudes in the categories referred to as disease concept, acceptance, view of AA, and the pastor's role. If Marty Mann is correct in pointing to positive attitudes as a significant key to the successful treatment of alcoholism, then it is reasonable to suggest that more positive attitudes than those revealed by the survey would be an important factor for a more effective ministry to alcoholics.

APPENDIX 1

COVER LETTER

Dear Pastor:

I am currently involved in a research project which attempts to investigate attitudes of LC--MS pastors toward alcoholism and alcoholics. I am attempting by means of the enclosed survey to gather data which can be used in the course of my writing a thesis for the Master of Sacred Theology degree (Concordia Seminary, St. Louis, MO).

I recognize that you have a busy schedule, but I am hopeful that you can take the time to assist me in this project. I believe that my project has significance for pastoral care, and I am hopeful that my work in this area can be of use to the life of the church.

The enclosed instrument is a survey, not a test. The purpose of the instrument is not to test your knowledge about alcoholism, but it is designed to attempt to give opportunity for you to reflect your feelings and attitudes. My request is very simple: Please complete the enclosed survey after reading the instructions at the top of the first page and respond to the statements of the survey as honestly as you can.

You will find that it will take you about 20-25 minutes to complete the form. If it is possible for you to complete and mail the survey on the day you receive it, that will be especially helpful. I ask that you return the survey within seven days.

I have enclosed an addressed and stamped envelope for your use in returning the survey.

On the last page of the survey, you have opportunity to inform me of your interest in learning about the results of this survey.

I express my sincere thanks for your cooperation and for your returning the completed survey. It is important that you respond to all statements and that all surveys be returned.

Sincerely yours,

Rev. James W. Hallerberg

APPENDIX 2

SURVEY INSTRUMENT

[In order to conserve space, abbreviations are used in this appendix to represent the choice of responses which were offered and stated in complete words in the original survey instrument. In the original survey, which was in elite rather than pica type, the complete words here abbreviated fit onto one line. The key to the abbreviations which are used in this appendix is as follows: SA = Strongly Agree; A = Agree; AS = Agree Somewhat; DS = Disagree Somewhat; SD = Strongly Disagree.]

On both sides of the following pages you will find a number of statements about alcoholism. We want to know how much you agree or disagree with each of the statements. You will find a rating scale under each statement. Please circle only one of the choices offered. Whenever possible, circle that choice which is your first spontaneous and instinctive response to the statement.

1. In reality, the pastor is not in a position to make a significant contribution in helping an alcoholic toward recovery.

1. SA A AS DS SD

2. Venereal disease and alcoholism are both the result of immoral behavior.

2. SA A AS DS SD

3. The average alcoholic is usually employed.

3. SA A AS DS SD

4. Life-long total abstinence is a necessary goal in the treatment of alcoholism.

4. SA A AS DS SD

5. The alcoholic's family suffers more from excessive drinking patterns than does the alcoholic himself.

5. SA A AS DS SD

6. I generally recommend Alcoholics Anonymous to an alcoholic.

6. SA A AS DS SD

7. Effective pastoral counseling with an alcoholic begins with an understanding of the illness of alcoholism and acceptance of the alcoholic as a sick person.

7. SA A AS DS SD

8. Uncontrolled drinking as an escape from normal responsibility is evidence of lack of will power.

8. SA A AS DS SD

9. Alcoholics frequently hold important positions in business and the community.

9. SA A AS DS SD

10. Before an alcoholic is able to stop drinking, he needs to gain some insight into the reason(s) for his drinking.

10. SA A AS DS SD

11. Alcoholism is best described as an illness rather than as a habit.

11. SA A AS DS SD

12. Alcoholics Anonymous is probably not the best program for recovery for highly educated and intellectual people.

12. SA A AS DS SD

13. The pastor is especially helpful for the recovery of the alcoholic when he reminds him of his sin and points him to his responsibilities.

13. SA A AS DS SD

14. Those of us who are not alcoholic are less sinful than we would be if we were alcoholic.

14. SA A AS DS SD

15. There is something about alcoholics that makes it easy to tell them from "normal" people, even when they are sober.

15. SA A AS DS SD

16. I honestly believe that alcoholism is as appropriately defined as a disease as is mental illness.

16. SA A AS DS SD

17. Most alcoholics are unconcerned about their problems and the problems they cause others.

17. SA A AS DS SD

18. Alcoholics Anonymous is the most effective resource for helping alcoholics to recover.

18. SA A AS DS SD

19. Generally, I feel that when working with an alcoholic, I am positive and optimistic about my effectiveness and his recovery.

19. SA A AS DS SD

20. The alcoholic is a morally weak person.

20. SA A AS DS SD

21. Alcoholics, on the average, have a poorer education than non-alcoholics.

21. SA A AS DS SD

22. For the pastor, more benefits than problems come as a result of working with a disease concept of alcoholism.

22. SA A AS DS SD

23. Alcoholics have only themselves to blame for their drinking; in most cases, they just haven't tried hard enough to stop drinking.

23. SA A AS DS SD

24. My attitude toward the program of Alcoholics Anonymous is very positive.

24. SA A AS DS SD

25. My primary role in dealing with the problem of alcoholism is to minister to the family of an alcoholic. Directly ministering to the alcoholic himself may be important, but is secondary.

25. SA A AS DS SD

26. When all is said and done, I believe that the primary cause of alcoholism is personal moral failure on the part of the alcoholic.

26. SA A AS DS SD

27. Though there is a progressive nature to alcoholism, the vast majority of alcoholics do not end up on Skid Row.

27. SA A AS DS SD

28. Accepting a disease concept of alcoholism is a prerequisite to helping the alcoholic.

28. SA A AS DS SD

29. I believe that the alcoholic is powerless over alcohol.

29. SA A AS DS SD

30. Slogans used by Alcoholics Anonymous like "Keep it simple," or "Easy does it" are lacking in depth and not really very useful for recovery from alcoholism.

30. SA A AS DS SD

31. The pastor is in the position of being one of the most helpful agents available in relating to and helping alcoholics toward recovery.

31. SA A AS DS SD

32. Only the psychological cripples will become problem drinkers and develop into alcoholics.

32. SA A AS DS SD

33. The alcoholic is basically a spineless person who has found an "easy" way out of his problem.

33. SA A AS DS SD

34. I honestly believe that alcoholism is as appropriately defined as a disease as is diabetis. [sic]

34. SA A AS DS SD

35. I think most alcoholics are indifferent to the suffering they cause.

35. SA A AS DS SD

36. I believe the program of Alcoholics Anonymous is best suited for dealing with the problems of alcoholism and helping the alcoholic recover--at least for most alcoholics.

36. SA A AS DS SD

37. When I think about ministering to alcoholics, I feel more like giving up than trying to do so.

37. SA A AS DS SD

38. I tend to view alcoholism as a non-acceptable behavior caused by a lack of will power or a lack of moral strength on the part of the alcoholic.

38. SA A AS DS SD

39. I would estimate that less that 10% of the alcoholic population lives on Skid Row.

39. SA A AS DS SD

40. I realize that many people can be helped by accepting a disease concept of alcoholism, but I personally am not convinced that alcoholism is appropriately defined as a disease.

40. SA A AS DS SD

41. I feel that I am able to be accepting of an alcoholic.

41. SA A AS DS SD

42. If all else fails, try to get the alcoholic to an Alcoholics Anonymous meeting.

42. SA A AS DS SD

43. Generally, I feel frustrated in attempting to extend pastoral care to alcoholics.

43. SA A AS DS SD

44. I feel that the alcoholic is more in need of God's grace than I am.

44. SA A AS DS SD

45. It is really hopeless to try to treat alcoholism; the alcoholic may reform for a time, but he always slips back into the bottle.

45. SA A AS DS SD

46. Alcoholism is a disease.

46. SA A AS DS SD

47. I find it very difficult to be truly accepting of the alcoholic.

47. SA A AS DS SD

48. I recognize that Alcoholics Anonymous includes spiritual concerns as part of its program for recovery, but I believe that it should not include spiritual aspects as part of its program.

48. SA A AS DS SD

49. Most of the time I feel that alcoholics in my congregation use and manipulate me.

49. SA A AS DS SD

50. I would expect to find more venereal disease among alcoholics than among non-alcoholics.

50. SA A AS DS SD

51. The alcoholic must hit "rock bottom" (i.e., lose job, family, home, health) before he can get well.

51. SA A AS DS SD

52. I feel that if one defines alcoholism as a disease, responsibility is removed from the alcoholic, and that defining alcoholism as a disease is likely in the long run to hinder recovery.

52. SA A AS DS SD

53. Even if an alcoholic wants to stop drinking he may not be able to do so, and I can accept that as a realistic fact in his life.

53. SA A AS DS SD

54. In the course of my ministry, I have never attended a meeting of Alcoholics Anonymous.

54. SA A AS DS SD

55. I generally feel that I am helpful to an alcoholic in his recovery.

55. SA A AS DS SD

56. Generally, I feel just about as competent in my skills in the area of alcohol counseling as in the area of marriage counseling.

56. SA A AS DS SD

* *

You will find below six different statements. Circle that one statement with which you can most agree. CIRCLE ONLY ONE of the six statements below.

1. Alcoholism is a sin and not a sickness from start to finish.

2. Alcoholism begins as a personal sin and ends as a sickness.

3. Alcoholism is a sickness which involves the sin of abuse.

4. Alcoholism is a sickness which is caused by a combination of factors involving both sin and sickness.

5. Alcoholism involves sin in the sense that it has destructive consequences.

6. If one speaks of sin in relationship to alcoholism, then only the society (and not the alcoholic) is responsible for that sin.

* *

Please supply the following information. From which Seminary did you graduate?_____ How old are you?_____ When did you graduate from the seminary (year)?_____ To which District do you belong?_____ How many confirmed communicant members in your parish?_____ What percentage of your parish do you estimate to be

alcoholic?_____ How many alcoholics did you minister to, relating specifically to their alcoholic problem, during the past year (12 months)?_____ Are you interested in a report of the results of this survey?_____[1]

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[1]It is noted that in the original form there were six pages printed on three sheets of paper, and that on the odd-numbered pages directions were given to "(turn this sheet over and continue on page . . .)" and that on the even-numbered pages directions were given to "(go to next sheet, and continue on page . . .)." The use of elite rather than pica type in the original form accounts for the difference between the original and the form as reproduced in this appendix.

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