Alcoholism treated by systematic desensitization

A follow-up of eight cases*

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The use of aversion therapy in the treatment of alcoholism has tended to direct attention to the alcohol rather than the underlying problems of the patient. The aim of aversion therapy is to make drinking unpleasant, which may be achieved in several ways which include chemical aversion therapy using apomorphine (Raymond 1964), electrical aversion therapy (McGuire and Vallance 1964), and aversion which is verbally induced by the therapist when the patient is deeply relaxed. This method of treatment has been called 'covert sensitization' by Cautela (1967), and verbal aversion by Anant (1968). All aversive methods share the premise that alcoholism cannot be cured and that the patient, having completed his course of treatment, must abstain from alcohol for the rest of his life.

Recently, a new approach to alcoholism has been introduced by Kraft (1968), in which the patient is treated for his underlying social difficulties without special attention being paid to the alcoholism. The advantage of this method of treatment, once the patient has become socially competent without the assistance of alcohol, is that he can continue drinking socially without developing a desire to drink to excess.

The present report is a follow-up study of eight patients, five of whom were classified as suffering from primary alcoholism, and three from alcoholism 'secondary to social anxieties'.

Eight patients were selected for treatment and all have recovered, no longer need alcohol for their support, and have made satisfactory life adjustments.

Method of treatment

The treatment is based on Wolpe's (1958) method of systematic desensitization. Relaxation was induced by hypnosis in cases 1, 2, 3, 5, 6 and 7, and with intravenous injections of methohexitone sodium† in cases 4 and 8 (Friedman 1966). In the treatment session, the patient, deeply relaxed, is asked to imagine the stimuli listed in the hierarchy. In the patients treated with methohexitone sodium, a 2.5 per cent solution was used, as recommended by Friedman (1966).

Initially, the patient is asked to imagine talking to one person only, a friend or a relative with whom he feels entirely at ease. The patient is given the following instructions: "I want you to imagine talking to Ken. It does not matter what you imagine talking to him about, but I want you to indicate whether you feel entirely happy in this situation". If the patient signals that he feels anxiety, or if his facial expression betrays evidence of tension, the stimulus is repeated until he seems completely free from anxiety. It is only when the therapist is convinced that the patient is completely anxiety-free, that he proceeds to the next step in the hierarchy. Throughout the treatment session, the patient does not speak aloud, but silently imagines conversing with people.

The second stimulus consists of talking to two people, one male and one female, and the therapist may now say: "I want you to imagine talking to Ken and Susan".

*This work was undertaken at St Clement's Hospital, (The London Hospital), London, E.3.
†Marketed as Brietal Sodium by Lilly.
As friends are added, the therapist refers to each of them by forename, until the patient can imagine talking to 20 of his friends without any anxiety. It is important that the group of 20 has an equal distribution of the sexes. When the patient can imagine talking to this group, strangers are added, ten at a time, until he can imagine talking to 20 of his friends in a room containing 100 people altogether. The number of friends is then reduced, keeping the number of 100 people constant. Later, a stage is reached when the patient can imagine talking to several strangers in a room containing 100 strangers. Gradually, the number of strangers is reduced, until finally he is required to imagine talking to one stranger only, which seems to be the most difficult situation of all for these patients. When this stage has been reached, the patient usually finds that he is free from anxiety in all normal social situations.

Case histories

Case 1. The patient, a 23-year-old, single male (W.A.I.S. Full Scale IQ 119), was referred for treatment for primary alcoholism.

Having passed 'A' level Art, he joined an arts course at a technical college when he was 17, but failed to complete the course on account of heavy drinking. For the first six months, he felt relief at having left school, but at 17½, he found that he was doing less and less work at college, and later, he would take days off and wander round art galleries and museums.

In his second year at college, he realized that he was drinking more heavily than he should. Gradually, he spent more and more time in public houses, often drinking continuously from 11 a.m. to 3 p.m., only to return at opening time in the evening, and arrive home drunk. He admitted drinking 10 pints of beer and a quarter bottle of whisky a day, but he under-estimated. He carried a hip flask of whisky with him and his girl friend counted 20 pints of beer in one evening alone.

At the age of 21, he was admitted to St Clement's Hospital, for a period of two months, during which he was given 20 sessions of psychotherapy and 'librium' 10 mg. tds. He did not drink at all while in hospital, but relapsed two months later.

He found himself a clerical job, but discovered that, in order to speak to his superior, he had to drink large quantities of alcohol in the lunch-hour.

In his second admission to St Clement's Hospital two years later, he was given an intensive course of systematic desensitization, along the lines described earlier, and he received a total of 142 hours' treatment.

At first, he was rather puzzled that he should no longer wish to drink, but as the treatment progressed, he gradually became used to the idea.

When interviewed three years and four months later, he hardly remembered being an alcoholic, and had to be reminded of it. In the meantime, he has married, works regularly, and while he showed tremendous social anxiety before his treatment, he now says that he could not do without the company of other people. He might drink an occasional glass of sherry at a party, but the addiction to alcohol has entirely disappeared.

Case 2. The patient, a 20-year-old, single male (W.A.I.S. Full Scale IQ 106), was admitted to St Clement's Hospital, London, for treatment of primary alcoholism and psychopathic disorder (Kraft and Al-Issa 1967, Kraft 1968).

He began drinking when he was 16, and at this time he drank one measure of whisky a night. His consumption of alcohol rose rapidly when his fiancée broke off their engagement six months before his admission to hospital. He was now drinking one bottle of whisky a day, and on some days, two bottles of whisky, as well as wine, brandy and beer. He found it very difficult to estimate the quantity, but said that two bottles of whisky was the most he would drink in a night, and added that he did not regard this as too much.

From the age of ten onwards, he has had outbursts of rage, in which he hits out at anybody close by, usually other males, but has also frequently hit his mother, though he would not strike other women. He tells many lies, and finds it difficult to distinguish these from the truth. At week-ends, he joins a gang of boys, drifts from one party to another, and finally, after drinking a lot of alcohol, he can enjoy heterosexual intercourse.

His treatment was completed in four months, and he received 50 hours' treatment altogether. He soon learned to speak to men and women without the assistance of alcohol, and found that alcohol was no longer essential to him. He had exchanged the drinking for a powerful attachment to the therapist, and had to be weaned gradually from this. After the 50th session, the patient said that he did not require any further treatment, and felt very well indeed.

Following his treatment, he found he no longer needed to drink to excess, finding half a pint of
beer sufficient, and this has been maintained for a period of three years and three months. He has broken off his former relationships with alcoholic friends, and has made new friendships. He is working regularly, has moved to the country, and is happy. He shows normal drinking habits, occasionally drinking half a pint of beer in a public house, but has lost his addictive drive, without becoming a compulsive teetotaller.

Case 3. The patient, a 21-year-old, single male (W.A.I.S. Full Scale IQ 130), was referred for treatment of primary alcoholism and psychopathic disorder (Kraft and Al-Issa 1967).

He started drinking alcohol at the age of 18, with small quantities of beer, but later changed to brandy. He claimed that he drank in order to relieve feelings of depression, but became even more depressed after drinking. When his fiancée broke with him, he started drinking as much brandy as he could afford.

Expelled from school at the age of 15, he drifted from one job to another, but rarely stayed for more than a few weeks, for he was unpunctual and had many clashes with his superiors. He joined the Army at 19, but was discharged after seven weeks. He has had convictions for breaking and entering, and for car-stealing, and has stolen large sums of money from his workplaces to pay his gambling debts.

He received 13 hours' treatment in all. After the sixth session, he said that he no longer had any further interest in alcohol, and he was impressed with his newly-acquired tranquillity.

When interviewed two-and-a-half years later, he said that he no longer liked brandy and the craving for alcohol had entirely disappeared, though he did enjoy an occasional glass of wine with his evening meal. He recognized that he had markedly improved in his social adjustment. He can now go to large social events and feel perfectly at ease talking to other guests, without developing any desire for alcohol. Before treatment, he would have felt that everyone was looking at him. This symptom has now disappeared, as have his criminal activities, which he thinks were associated with his paranoid anxiety. He is now happily married, with two children.

Case 4. The patient, a 32-year-old, married man (W.A.I.S. Full Scale IQ 105), was admitted to St Clement's Hospital, London, with the diagnosis of primary alcoholism and psychopathic disorder (Kraft and Al-Issa 1967, Kraft 1968).

He started drinking rum at the age of 16, when he was a member of crew in the deep-sea trawlers. He was proud that he could drink as much as the older men, and claimed that he drank eight to ten pints of beer during the lunch-hour as well as a further 20 pints of beer in the evening. He enjoyed drinking, and recognized that it was important to him.

Brought up in an orphanage, he ran away to go to sea at 15, and later stayed with his grandparents for several months, but resented his grandfather because he drank to excess. At 17, he was sent to Borstal for three months for breaking and entering, and joined the Army two years later, but was dismissed by Court Martial shortly afterwards. At 24, he was charged and found guilty of attempted murder and was sentenced to seven years' imprisonment.

His reason for requesting admission to hospital was that he feared that he might kill six people, whom he hadlisted, and this provided a strong motivation for treatment.

He was given six treatment sessions for his alcoholism, and relaxation was induced by intravenous injections of methohexitone sodium. As soon as the treatment began, he was amazed to find that instead of looking greedily at the brandy bottle on the shelf in the public house, he was quite satisfied with one bottle of beer. He also noticed that he had become more interested in the people in the public house than in the alcohol.

When interviewed ten months later, he said that his alcohol consumption remained very low. He might drink one or two pints occasionally, but had no desire to drink to excess. He has now been followed up for over two years, and he remains well, is working regularly, and has not developed any desire to drink to excess.

Case 5. The patient, a 26-year-old, married woman (W.A.I.S. Full Scale IQ 87), was referred for treatment of primary alcoholism.

At 19, she had her first drink of whisky on her wedding day. She enjoyed the drink, and then began drinking a few measures of whisky during the week. She started drinking more heavily when divorcing her first husband, and admitted drinking half a bottle of whisky on several days a week at this stage. This drinking pattern continued until she remarried, when she almost stopped drinking altogether for about six months, only to begin again when she became pregnant.

A solitary drinker, she drank neat whisky, hiding the bottles in various parts of the house, before eventually disposing of them.

Her mother died five weeks before the patient was admitted to hospital, and in the fortnight immediately after her death, the patient drank nine bottles of whisky, and her husband, finding the empty bottles, was furious with her. She recognized that her mother's death was a great shock to her and that she used the whisky in order to combat excessive anxiety.
She might drink at any time of day, and often drank early in the morning to stop her hands shaking.

She was given nine treatment sessions for her alcoholism. At first, she missed the alcohol, and was afraid to take a drink, in case she might wish to drink to excess. When she had completed her treatment, she was pleased to report that, while she was able to enjoy a glass of shandy, she no longer needed to drink more. She said that she felt more confident in many ways, and was now able to talk to her neighbours, which she had not been able to do before. A follow-up of two years shows that her improvement has been maintained.

**Case 6.** The patient, a 19-year-old, single female (W.A.I.S. Full Scale IQ 106), was referred for treatment of a 'wedding-phobia' and alcoholism secondary to social anxieties (Kraft and Al-Issa 1967, Kraft 1968).

She first became aware of symptoms at the age of 14, when going dancing. She felt acutely embarrassed, started blushing and developed panic feelings. At 17, she found that she could not accept invitations to parties organized by the bank where she worked, finding various excuses. She found that gin made her feel better, and she needed to drink five or six measures of gin to make life tolerable. She recognized that she used the alcohol for its anxiety-relieving properties. Her main concern was that she would not be able to cope with the wedding, and the thought of the ceremony was so terrifying to her that this seemed insuperable.

A difficult hypnotic subject, she required 71 treatment sessions for her alcoholism and wedding-phobia. Gradually, as her condition improved, she started making better social adjustments. When she had completed her treatment, she no longer needed to drink gin in order to meet people, but was still worried about the wedding.

When interviewed two-and-a-half years later, she was delighted to report that she had not been anxious on the wedding day, and did not need to drink any alcohol. She thoroughly enjoyed the occasion, greeted all the guests, danced all night, to the surprise of the guests, and was extremely happy. While she might now drink the occasional glass of gin at a wedding, she no longer needs to drink in order to meet people. She is extremely sociable, enjoys life and was delighted with her excellent recovery.

**Case 7.** The patient, a 23-year-old, married woman (W.A.I.S. Full Scale IQ 96), was referred for treatment on account of excessive blushing and alcoholism secondary to social anxieties (Kraft and Al-Issa 1967, Kraft 1968).

She felt perfectly well until she was 17, when she went to the cinema with her fiancé, and saw a film of a child being born. She felt faint and could not bear to look at the screen. After this incident, she avoided going to the cinema.

At the age of 18, she became conscious of excessive blushing which embarrassed her. The blushing would happen at any time of day, but mainly when she was in company. At first, the blush would subside after a few minutes, but from the age of 21 onwards, the blush tended to remain as long as she remained in company. The symptom prevented her from going to visit friends, interfered with going to parties, and recently she avoided travelling by Underground, and preferred to travel by bus. She was aware that she found difficulty meeting people of either sex.

She found that she felt much better after drinking four measures of gin, and when she had seven measures of gin, she did not even think of blushing, and she was happy that she could remove the symptom by drinking gin.

She received 25 hours' treatment in all for her social anxieties and associated alcoholism. Even after the first treatment session, she reported that her blushing had lessened, and in the fifth session, she said that she had been able to speak to her employer for ten minutes without any difficulty, which was unusual for her. As the treatment progressed, she continued to improve, and her husband was well pleased with the treatment result.

When interviewed two years and nine months later, she said that, though she would not regard herself as 'fully recovered', she is more socially competent since her treatment. She no longer needs to drink gin at all when meeting people, has a much better relationship with her husband, and is working regularly as a machinist. She recognizes that she is much better than before her treatment.

**Case 8.** The patient, a 19-year-old, single male (W.A.I.S. Full Scale IQ 124), was referred for treatment of alcoholism secondary to social anxieties.

He first became aware of blushing when talking to people at the age of 16, in his first job as shop assistant. He blushed when talking to people of either sex in any age group, and he has also developed a pain across the forehead. He felt very embarrassed by his symptoms, which prevented him from listening to their conversation.

At the age of 18, the blushing lessened, but he now developed feelings of depression and anxiety, and it was at this stage that he started drinking more heavily. He started drinking beer at the age of 17. At first, he drank about four pints of beer during the course of an evening, but gradually his drinking increased, and he enjoyed being drunk, because then he felt completely uninhibited and was very happy.
He spent a fair amount on alcohol, and borrowed money from his friends. He carried a hip flask of whisky, and drank this before meeting his friends on a Saturday night, so that he could enjoy the evening with them. He was well aware that he used the alcohol to combat social anxieties.

He was given 51 hours' treatment in all: Even after the second treatment session, he felt much happier when meeting his friends in the evening, and towards the end of his treatment, he said: "Where before treatment it was all depression with little bits of happiness, now it is all happiness with little bits of depression."

When interviewed one year later, he said that he now found it much easier to meet his friends, and could talk easily to men and women. He finds that, where before treatment he used to gulp the first pint of beer, he can now take his time about it. He is now happy in a clerical post, has passed the first book-keeping examination with distinction, and hopes soon to begin a course at a training college.

Discussion

Most treatments for alcoholism demand that at the end of the treatment, the patient must abstain from alcohol for the rest of his life. Aversive treatments in general aim to make alcohol unpleasant for the patient, but no attempt is usually made to correct the underlying disturbances which led the patient to drink in the first place.

In this paper, alcohol is considered in terms of social anxiety, and the aim of the treatment is to counteract the patient's social difficulties rather than to concentrate on his drinking behaviour. It is of great interest that a treatment which aims to make a patient socially competent should at the same time remove the desire to drink to excess and yet allow him to continue drinking socially. All the patients described in this paper were under the age of 35; it may well be that this treatment method would not be applicable to older patients in whom the alcoholism has become an established way of life.

Although it is not possible to reach any general conclusions from this small study, treating patients for their social anxieties might well prove an efficient method of curing some alcoholic patients.

Summary

Eight patients, five of whom were diagnosed as suffering from 'primary alcoholism' and three as 'alcoholism secondary to social anxieties' were treated by systematic desensitization. The patients were relaxed either by hypnosis or by methohexitone sodium and the aim of the treatment was to ensure that they would be socially competent in all normal social situations. All eight patients no longer need to drink to excess, and yet can continue drinking socially. The patients have been followed up for periods ranging from one year to three years four months, and their recovery has been maintained.

Acknowledgements

The author wishes to thank Dr John Denham for his permission to publish this paper. The author also wishes to thank Mr R. Adams for reading the proofs.

REFERENCES