TREATMENT OF THE ALCOHOLIC

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THE problem of alcoholism has recently received more notice in the press, on television and in parliament. The formation of the National Council on Alcoholism in September 1962 and the opening of the first information centre in Liverpool last year in particular attracted attention.

In 1957 when I first came to this hospital I used the various forms of aversion therapy, helped the patient over the withdrawal phase with suitable drugs, saw the patients after discharge at clinics, and found the results disappointing. Four years ago it so happened that a number of alcoholic patients were inpatients together and I formed an alcoholic group, which at first met twice weekly, but after a few months once weekly for one hour and has continued to do so ever since, slowly evolving, with much more rewarding results. This article is an attempt to state the principles discovered over these four years which can help the alcoholic. Other doctors, notably M. Glatt, have written on this topic, but patients frequently complain of being misunderstood even by their own general practitioner, and to state a few basic principles and facts will I hope contribute towards a better understanding.

Firstly, the alcoholic discovers that coming in for a ' cure ' is a misnomer. The immediate treatment of withdrawal, of delirium tremens, of ' drying-out ' is in the long run far less important than the prolonged treatment of addiction, remaining abstinent. Secondly, what is an alcoholic? The patient has to accept he is an ' alcoholic ' as a first step, and this is often a difficult emotional experience, but with explanation and support can be achieved. The patient discovers that the term is not one of abuse when used in a special sense, as a form of illness requiring treatment. The alcoholic is an unfortunate person, who may be drinking less than his neighbour, but as a result of his drinking (which usually follows a period of socially enjoyable drinking but at times is actively disliked), finds that as a result of tension or depression his alcoholic intake has increased, and he has lost control, unable to reduce the intake which has become compul-

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sive, linked with a biochemical need to replenish the blood level as it falls, especially the morning after the night before.

For the sake of simplicity I link this with three effects, damaging of physical health, of mental health or of one's relationships, social, domestic or employment. It is important to stress that heavy drinking alone is not alcoholism, that a paradox very confusing to the lay public is often found, that the ' drunk ' is usually not an alcoholic and that alcoholics rarely get drunk. It is wise to stress that one has no antagonism to the consumption of alcohol as such, which tends to place one in the eyes of the patient as a rabid teetotaller, and I personally mention at appropriate times I am a very moderate drinker.

Once the patient accepts he is an ' alcoholic ' (for want of a better word) the next phase is attitude towards treatment. At this stage one has to distinguish between (1) the alcoholic where this is the main problem and (2) where alcoholism is only an aspect of a disturbed personality and more in the nature of a symptom. It is noticeable the prognosis is poor in the latter.

The ' genuine ' alcoholic usually has a family history of alcoholism, has graduated to his present condition after years of moderate drinking, and is usually over 40. Patients sent to me in their twenties usually turn out to be primary personality disorders. Although, of course, personality factors enter into the problem of the alcoholic they are not the major concern and the work record is usually good in contrast to the second group. I have been fortunate in treating a number of intelligent professional men, but this alone cannot account for good results, because one founder member of four years ago was in hospital for the third time, having failed twice with the previous regimes and also in nursing homes, and a number of the patients had received expensive private treatment in various units. Motivation is of vital importance, yet fear alone, the cost in money and health and happiness, are not enough to enable an alcoholic to stop drinking. This accounts for so many patients becoming self critical, a period of remorse and complaint of lack of ' will power ' being common. This attitude is counteracted by an explanation of the compulsive nature of addiction, that a hypothetical ' will power ' is not involved, because treatment in the group does not give them this virtue. They can achieve their goal of control by understanding, and concepts of will or lack of it confuse the problem.

Colleagues who have attempted to treat alcoholic patients where the majority are psychopathic personalities have had disappointing results which may influence the attitude of alcoholics generally. Even the Henderson Hospital which specializes in the treatment of personality disorders rejects the patient where this is combined with alcoholism.

The most important aspect of attitude to treatment is the differentiation between active and passive roles on the part of the patient, for example, in the latter the patient symbolically throws his arms open stating " I can't help myself. Please doctor help me ", expecting the doctor to produce a magic pill or wave his wand and instil resistance. This links with what I term external and internal forces. In the former treatment consists of various measures, such as prohibition, imprisonment, antabuse or aversion methods. It is interesting how prohibition may lead to a state of mind where even more alcohol is consumed, and a number of patients have explained how if this method were attempted they would feel a need to rebel against such force, and of course prohibition can be attempted at the individual level as well as nationally. Imprisonment enforces abstinence (except one patient drank cooking sherry in the kitchen), but the moment of release is usually the beginning of a binge at the nearest pub, as the seaman coming off his ship. One female patient spent nearly six months in a convent where alcohol was not obtainable by careful supervision of pocket money and similar measures, but, after an upset, left and drank a bottle of gin during the 30 miles home in a taxi. Antabuse, although a valuable drug for some patients, must be classed with the external forces, as the patient knows the introduction of an outside chemical will forcibly prevent him drinking (although even here not in every case).

The development of understanding is the equivalent of an internal force, the alcoholics being able to feel that they are contributing to their improved condition, that they may regain pride in themselves once again, to realize that they have suffered from an unusual form of disease although not unusual in frequency.

Treatment progresses through various stages which varies with individual patients, anxiety, remorse and despair in contrast to over confidence in others. One patient required three admissions in rapid succession before his confidence gave way to a sufficient degree of anxiety lasting enough months to start him on the ladder to his present condition of three years' control. This understanding is in my opinion the only long term force which can act as a buffer between the patient and the stresses of everyday life. A hospital is a protected environment, but I encourage patients to lead eventually a normal social life, not to be afraid of alcohol in society, but to entertain others in their homes, to go to parties, even if they find the conversation boring when the ' normal ' guests have drunk freely, although some can enter into an animated party mood relying on their personality alone, in contrast to their escape from their personality before, needing alcohol to mix, or for ' dutch courage ', or to forget. The alcoholic begins to realize those favourable aspects of his personality which emerges in sober aftermath, and finds the

qualities often greater than estimated. In the patient's early treatment in the group he can see other ex-inpatients who are now once again respectable citizens and take courage as well as encouragement.

As the group proceeds weekly, new members are welcomed, old members keep in contact even from far away places. The tone of the meetings is casual and a visiting registrar called it a club. A too serious vein all the time would not be helpful, and although reference is made at times to cirrhosis, the pharmacology and action of alochol, homeostasis, brain damage, biochemical factors, the fearful side is not over-emphasized, because every alcoholic knows that fear alone, which many experienced with their desire to stop, could not help before without medical help. The majority of patients require admission for withdrawal, but recently a few have been helped by outpatient treatment alone. The main stress is on psychological factors, not necessarily dynamic in depth, but appreciating the theme of developing a buffer for the future.

At this point mention should be made of female patients, who come for treatment less readily, with greater shame, and in my somewhat limited experience with poor results.

One or two other points are worth mentioning. Because the base hospital is 15 miles from Brighton and the Alcoholic Anonymous group there, contact is rather tenuous, only one or two patients attending both at different times throughout four years. The hospital group is not anonymous, is medically orientated, and moral and religious themes are avoided except when specifically introduced by a patient, and I explain the fact that the patient is attending the group or in hospital is implicit moral concern about his behaviour and indicates a desire to ' reform '.

A frequent concern is about the possibility of becoming a moderate drinker once again. This is coped with on the lines that possibly one in ten present might achieve this, but it would mean seeing nine relapses in addition, and I was not prepared to gamble with such odds. Many alcoholics, however, put this to the test, because they desire to be a ' normal ' person, and gain by the experience of relapsing, as long as they are capable of not trying again. The group benefits by the relapse of others, as it saves them all trying the experiment. A useful analogy is with diabetes, where there is no ' cure ' but good health with insulin, the alcoholic enjoys good health but no ' cure ' only as long as he abstains, otherwise he sets up a craving even after a lapse of many years due to the metabolic state of the brain cells.

The group are but part of an acute admission unit of an area mental hospital, and at times they have been asked if they would prefer to

be treated in an alcoholic unit in isolation, and almost unanimously patients prefer to be treated as for any other nervous disease, in a mixed unit, the only difference from the other patients involving weekly attendance at the specific group. Regional units as postulated by the Ministry of Health would detract from the prolonged after-care which must be local.

Motivation is important as previously stressed. A patient must have something to lose to make it worthwhile going on, and many of the cases with personality disorders who do badly have remarkably few assets of mental health or relationship to lose.

The personality of the therapist will obviously influence the type of group. I was made aware that interest and enthusiasm is not shared by all when some of these ideas were voiced to psychiatric colleagues at a meeting last summer, that some colleagues would not feel at ease with such a group. If others will be tempted by this paper to start such a group they will find the results rewarding as well as often disappointing.

Lastly, a sense of humour may help when the disappointments recur. I remember the enjoyment of a meeting when, stressing the failure of external forces, I quoted " You can lead a horse to water but you can't make it drink." I have avoided statistics, numbers of successes and failures, age, duration, and the like, as I think the facts emerge in the basic principles outlined to rescue patients often given up for lost by all, yet capable and valuable members of the community when in remission.

Night calls in general practice. G. L. WEBSTER *et al. Brit. med. J.* 1965, **1**, 1369.

In an industrial urban practice in Stockton-on-Tees, 342 calls were received between 11 p.m. and 8 a.m. over four consecutive years. The number of patients in the practice was 7,751 at the beginning of the period and 8,243 at the end.

The rather low rate of night calls—10.7 per 1,000 per year—is attributed to the preponderance of younger age groups in the practice. Twenty-five per cent of the calls took place between 11 p.m. and midnight. Seven per cent fell in the category of 'unnecessary calls'. Maternity work accounted for 26 per cent of the calls and in 15 cases (4.5 per cent) advice was given by telephone.