ALCOHOLISM IN GENERAL PRACTICE

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After 2 years of registrarship at a psychiatric hospital (Tara Hospital, Johannesburg) I returned to general practice, confining myself almost exclusively to psychiatry, and soon found myself seeing an ever-increasing number of alcoholics. This involved overcoming a deep-seated prejudice, unfortunately shared by most colleagues, including some psychiatrists. As the number of my alcoholic patients increased, my prejudice diminished (or was it the other way about?). I found this work gratifying in all respects, for the recovering alcoholic is a good patient, a devoted husband and a conscientious worker.

In the 4 years preceding 1959 I saw 475 alcoholics in Johannesburg, and the following is an attempt to review the subject and to give an account of alcoholism as I saw it clinically. For the purpose of this article I chose the following definition: 'Alcoholism is a periodic, progressive disease, severely affecting the total personality, body and mind, characterized by addiction to alcohol and attended by failure at home, at work and socially'. Addiction is determined by its cardinal feature, viz. mental and physical suffering on withdrawal of the drug (the withdrawal syndrome).

CLINICAL FEATURES

'He was not merely addicted to drink, he was dejectedly chained to it, as the great sheepish dog whom he resembled might be chained to a kennel. He did not drink at parties, or with friends, but in no company but his own, in solitary, irregular and frequent bouts; sometimes every week, sometimes at intervals of several months, sometimes every day for a month.'

From *Charmed Lives* by Nadine Gordimer.

The onset of alcoholism varies enormously, some patients becoming compulsive drinkers from the beginning of their use of alcohol, the true or *primary addicts;* others after long association, after many years of so-called social drinking, the *secondary addicts*.[1] Clinically, all patients go through 2 main stages, the early pre-alcoholic stage and the fully developed crucial stage.

Months or years before control is lost alcoholics show a pattern of drinking that differs from ordinary drinking in several respects. To an extent and for some time they may appear to exercise control, confining their drinking to hours after work and to weekends. However, alcohol with them is a need rather than a pleasure, and they are preoccupied with it, one drink always calls for more and often leads to intoxication; they have a high tolerance for alcohol, boasting hard heads for drink and usually experiencing no hangover.

The patient may insist on calling himself a 'social drinker', but the drink itself is the attraction, not the social occasion at which it is served. Severe damage to the

sufferer, to his family and to his career results, even during this stage. Devoid of insight and enslaved by the inexorable need for alcohol, he refuses to accept his drinking as a problem, minimizing it and using all manner of rationalization and 'proof' that he is not an alcoholic because he 'can lay off' for months and because he is fit for work in the morning. He may admit that drink is doing him harm, but he will obstinately turn down offers of help. The few patients who accepted treatment at this stage did relatively well.

Established Alcoholism

Sooner or later drinking intensifies, 'one or two' have to be taken at lunch time, and weekend drinking becomes a minor bout that goes on into Monday. A memory blackout, where part of the day is a complete blank, may frighten the patient into his doctor's consulting rooms. This stage marks a definite breakdown. Loss of control is intermittent, but remissions result from the periodic nature of the condition rather than the patient's ability to exercise control. In advanced cases tolerance drops, and the patient becomes drunk and incapable on much less alcohol than formerly. The alcoholic now drinks alone, at short intervals throughout the day, and protects his supply. With the bottle at hand he is a slow drinker, but after an interval of hours he may swallow several ounces to gain relief.

The Classical Bout

The tendency at this stage for drinking to mount and culminate into the classical bout is characteristic, and over 80% of my patients were seen in this state. It was impossible for them to remain without drink for more than brief intervals without experiencing intense physical discomfort and mental suffering. This suffering on withdrawal of alcohol during the bout is the cardinal feature of alcoholic, or for that matter any drug, addiction, hence the urgency and the need for a 'curer' ('regmaker') in the morning, the resistance to removal to hospital, the great fear of being left without drink, the resentment of criticism and offers of help and the irresponsible, psychopathic behaviour. Running short of supply, the boutbound alcoholic will lie, borrow, sell his belongings, and pay any price for his greatest, his only need.

Accompanying the discomfort there may be restlessness, irritability, fright, psychomotor agitation, tension, distressing tremors, insomnia and palpitations, all immediately relieved by alcohol, but aggravated by it ultimately. At the height of the bout the alcoholic drinks because he has to, not to overcome his social inadequacy or as an escape from intolerable life situations, not even to achieve oblivion for its own sake, but because to stop drinking is to suffer. This goes on for days or weeks without food or natural sleep, until, unable to stop and too ill to continue, he reaches the peak of his agony, when he appeals for help and is only too glad to receive it.

Asked what he is complaining of he can only describe the feeling as 'terrible', 'rotten' or 'butterflies in the stomach'. Other symptoms are not uncommon, e.g. biliousness, diarrhoea, frightening dreams, convulsions, and defective judgment, memory and concentration. If death does not supervene the bout comes to an end because the patient is too ill and bilious to drink more, or it terminates by lack of supply or hospitalization. In any event, the dreaded withdrawal symptoms will be experienced.

Remission

Whether the patient undergoes treatment or 'sweats it out', termination of the attack and remission will be marked by complete relaxation, restoration of sleep and appetite and by relief from craving for drink within a few days, although mental symptoms may take weeks to clear up. Some patients, discharged from hospital too soon, may go on 'nibbling at it' and seem able to take 2 or 3 drinks daily between the attacks. Again I believe this to be due to the periodicity of alcoholism, for within days or weeks drinking mounts and becomes uncontrollable again. This stage is so marked by absence of symptoms or need for alcohol that the patient tends to become over-optimistic. His post-alcoholic remorse is followed by assurance that drink 'never enters his mind', which is true, and that he will never need it again, which is far from true. Some patients go through a period of depression, apparently endogenous in those who are prone to depression, or related to the thought of having to give up a long-standing habit, or caused by the depressive effect of alcohol on the brain. Others experience a feeling of apathy and a void in place of the long drinking hours of the past.

However, as surely as the pain of the peptic ulcer or the attack of asthma returns, so does the need for alcohol in the alcoholic. Few describe it as a craving, though once drinking is resumed craving may become intense. In some it is triggered off by inimical life situations from which they apparently escape into the carefree oblivion produced by alcohol. Others make use of minor daily setbacks to explain away their return to drink. Nevertheless, I have no doubt in my mind that, whatever the original cause of this disease, once alcoholism is established the need to go back to the bottle arises irrespective of any life situations. In many cases the occasion is one of joy or a feeling of elation (a party in the office or a successful business deal). The spouse will often deny the story of a setback, or even reveal that drinking preceded it. I have seen many patients go through trying and unhappy events during their remission without resort to drink, only to start drinking at some later date for no reason at all, and the frank patient admits this.

Alcoholics Anonymous often stress, and rightly so, the danger of the first drink ('there is only one drink between me and a drunk', 'one drink is too many and a whole bottle not enough'). In many this is literally the case, others drink moderately for days before control is lost.

'Dry Drunk'

The phenomenon of 'dry drunk' deserves mention. Alcoholics Anonymous (AA) use the term for members who achieve sobriety, but remain restless and without peace of mind. Clinically, one or more of the following symptoms are experienced during the 'dry' period preceding a bout, symptoms accompanied by a feeling that only alcohol will give relief: irritability, restlessness, depression, mounting tension, sleeplessness, bodily pains. Patients sometimes describe it as "a feeling like 'flu" or a hangover, although no alcohol was taken for months. This syndrome, I feel, represents an attack in the 'dry' alcoholic undergoing treatment or receiving AA support. Its recognition and handling should help to ward off an attack, and a number of my patients with severe symptoms were actually admitted to a nursing home for a few days until the symptoms subsided.

Periodicity

Appreciation of the periodicity of alcoholism is important to patient and doctor alike. The patient learns that remissions support the diagnosis of alcoholism rather than disprove it, and that he cannot claim credit for them unless they are increased by treatment. The doctor regards recurrence as he would a relapse of depression. He is able to discharge the patient safely when the attack is over and to assess response to therapy by the increase of the period of remission. Lack of appreciation of the periodicity is often responsible for the patient's drinking the day he leaves hospital, because of either premature discharge or unnecessarily prolonged retention with consequent loss of work and resentment.

Jellinek,[2] stating that the term dipsomania is no longer used in North America, nevertheless described periodic

bouts as a feature of late alcoholism.

One patient showed me a 12 months' chart for 1958 kept by his methodical wife, who marked every drinking day of the year. It showed 13 drinking attacks, of 2 - 5 days each, and bore a striking resemblance to a menstrual chart. This patient did well, but during January, February and April 1959 he had 'dry drunk' attacks that disappeared eventually. Knowledge of the periodic nature of alcoholism and of these attacks helped this patient to combat alcoholism.

Chronic Alcoholism

Histories and follow-up of cases suggest that the condition is slowly progressive, attacks tending to become longer, more frequent and more severe in their effects, with tolerance for alcohol dropping. Physical and mental sequels, reversible during earlier remissions, eventually leave permanent damage. The term *chronic alcoholism* is reserved here for these complications: Korsakoff and Wernicke's syndromes, polyneuritis and liver disease, and the commoner and frequently overlooked brain damage short of frank psychosis. All aspects of mind are badly hit: affective (anxiety, depression), cognitive (memory, comprehension, judgment), and conative (striving, will power). Hence the frequency of suicide, the lack of will power to recover, the deterioration of the personality and the poor prognosis in advanced cases.

AETIOLOGY

This is at present controversial and our knowledge of it incomplete. Writers speak of multiple factors: psychological, physiological, socio-cultural, and hereditary, and alcoholism has been stated to be symptomatic of or secondary to psychotic disease.

Psychological theories relate alcoholism to abnormal early childhood relationships with parents leading to insecurity in the child. It has been described as a psychoneurosis of introversion,[3] the introvert drinking to overcome his social inadequacy, and as a form of regression to infantile lower levels of immaturity with lessened responsibility, and of dependency. Psychoanalytic theories include self-destructive urges, repressed homosexuality, and oral fixation, which is said to result from psychological trauma, such as deprivation of a significant emotional relationship, occurring during the earliest stage of psychosexual development, at a time when security and release from tension is achieved through the oral cavity. It is supposed to be a perversion, the alcoholic like the infant seeking gratification through ingestion, leading to oblivion, symbolically the blissful infantile state.

Physiological theories include allergic, nutritional, glandular, and metabolic causes. Williams,[4] basing his theories on laboratory studies, suggested that the need to consume alcohol is mediated by regulatory nervous structures situated in the hypothalamus. Figures for the incidence of hereditary factors vary. Jellinek[5] put it at 35%, adding that what is inherited is a constitution that does not offer sufficient resistance to the social risks of inebriety.

Alcoholism in Countries and Races

Alcoholism is said to differ aetiologically from country to country and from one ethnic group to another. In Anglo-Saxon countries psychological factors are believed to play the greater part. In France, where economic factors favour large consumption, there is a general rejection of the idea that alcoholism is related to psychological maladjustment.[6] Investigations carried out in an Aleutian community[7] and the Bolivian Comba[8] have shown that, in spite of heavy and extended drinking by some and frequent drinking by all, no cases of alcoholism were observed. The prevalence of alcoholism among the Irish is related to the tendency to use alcohol as a social lubricant and for business transactions,[9] and the low rates among Jews to ritual orientation in the use of alcohol and the strong disapproval of drunkenness.[10]

Attempts to describe an alcoholic personality have failed. Dependency and schizoid features are common, but they characterize other clinical groups and personality constellations. Landis[11] stated that there is no grouping of personality traits which truly characterizes any considerable number of alcoholics.

Observation of cases in a multiracial South African community showed that clinical types and aetiological factors varied from individual to individual rather than from one social or ethnic group to another. The greater proportion of my patients were South African Whites of British and Afrikaner origin, immigrants from the British Isles, and Jews, but a small number of alcoholics were seen from each of the following countries: Holland, France, Norway, the USA, Italy, Greece, Germany, Yugoslavia and Portugal. Yet all showed the characteristic clinical features, in spite of the absence of uniform social and cultural patterns in South Africa, each of the above national groups following patterns of their own countries of origin.

I did not find alcoholism among Jews as rare as reputed. I saw 25 patients (5·2%) in a city where the Jewish population is 15% of the total European population. Altogether, I saw 157 female alcoholics, a male : female ratio of 2 : 1, and only 5 (1%) non-Europeans, all brandy drinkers of the higher income group — a rarity among the Bantu. This is no indication of the incidence of alcoholism in these Africans, who often drink kaffir beer and pepped-up 'skokiaan', and end up in mental hospitals with toxic psychosis.

Other Aetiological Factors

I could find very little evidence in support of some statements made in current literature on alcoholism: that it is frequently a symptom of mental disease; that it is associated with homicide and sex crimes; that it is common in barmen and infrequent in women; and that most alcoholics are psychopaths. In this series only 7 (1·4%) were psychotics, and 2 patients had criminal records. This is supported by an investigation at Sing-Sing prison showing no greater homicidal tendencies among inebriate criminals than among non-inebriates. I have come across no sex crimes or any other major crime among my alcoholics. I saw 7 alcoholic barmen, but at least 5 of them chose this occupation because they were alcoholics to begin with.

There were 29 psychopaths (6%) among my patients. This diagnosis of a definite abnormal personality was made on the constellation of the characteristic features observed during the period of remission: immature, self-centred, disregarding feelings and rights of others, unable to conform to social standards, irresponsible and lacking restraint, unable to profit by experience.

TREATMENT

The Acute Phase

Before the management of the problem as a whole can be undertaken, the acute phase (the drinking bout) must be terminated ('drying out'). Admission to hospital is essential in all but the few cooperative patients with good home conditions. The art of treating the drinking alcoholic is the art of handling an unwilling patient who resents interference with his greatest need. The approach and attitude of the practitioner to the patient and his problem may make or mar good rapport and success.

Pleading, reasoning, warnings and threats are a sheer waste of time. An active attitude, empathy and the ability to listen without contradicting will win the day. Resistance, usually from fear of withdrawal from alcohol, should be met with action rather than argument. The patient will seldom refuse a pill or an injection and, if he is put to sleep and an ambulance is ordered, will be grateful and full of remorse when he wakes up in hospital. If ill enough he will readily accept treatment. If he flatly refuses all help he may accept it at a later date.

Depending on the severity of the withdrawal symptoms, I keep my patients asleep for 12 - 48 hours and thereafter

tranquillized until tension, tremors and other symptoms abate, the principle being that of the therapy of withdrawal of any drug addiction, viz. withdrawal with substitute therapy.[13] Tapering off with alcohol is inadvisable, since the patient should reconcile himself to the idea that alcohol must never be taken again. Paraldehyde by mouth is still the most rapid and effective hypnotic. Godfrey *et al.*[14] disapproved of it because it prolongs the period of withdrawal. This was true in about 5% of my patients, who continued to crave for paraldehyde as they did for alcohol. However, these patients, observed during several admissions, proved to be extremely difficult to 'dry-out' with any treatment. The difficulty was not with the drug, but with the patient, who felt relaxed, but clamoured for sleep and oblivion — the blissful infantile state. Paraldehyde is followed by chlorpromazine, 'serpasil', barbiturates, meprobamate and other tranquillizers, so that no drug is used for more than a day or two. The dosage varies greatly from one patient to another. Very ill and comatose patients are given intravenous saline and glucose with large doses of vitamins.

Within 3 - 10 days the average patient is over the attack and fit for work. Patients in the pre-alcoholic or early crucial stage may 'dry out' while ambulant, with sedation, while severely ill patients with complications may take many weeks to recover. For reasons already mentioned it is important to recognize the termination of the attack. The relaxed, feeding, sleeping, smiling patient off all drugs should be distinguished from the restless, grumpy alcoholic requesting his discharge. Institutional treatment and prolonged isolation is necessary for the *habitué*, the 'chronic alcoholic', and for the psychopath, to protect themselves and others. Here a good case can be made for compulsory treatment as proposed by the Medico-Legal Society of Toronto.

The Dry Alcoholic

Since alcoholism cannot be cured in the sense that the alcoholic can become an ordinary drinker again, the objects of therapy are: (*i*) To cut down, ease and shorten the attacks and lengthen the period of remission, ideally to last indefinitely; (*ii*) marital, vocational and social rehabilitation; and (*iii*) psychological improvement — to gain insight and ego-strength and to grow up emotionally.

Achievement of these aims will depend on: the patient's constitutional endowment, his intelligence, his psychological health, the extent of damage already done by alcohol to the brain, his wife and environment, his willingness to recover, and the amount of effort his doctor is prepared to make. Every person concerned (patient, spouse, relative, employer, AA sponsor) is seen and heard, all forming a team led by the doctor. Immediate problems may have to be dealt with while the patient is still in hospital. His wife may have walked out on him or he may have failed to go to work. Prompt action will save both his marriage and job. A full history is taken, a psychiatric and physical assessment made, and an eclectic therapeutic plan offered to him. This includes knowledge of the subject of alcoholism, environmental handling, marriage counselling, individual and group psychotherapy, and chemotherapy.

The clinical facts are best imparted in group discussions and the following are some of the points that should emerge: alcoholism is a progressive, pernicious disease; although it cannot be cured it can be overcome and recovery is compatible with normal life; if drinking is resumed it sooner or later becomes uncontrollable; it is almost impossible to recover without help; and surrender is essential for recovery. The patient must admit alcoholism and accept treatment.

The fallacy of the 'curer' or 'regmaker' (the hair of the dog that bit you) should be pointed out: that although the immediate effect of alcohol is to relieve symptoms — sleeplessness, depression, tension, bodily pains — it was the original cause of them and will eventually aggravate them.

Environmental Handling

This amounts to social work which, in private practice, must be done by the practitioner himself. Here again active interest rather than perfunctory advice is the keynote: introducing the patient to veteran AA members, personal contact with employer and family, and checking on progress with social and occupational outlets. Marriage counselling and treatment of alcoholism are interdependent, the former promoting sobriety and the latter saving the marriage.

Situations and relationships that form stumbling blocks to recovery must be looked for in cases where no recovery takes place in spite of apparent cooperation on the part of the patient. These usually involve what, for lack of a better term, might be called reciprocal dependence on each other's failings. Examples are: the wife who condones the patient's drinking while he overlooks her love affair; one alcoholic marrying another; the patient who drinks with his employer, etc. Far from these being 'intolerable life situations' that lead to drink, alcoholics conveniently manoeuvre themselves into such situations to perpetuate their drinking.

Group Activities

These are of great value, particularly for the lonely, the unmarried, the aloof and the withdrawn. I have conducted groups of 8 - 15 such patients discussing the problem, to initiate integration before introducing them to more lasting AA groups. Alcoholics Anonymous are a loose fellowship of alcoholics who meet in groups with 'an honest desire to quit drinking', giving each other support in their efforts to remain sober. Their value lies in the following:

(*i*) *Group therapy* with the therapeutic value of the group situation and relationship. As in any other group members 'speak the same language', and feel accepted, understood and protected against the outside world. They re-establish social contacts, learn to speak in public and feel better for their mental catharsis.

(*ii*) *'Twelve-stepping'*. As explained in their twelfth step, this is the art of carrying the message to the new 'recruit'. The 'sponsor' who adopts him as his 'baby' introduces him to the group and guides him towards integration.

(*iii*) *The religious aspect of AA*, its permissiveness, simplicity, and lack of ritual, appeals to most members who are asked to surrender to a Higher Power as they understand Him.

(*iv*) *The family group*, which is the meeting ground of the families of members, where they learn to understand the problem and benefit from the group situation.

Other Therapy

Individual psychotherapy with a view to gaining insight, ego-strength, and growth towards maturity, is beneficial to some alcoholics and essential for others, but few will accept it or can afford the luxury of prolonged therapy.

Chemotherapy is of limited value. Prescribing disulfiram indiscriminately and relying on it in all cases proves disappointing. Patients take it for days or weeks, as long as their period of remission lasts, discontinue, wait 3 days, and start drinking. I have therefore used it as a deterrent in a limited number of patients: those who had to return to work before the attack was over to save their jobs; those who reported for treatment for the 'dry drunk' attack; and cases where a dominant spouse could be relied on to administer it regularly for a long time. I have not tried the hallucinogens so far, but I understand that d-lysergic acid diethylemide (LSD) and mescalin have been used with some success. These drugs produce a great variety of symptoms and sensations, such as 'being at one with the universe', and the experience of religious conversion not unlike that of AA.[15]

RESULTS AND PROGNOSIS

Results

It is difficult to assess results of treatment, and therefore published reports are few and may not reflect the true value of various methods of therapy. The source of the material (institution, private practice), criteria of judgment and methods of treatment must be taken into consideration. Results given by clinics, where patients report voluntarily, cannot be compared with those obtained in institutions or general practice, where the greater number of patients are unwilling. It is not that these are necessarily poor therapeutic risks. Follow-up of cases is made no easier by the alcoholic's frequent change of doctor and address and exaggeration of his period of sobriety. In an investigation of 50 alcoholics over a period of 2 years at Maudsley Hospital, Davies *et al.*[16] found that 18% remained abstinent during the whole period and another 18% 'for the greater part of the time'. Patients reported of their own free will and those who did not wish to give up drink were excluded, though their number is not given.

For my own assessment of response to treatment I have taken the following criteria: increase in the period of remission, good rapport, active membership in AA and evidence of psychological improvement.

Out of the 475 patients in my series, 269 were not seen again after the first 2 or 3 interviews, and for all I know may have done well elsewhere. If the 15 deaths are added to the figure of those who disappeared, there remained 191 patients (40%) who continued their treatment or could be followed up through AA and their excellent 'grape vine' and group activities (a member's 'slip' is soon known to group leaders and each year of sobriety is celebrated as a 'birthday' with speech, cake and candles). Of these 191 patients, 68 remained abstinent for at least 12 months (some for 2 - 5 years), and showed evidence of good prognosis. I considered them 'recovering'. Another 60 I called 'improving' on account of good rapport over a number of years and ability to keep their jobs in spite of 2 or 3 drinking sprees a year.

The remaining 63 showed no evidence of improvement, receiving treatment only when ill, 'nibbling at it' between attacks, moving from job to job, and generally deteriorating over the years. Most of them were chronic alcoholics with mental complications that precluded recovery by any measures, psychopaths and drug addicts. Thus, of all cases treated, whether willing or not, 14% were 'recovering' and 13% 'improving'. If those who reported voluntarily for treatment only are considered, the numbers would be 35% and 31% respectively. Even some of those 'recovering' had an occasional 'slip' after 1 - 5 years of abstinence, though many of them must have recovered for good.

Prognosis

Patients responding to treatment as assessed by the above criteria have a relatively good prognosis, although a given patient has to be well out of the bout before an assessment can be made. Those showing permanent mental damage, referred to in this article as 'chronic alcoholics', have a poor prognosis.

Although only 15 of my patients died (and I heard indirectly of a few more) during the 5 years under review, mortality must be high. The commonest cause of death was suicide (8 patients), followed by acute intoxication (2), intercurrent disease (2), and delirium tremens (1). Once the hepatorenal syndrome develops with painless jaundice, large firm liver, irreversible hypotension, and oliguria, the condition is fatal. In some patients surviving middle age, alcoholism appears to be self-limiting. I saw only 5 patients over the age of 60 and came across a few other aged persons with a history of alcoholism, who 'took a drink or two', now 'social drinkers' as it were, 'because my system cannot take it any more'.

SUMMARY AND CONCLUSIONS

The greater part of the literature on alcoholism deals with the aetiology, complications and treatment. In this article these aspects of the malady are reviewed and alcoholism defined. The clinical features, usually taken for granted, are described in some detail as observed in general practice. These features show that alcoholism is not merely harmful excessive drinking, but a definite clinical entity, a severe illness affecting only a small percentage (3 - 6%) of drinkers. If they can be accepted as described — the characteristic periodicity and the recurrence of the classical bout on chance drinking after years of abstinence — they should lend support to physiological theories of aetiology, to which more research should be directed. Appreciation of physiological causes and distinction from the mental and physical complications should lead to more effective measures and social handling of the problem.

There is no known cure for alcoholism in the sense that an established alcoholic can be made a social drinker again. Treatment therefore aims at helping the alcoholic to live without alcohol. It amounts to 'drying out' followed by social work, which is best done by the general practitioner.

Alcoholism is a major public health problem. Yet the majority of alcoholics are still left untreated and unheeded, to cause themselves and others untold damage, to break good homes and destroy successful careers. Their refusal

to accept treatment is not so much at fault as is lack of legislation, adequate hospital facilities and policy, prejudice and general ignorance of the problem.

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