HOSPITAL TREATMENT OF ALCOHOL ADDICTION

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This paper describes the establishment of a hospital for the treatment of alcoholism and the clinical results after a year of functioning. During this time 180 in-patients were admitted and treated, and 105 additional patients were seen who were not admitted but given some alternative form of treatment.

Alcohol addiction remains a largely unsolved clinical problem. Not only is it uncertain how alcoholic patients should best be treated, but, even if a formula for treatment existed, it would still have to be adapted to the social conditions that apply in any particular locality. (A Transvaal hospital provides prolonged in-patient stay without emphasis on follow-up out-patient treatment after discharge). The method of treatment which this paper describes provides for brief in-patient hospitalization (each patient stayed in hospital for an average of 23·7 days), with prolonged and intensive out-patient treatment after discharge.

Alcoholism is not only a medical problem, but it also has important sociological aspects. The social and economic loss through alcoholism is a grave handicap to the community.[1,2] Regarding treatment of this widespread[3] medico-social disorder, the medical profession has taken a serious, often gravely pessimistic, view. In the affected individual, alcoholism complicates more deep-seated psychiatric illness of varying type.[4] However, in the alcohol addict the emotional disorder takes a secondary place to the disastrous and often fatal mental and physical effects of prolonged alcohol intake. Failures in treatment are common[5] and in many cases successes are obtained only after much effort and even then they must be regarded as tentative, because relapse is the spectre always hanging over the recovered alcoholic.

PARK ROAD HOSPITAL

After representation from the lay Council on Alcoholism, the churches and medical practitioners, the Cape Provincial Administration undertook to equip and run a hospital for the treatment of alcoholism. A steering-committee made recommendations for clinical organization and staffing, and on 20 March 1959 the Park Road Hospital, Rondebosch, Cape, was opened. There is accommodation for 30 in-patients, and out-patient facilities are arranged to provide supportive psychiatric treatment for patients once they are discharged. Clinical direction and medical staffing was given from the Department of Neurology and Psychiatry, Groote Schuur Hospital. A carefully selected and trained treatment team aimed at creating a specialized hospital atmosphere, in which each patient could discover the implications of his own status as an alcoholic, and receive active out-patient care after discharge.

Admission of Patients

Application for admission of a patient may be made by any social agency. Medical practitioners, social workers, probation officers, ministers of religion, magistrates, etc., on being contacted by an alcoholic seeking treatment, can telephone the full-time hospital doctor and obtain an appointment for the prospective patient. Patients are only admitted if they are regarded as good subjects for treatment with a reasonable chance of being helped. Medical treatment, which aims at interrupting the habituation to alcohol and afterwards aiding the patient in his adjustment to his problems without alcohol, cannot be tolerated by all alcoholics. Patients who come involuntarily, on the insistence of their family or the courts, or who present themselves and then deny that they are in fact alcoholic (i.e. hold that they can continue to drink with impunity) are not suitable cases. To benefit from the facilities provided by the hospital, the alcoholic must himself seek treatment and undertake to cooperate.

Many patients living outside the Cape Peninsula applied for admission, but they would not be able to participate in an important phase of the treatment programme: continued follow-up treatment after discharge. A few patients were prepared to live for a while in the Peninsula in order to accept the conditions of out-patient treatment.

Mr. X., a municipal employee in a distant town, was very eager to be admitted, and undertook to get permission from his Town Council for long leave so that he could find work in Cape Town and meet the requirement for out-patient therapy. He was admitted on 31 March 1959 and benefited from in-patient stay. He was much encouraged by his second wife.

He left hospital on 12 March to get an extension of leave. He then returned to hospital, the social worker continuing her efforts

to find a temporary post for him. He became depressed and discouraged as attempts to find a job for him failed. Then the City Council, Cape Town, was persuaded to employ him temporarily and he left hospital for his own lodgings in the home of a church deacon on 4 May 1959. After 2 months of group psychotherapy, while managing socially without alcohol, he returned home. His last letter indicated he is sober and satisfactorily adjusted at work and in his family life.

One hundred and five patients were not admitted to hospital, but were given out-patient treatment, usually in the form of individual out-patient interviews or antabuse therapy.

The Treatment Team

Every member of the treatment staff contributes to the total therapeutic atmosphere of the hospital. It is known that patients will not discuss their own anxiety-provoking conflicts if the staff is disorganized and fails to weld itself into a harmonious treatment team. A hierarchical ranking of the staff, with some members considering themselves above criticism, is counteracted. Frank discussion of irritating or anxiety-provoking behaviour in individual staff members is encouraged regardless of seniority or status. In this way free communication of hospital information is fostered. The role of each worker is defined as clearly as possible, and all are put in possession of the facts concerning the behaviour of patients and their treatment, so that ambiguity of therapeutic approach is reduced.

Once a week there is a staff meeting, where problems of individual patients are discussed openly, where policy is decided, and where inter-staff relationships receive attention. Conflicts of attitude or interest between different staff members are discussed frankly.

(*a*) *The medical staff*. The hospital is under clinical direction from the Department of Neurology and Psychiatry, Groote Schuur Hospital. There is a full-time medical officer (registrar) who is a psychiatrist in training. Four consultant psychiatrists each work 1 session per week, including the conducting of a long-term out-patient psychotherapeutic group. One consultant psychiatrist works 3 sessions a week, and conducts the nurses' group and a closed wives' group. All consultants also see individually in-patients allocated to their care.

(*b*) *The nursing staff*. Psychiatrically-trained nurses are very scarce in the Cape Province. Most members of the nursing staff have obtained their training in psychological handling of patients since starting work in the hospital. The staff consists of a matron, 2 sisters, 3 staff nurses, and a small number of nursing aides. Professionally-untrained nursing aides have proved of limited value and even an actual liability at times, because of their unprofessional interactions with patients and their incapacity to understand the limits of their role in treatment.

Most of the nurses have problems in handling alcoholic patients (who are often demanding and socially-provocative). Lacking training, they sometimes become excessively involved emotionally with disturbed patients. In the nurses' group each week, under regular direction from the same psychiatrist who encourages frank communication, the difficulties of treatment interaction receive detailed discussion, and the opportunity presents itself to teach the nursing staff about psychiatric treatment methods. Although all nursing appointments were made only after personal interviews with the psychiatrist in charge, many applicants had unsuitable motivations for this kind of work (father an alcoholic, need for personal psychiatric treatment, etc.). On a few occasions nurses, lacking the necessary psychiatric training, gratified their pathological needs for dependency by developing emotional attachments to patients.

(*c*) *The social worker*. The social worker's chief activity is supervising the social rehabilitation of the patients. The most onerous responsibility is helping patients to find employment. Most patients feel that their present, or prospective, employers should not know of their illness and treatment; they fear that if they are known to be alcoholic they will be distrusted and a stigma attach to them. Only some employers have been willing to co-operate actively with the hospital, urging the patient to come for treatment while keeping his job open for him. (Such cooperation with employers has made possible a very important advance in hospital treatment of alcoholism in the United States.[6]) There is no doubt that the hospital will attract the most promising type of patient only when employers accept the fact that the best patient is one who is still employed, is given leave to come to hospital and who, on return, can be thought of as on a type of probation, with active encouragement to continue with his out-patient treatment.

In addition to assisting the patient in his rehabilitation, the social worker undertakes psychiatric case work with the relatives. Some familes are very disrupted and call for much intervention in aiding their social readjustment.

The social worker has a key position in the functioning of the hospital and in maintaining contact with patients' relatives after discharge. She is usually approached by a relative if a patient has relapsed and is drinking again.

(*d*) *The occupational therapist* provides patients with the means for keeping themselves creatively occupied while in hospital. At first some men consider 'craftwork' unmanly, but soon participate when they witness the satisfaction that other patients derive from constructive activity. The occupational therapist observes and reports how individual patients behave while in occupational therapy, e.g. inability to complete a task and dependency in making work decisions. The hospital shop is under the supervision of the occupational therapist. She maintains contact with patients after their discharge through her supervision of the social club (which is conducted by the patients themselves).

THE METHOD OF TREATMENT

The organization of the hospital is on the lines of a therapeutic community.[7] Milieu therapy occurs with the democratic absence of barriers between patients and staff. The patients, to a varying degree, have been isolated and disorganized socially, and opportunity is provided in the hospital for the resumption of individual social responsibility by each patient. They associate closely with other alcoholics; frequently patients indicate what a beneficial effect is exerted by their realization, through their fellow-patients, that alcoholics are not evil and ostracized, but often likable people who can be respected. All members of the staff participate in counteracting the estrangement of newly-admitted patients, and in establishing communication with other patients on the one hand, and between patients and the medical and nursing staff on the other hand. As he becomes a responsive member of the hospital community, the patient becomes increasingly accessible to psychotherapy.

Group psychotherapy[8] is the main form of psychological treatment. Daily group meetings are held, conducted by the full-time medical officer 5 times weekly, and once weekly by the psychiatrist in charge. Newly-admitted patients soon gather from older in-patients the aims of treatment. Among the patients themselves a marked fellowship is achieved, and intimate problems and preoccupations are openly discussed. Confidential matters, which the patient feels constrained to ventilate more openly, can be discussed with the consultant psychiatrist to whom the patient is assigned and with whom he has individual interviews in addition to the common hospital treatment. Active medical care for physical disorders may be needed during the first few days of hospitalization. In Table I a summary is given of the nature and incidence of physical abnormalities present on admission.

TABLE I. PHYSICAL ABNORMALITIES PRESENT ON ADMISSION

History of periods of amnesia ('blackouts')	25·3%
Hepatomegaly	13·3%
History of epileptic seizures	12·6%
Peripheral neuritis	8%
Optic nerve dysfunction	2·6%
Limb incoordination	2%
Pancreatitis with cirrhosis of the liver	2 patients
Subdural haematoma	1 patient
Coronary thrombosis	1 patient
Diabetic pre-coma	1 patient

During his stay in hospital the patient is encouraged to explore his personal problems. He makes frequent contact with the nursing staff, who are being trained to encourage the confidences of patients and to point out where the patient's view of reality is a distorted one. Therapeutic relationships also spring up between the patients themselves who, in informal discussions with each other, make warm personal contacts. The total hospital atmosphere is aimed at encouraging communication. In addition the patient obtains a thorough understanding of the nature of alcoholism and of the fact that his only cure is to stop drinking altogether; he also becomes acquainted with what he should anticipate if he continues drinking.

Each patient is taught how to use antabuse,[9] learning that if he takes a tablet he confers upon himself a temporary inability to

drink; the tablet is non-toxic in therapeutic doses, but when combined with ingested alcohol a sudden and severe acetaldehyde poisioning results. For 36 hours after taking a tablet any alcohol ingested will lead to unpleasant effects.

The patient has contact with the social worker who sees his relatives, looks into his employment situation and may interview his employer. She may arrange for his wife to be seen by the psychiatrist who conducts the wives' group, to which the wife may be invited if suitable. The occupational therapist has daily contact with each patient. Every staff member is regarded as a significant part of the treatment team: it cannot be foretold to whom the patient will turn and with whom his most significant contact will be made.

Emphasis is placed on the need for continued treatment after discharge and that if drinking is resumed the patient should contact the hospital either for readmission, should the medical staff consider this appropriate, or to evaluate or modify the out-patient treatment plan. Any self-help in this capacity (e.g. attending Alcoholics Anonymous meetings) is also encouraged. Facilities for re-socialization occur through the social club. Contact with the surrounding community (for work, lodgings, etc.) is effected by the social worker and through the advisory committee.

The social club. Each Wednesday night the patients themselves organize a social event to which all patients, current in-patients as well as discharged patients, are invited. The social club has been successful since its inception; wives accompany patients, and a doctor attends to enable anybody with a problem to mention it. The occupational therapist takes organizing responsibility; the elected committee arranges the film, card game, concert, dance, supper party, etc. for each week. The meeting of the club is regular, so that patients who find difficulty in participating in active group psychotherapy still have this less demanding means of contact with the hospital open to them. Lonely, friendless patients and their wives are enabled to resume social contacts which may have been in abeyance for years.

The hospital shop was started with the dual intention of enabling patients to buy necessities on the premises, and at the same time to give them opportunities for democratic conduct of their own affairs. Two patients are elected to run the shop, which is under the supervision of the occupational therapist.

The wives' group, on the understanding that wives are involved in their husbands' drinking pattern, has given treatment to a selected number of wives. (The weekly open meeting provides another opportunity for treatment of relatives.) A wife expressing anxiety (either through her husband, or directly to a psychiatrist or the social worker) is invited to see the psychiatrist in charge of the wives' group. It is emphasized that the group functions intensively, and that it is not intended for casual members. Seventeen wives joined the group during the course of the year, and 12 attended for more than 4 sessions. An average of 10 attended at each meeting. Although the husbands' drinking problems featured prominently in the group discussions, the wives soon expressed the recognition that they were getting direct help with their own emotional difficulties. Each member was bringing to the group her own personal problems in her marriage to an alcoholic, and difficulties in the upbringing of her children. All the wives attending regularly over a period of months experienced personality changes within themselves which they said contributed to their families' happiness. This was particularly marked in a woman whose husband did not respond to treatment.

> Mr. B., despite 2 admissions to the hospital, continued drinking. But Mrs. B.'s attendance at the wives' group enabled her to remain relatively calm through the successive domestic crises, and to protect her children from the accompanying strains. She could say 3 months ago that although her husband had not changed beyond getting a job, the family life had become reasonably happy, whereas previously they had all been miserable. Now that it is clear her husband will not keep a job and cannot control his addiction, she has competently arranged lodgings for herself and the children, has kept working, and has left him.

The weekly open meeting. A psychiatrist conducts a meeting on Thursday nights for alcoholic patients, their wives and any other relatives interested in obtaining information about alcoholism. Wives attend who have not yet succeeded in persuading their husbands to attend for treatment, in the meantime obtaining advice and also support in the domestic difficulties with which they are met. Some ex-in-patients, not able to cooperate in intensive group psychotherapy, attend this meeting.

Out-patient Follow-up Treatment

The most important part of the treatment is that occurring after discharge, when the patient is resuming his work and family responsibilities and is learning to conduct his affairs without recourse to alcohol.

Out-patient treatment consists of intensive psychotherapy in small closed groups. Groups consist of about 10 members and meet for 1½ hours weekly. The first group, now nearly a year old, has met for 50 sessions. Four out-patient groups are now in progress.

Some patients on discharge decided they have had enough help and attempt to manage on their own. Others drop out of their group after attending for a variable time, fail to reply to inquiring letters, and may be assumed to be drinking again. Sometimes such patients decide after months that they must take further steps for treatment, and either present at the hospital (when they may or may not be re-admitted) or alse re-attend the group to which they had been allocated. Twenty-eight of the 180 patients (15·6%) have been re-admitted. Antabuse tablets may be obtained from the hospital at the time of out-patient attendance.

RESULTS OF TREATMENT DURING THE FIRST YEAR

Personality Change

Modification in drinking habits is the primary goal of treatment, but the psychiatric treatment techniques used (chiefly group psychotherapy and milieu therapy) also aim at aiding the patient to change his personality patterns. The social adjustment of the patient is as much a matter for treatment as his alcohol addiction. His personal relationships are examined, and his problems in living with other people are explored. Successful treatment should lead to improved social adjustment.

Very marked changes have occurred in a number of patients. This type of psychiatric information, however, cannot be communicated statistically but only by description of individual patients. One patient, for instance, has lost his stammer in the hospital; an aggressive policeman has become a contented man who enjoys being helpful to others in his work; a senior psychiatric nurse has transferred to his own work the treatment methods which at the hospital led to his own improvement; an isolated, bitter woman has married; and so on. It is these changes in personal adjustment of individual patients which are most interesting to work for and observe when they occur, and which, of course, provide the treatment staff with incentive and satisfaction.

Change in Drinking Pattern

A follow-up study of all patients admitted up to 20 March 1960 has been made:

Total admissions during year ..	180
Re-admissions	28 (15·6%)
In direct contact	105 (58·3%)
In indirect contact	32 (17·8%)
Out of contact	38 (21·1%)
Deaths	5 (2·9%)

Direct contact implies that the patient himself had come for treatment or attended some hospital activity (e.g. social club) so that he was seen personally for checking on his present status. *Indirect contact* implies that a relative or close associate in immediate touch with the patient reported on his status. It will be seen that the hospital has lost all contact with only one-fifth of the patients admitted.

Eighteen of the patients (10%) were female.

Deaths. Five patients included in the above 180 have died during the time under review. One, in out-patient treatment and sober, died in a motor accident. Another, drinking status unknown, died of diabetes. A patient out of contact with the hospital (drinking unknown) died of cerebral haemorrhage; another, drinking status improved, of coronary thrombosis; and one patient, drinking status unknown, of cardiac failure.

Four categories of treatment-outcome have been used in clinical assessment: sober, improved, unchanged, not known.

Sober	87 (48·3%)
Improved	26 (14·4%)
Unchanged	39 (21·7%)
Not known	23 (12·8%)
Deaths	5 (2·9%)

Patients therefore known to have benefited from treatment during the course of a year number 62·7%. Only continued follow-up study will show how many maintain their improvement and for how long.

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REFERENCES

1. Shannon, F. P. (1953): Publ. Hlth News (Trenton N.J.), **34**, 157.
2. Franco, C. S. (1957): N.Y. J. Med., **57**, 3510.
3. Keller, M. and Efron, V. (1955): Quart. J. Stud. Alcohol, **16**, 619.
4. Rado, S. (1933): Psychoanal. Quart., **2**, 1.
5. Moorhead, H. H. (1958): Bull. N.Y. Acad. Med., **34**, 99.
6. Pfeffer, A.z. *et al.* (1956): J. Amer. Med. Assoc., **161**, 827.
7. Jones, M. (1956): Amer. J. Psychiat., **112**, 647.
8. Gliedman, L. H., ed. Hoch, P. H. and Zubin, J. (1958): *Problems of Addiction and Habituation.* New York: Grune & Stratton.
9. Jacobsen, E. and Martensen-Larsen, O. (1949): J. Amer. Med. Assoc., **139**, 918.