ALCOHOLISM — PSYCHOLOGICAL AND PHARMACOLOGICAL ASPECTS OF THERAPY

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Consideration of therapy in alcoholism at once raises a number of questions, for instance, is alcoholism a condition which lends itself to therapy? Is it in fact an illness? Is it a unitary condition, or does the term 'alcoholism' mask a number of different conditions? Should it be regarded as primarily a social disorder or is it a disorder of the individual? Where does therapy begin: through pressures from without or by an inner awakening? These and other questions spring to mind as we survey the ground around the problem of alcoholism, while each interrogative leads to a further one.

Is Alcoholism an Illness?

The first question to be answered is the one which attempts to place alcoholism into its medical perspective: is alcoholism an illness? The Oxford Dictionary's definition of 'illness' is not very helpful, because it implies that the condition of being ill is a bodily state. This is certainly a limitation of the term, to which most medical practitioners will object since they have no difficulty in envisaging mental illness. If the term 'illness' is accepted as representing that condition of bodily or mental deterioration out of which an individual, despite apparent freedom of action, is unable to extricate himself, then there can be no doubt that alcoholism is an illness. This definition implies that the condition is one of deterioration from some more normal state, and it raises no hint of moral responsibility. The alcoholic is subject to both mental and physical deterioration, but despite his efforts he is unable to rid himself of his affliction. The question of whether or not he seriously wishes to get well is not raised within this definition. The alcoholic *apparently* can rid himself of the immediate cause of his illness, alcohol, and yet he virtually never does so.

Accepting alcoholism as a disease does not mean that it is considered to be a single unitary entity stemming from unitary causes. As Tiebout[5] has pointed out, alcoholism is a symptom which has taken on the significance of a disease, and even though one may be aware of all the multiform factors that lead to alcoholism, there is still something to be said for continuing to regard it, in practice, as a fairly homogeneous disorder. A purist might demand that each of the contributory factors be treated while ignoring the major clinical problem, but this would be as logical as an insistence that a patient with lung cancer should give up smoking while ignoring the malignant condition.

Therapy of the disease called alcoholism must begin on two separate but not unconnected fronts — social education concerning the whole problem of alcoholism, and the enlightenment of the sufferer so that he can regard himself as someone in need of medical help. The initial stress is to help the alcoholic into admitting that he is an alcoholic. Without this apparently simple, but in fact tortuously difficult, admission there is really no possibility of help, and all the vehement promises of 'cutting it down' and 'cutting it out' are meaningless. Secondly, the subject's motivation to get well must be used as one of the mainsprings of any therapeutic machinations, since therapy without motivation is an impossibility. These two primal processes of admission of illness and of desire to recover are conjoined implicitly into what Alcoholics Anonymous call their First Step, which reads: 'We admit that we are powerless over alcohol and that our lives have become unmanageable'. It is the duty of every doctor to help the alcoholic to make this simple admission long before the stage known as 'rock bottom' is reached.

Every physician has his own individual approach to any illness, and any attempt to force too great a conformity into the therapeutic situation must be harmful, in that it

removes the vitality from the patient-doctor relationship, forcing it to be rigid just where it should be flexible.

Remarks on Treatment

The following remarks on treatment are set down as suggestions; they represent my own, personal approach.

Probably the first difficulty the physician has to face is the necessity for resolving his own ambivalency towards alcoholism. It is only too easy to stress the awkwardness of the alcoholic, his unreliability, his disinclination to pay for medical expenses, his dependence on others, and his failure to see his problems in reality terms, and, of course, his well-known inclination to call for help at the most awkward times and to demand it in polemics of the greatest urgency. If these factors are, however, not seen in their true setting — as reflections of problems inherent in alcoholism — then the physician will not get very much further in his efforts. He must disentangle himself from moral prejudices and from all suggestion of a holier-than-thou attitude, but on the other hand he must be prepared to call a spade a spade and remember that a drink is a drink and not a nightcap or an appetiser. He must insist on certain elementary principles which clear away any doubt as to the seriousness of the condition. There can be no question of tapering off the consumption of alcohol or of limiting it to relatively mild drinks such as beer or light wines. An alcoholic is an alcoholic and virtually can never drink alcohol again. The almost negligible number of alcoholics who do manage to return to controlled drinking are the exceptions who prove the rule.[2] The objections to abstinence, such as insomnia, loss of appetite, tension, nervousness and social ostracism must be dealt with sympathetically but thoroughly, and the patient must be helped to see and understand his own reluctance to give up drink. Equally important is the ability of the physician to refrain from showing too critical an attitude towards 'slips'; at the same time, however, he must not condone them, but use them as an experience to help the patient to avoid future repetitions. Nothing helps so much in establishing a rapport with the patient as a good understanding of the language of alcoholics and an easy familiarity with terms such as bender, binge, blackout, and so on.

No physician is able to help his patient with a purely permissive attitude to drinking — he must help him to see what alcoholism means in terms of illness, and talk to him about the techniques of avoiding having to drink. There are dozens of ways of saying 'no', but the alcoholic must be ready to fit his denial into all kinds of settings. He will have to deal with situations that include the friendly invitation to 'just have one to be sociable', and also the indignant 'so you won't drink with me' and the 'you simply must try my home-made cherry brandy'.

As contact grows between physician and patient the underlying psychodynamics of the particular alcoholic problem will begin to be manifest, and the patient will be helped to see the pattern of his behaviour in terms which are no longer entirely overt. There is no typical alcoholic personality, but certain traits are commoner than others. Knight[3] described the over-indulgent, over-protective mother and the authoritarian but inconsistent father as being typical of the alcoholic family constellation, but rejecting mothers are found almost as frequently. Certainly the family background often contributes to the sense of alienation common among alcoholics, which leads them to regard people, situations and even occupations as being hostile and threatening. In this inimical atmosphere the alcoholic uses alcohol to dissolve reality into fantasy and to acquire omnipotence in a world that does not exist — with alcohol the infantile and unresolved love-hate ambivalencies vanish; pain and frustration are dulled; time is blurred, and pressures abate. Against the absurdity of the situation and the failure to face up to facts the alcoholic has always the blissful certainty of self-abasement and the destruction of all that is valuable to him.

Vogel[6] examined the introversion - extroversion polarities in alcoholism and, while making it clear that she did not necessarily imply a fixed typology of introverts and extroverts, found that 'introversion' was associated with a steady-drinking pattern, solitary drinking, and a later onset of frequent blackouts; and that 'extroversion' was found with periodic drinking bouts in the company of others, with an earlier onset of frequent blackouts. If this work proves to be valid it may be useful in determining which type of alcoholic is more likely to benefit from aversion therapy.

Many alcoholics adopt a formula whereby they use alcohol to deal with certain physical symptoms and demand that attention be paid to these symptoms so as to exonerate themselves in the taking of alcohol.[1] This is a type of 'double think' in which the alcoholic defends his ego from the label of weakness or failure, but it may prove a therapeutic asset since the physician can attend to physical symptoms while preparing the way for deeper psychotherapeutic approaches.

Pharmacological Aspects

The drug treatment of alcoholism is described fully elsewhere in this issue of the *Journal*. Here only a few general remarks need be made.

Depression, tension and anxiety are frequently found singly or in combination in alcoholics during the period of withdrawal. For the depression one of the monoamine oxidase inhibitors or imipramine may be used. For tension 'librium', often in doses of 20 mg. three times a day, may be used. Meprobamate is also useful and relatively free from toxic side-effects. For agitated anxiety states, one of the phenothiazine derivatives such as chlorpromazine or 'melleril' in relatively high doses should be given. Insomnia haunts many alcoholics, but as a rule it is best to avoid barbiturates since they may at times result in increasing excitement. One of the non-barbiturates such as 'doriden' or 'noludar' is usually quite adequate, especially if given together with 'largactil'. Supportive treatment with vitamins, particularly thiamine, may be important. There is some indication that pyridoxine is useful in those who have 'rum fits', i.e. fits coming on 36 - 72 hours after stopping alcohol.

It must be clear in the therapist's mind that pharmacological treatment of this type is symptomatic, but nevertheless useful in making the patient more amenable to psychotherapy. Pharmacology should never be allowed to become an end in itself or it will prove to be a block to the development of insights, and it may indeed simply replace alcohol in a kind of substitution exchange.

For the treatment of the acute 'drying out' period, once again simplicity of methods should be aimed at. My personal opinion is that complete withdrawal of alcohol makes the handling of cases infinitely easier than 'tapering'. There is little evidence that tapering reduces the onset of delirium tremens and much to show that it confuses the picture further and lengthens the time taken before the patient becomes mentally clear. The drug treatment of the acute phase and aversion treatment once the acute phase is over, are discussed on page 788 of this issue of the *Journal*.

Psychotherapy

Psychotherapeutic procedures in the treatment of alcoholism may be considered under several headings: individual therapy, group therapy, rehabilitative measures, and social strategies. For those who are quite unable to cooperate in a therapeutic programme, i.e. psychotics and seriously brain-damaged alcoholics, some kind of institutional control may be necessary.

It may be said that in general individual therapy is disappointing, and without full cooperation of the relatives it is worthless. Alcohol is always a social problem and the process of reintegration is more easily carried out in the dynamic atmosphere of a group than by individual contact. Two types of groups may be distinguished: the open group, whose members are frequently changing, and the closed group, whose membership, as the name implies, is more or less fixed over a long period of time.

The open group is of necessity run at a relatively superficial level, but it may nevertheless be a source of most useful acting-out, and to many alcoholics may provide the first opportunity of social cohesion and of acceptance of their own problem. Alcoholics Anonymous is an example of a nondirected, permissive group whose value needs no underlining; but groups attached to hospitals and clinics provide their members with an interaction which emphasizes the exploratory and epistemological approaches rather than the evangelical and revelationary reactions found in the AA groups. The only subjects unsuitable for group therapy are those who are severely brain-damaged, psychotics, or overtly sexually deviant. Sexually deviant subjects are often disruptive to the group and are unable to communicate adequately within the group, but there are exceptions, and no homosexual person should be excluded simply on the grounds of his sexual malalignment.

The closed group offers a deeper identification and participation than does the open one. The group becomes a miniature cosmos and, through it, hostilities and conflicts may be acted out, behaviour patterns revealed and comprehended, and interpersonal relationships widened; and through communication the barren sense of alienation can be broken down. Group therapy is not an easy way out of difficulties; no change can be completely painless and group sessions go through changes that can be painful, humiliating and exasperating, but in the end the members develop gradually an awareness of the meaning of reality and of the immensity of the problems of life — facts which they had never faced up to before.

Alcoholism is a disorder of living, and no therapy, whether it be individual or group therapy, acts as a panacea. There is no such thing as a 'cure' for alcoholism, but there are many techniques that are used in helping alcoholics to understand their problems, to re-learn ways of dealing with inattentions and external stresses and of moving towards a fuller self-integration and social adaptation. It is up to those who wish to help in the problem of alcoholism to learn as much as they can of these techniques and to help in this grave and extensive problem. Alcoholics are not the only group of misfits who need help, but they constitute a group who destroy themselves and bring a great deal of unnecessary suffering on those around them. After a period of therapeutic nihilism and hopelessness we are now entering a phase in which we are learning to understand and to some extent to help the alcoholic. Much has been written about the ambivalency of the alcoholic and of his immaturity and psychic obtuseness. These are phrases which could very well be applied to any group. The alcoholic needs help. Emotional barriers have prevented him from obtaining help, but the emotions are present both on his side and on the part of non-alcoholics, and it is the duty of the medical profession to do a great deal more than it has done in the past towards helping those who have become submerged in a situation in which they are largely helpless.

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