THE MULTI-DISCIPLINED APPROACH TO ALCOHOLISM AS PRACTISED IN A SANCA CLINIC

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In 1957 the Rotarians of Pretoria renovated and equipped Castle Carey premises, after which the clinic was handed over to the Pretoria Society on Alcoholism. The maximum number of beds at that time was 12, but the demand for treatment necessitated continual expansion and at present the Clinic at its maximum capacity has 25 beds available. In 1962 it was decided to reserve 7 beds for female alcoholics.

At this clinic an alcoholic patient is defined simply as one who has lost control of his drinking. Loss of control denotes that once he has started to drink, he is unable to stop. This loss of ability to stop drinking may be as insidious as a student getting drunk in spite of himself, or as unconcealed as the party-goer who drinks everything in sight within the first hour, even though he started with the idea of only having 3 drinks.

TREATMENT OF THE ALCOHOLIC

The objects in the treatment of an alcoholic patient coming to the clinic during or at the end of a drinking bout, are as follows:

(*a*) To get the patient sober as painlessly as possible.
(*b*) To attempt to make the patient recognize that alcohol has brought him to the clinic. He must be made aware that one drink is all that stands between a good productive life and repeated returns to the clinic, or worse.

In order to accomplish these objects, it is of paramount importance that the patient be in the best possible condition, physically and mentally, as soon as possible. Institutionalization seems the best way to attain these ends. Although some patients may be treated on an outpatient basis, most need a period of insulation in a place where the next drink—which has become so important as to exclude everything in life—cannot be obtained.

We are continually confronted with 2 problems in the treatment of the alcoholic: (1) acceptance of diagnosis, and (2) persuading him to accept treatment.

Unless these 2 ends are reached, or least approached, the results with any type of treatment are doomed to be something less than dramatic.

1. *Acceptance of Diagnosis*

One factor in making the idea so unacceptable, is the loss of self-esteem the patient suffers if he agrees and then continues to drink. As long as he denies the illness, he ostensibly preserves his status as a non-alcoholic and has no real reason to abstain.

It may be difficult to understand how the patient can continue to regard himself as a non-alcoholic in view of his drinking behaviour, but this paradox is resolved by his definition of an alcoholic which always excludes himself. The exclusion is comfortably accomplished by taking some one facet of the problem which he lacks as essential to the diagnosis. For example the patient who habitually drinks in bars says: 'I never drink alone'. The alcoholic who drinks alone says: 'I never drink in the morning'. Perhaps one of the most widely used rationalizations is: 'I only drink beer, and never touch the hard stuff, therefore I am not an alcoholic'.

Another factor in the reluctance to accept the diagnosis is that, being a member of the responsive public, the alcoholic shares the general derogatory view of the diagnosis, and for most of his drinking career refuses to apply it to himself. The suggestion to a patient who has recovered from a severe bout of delirium that he talk to a member of Alcoholics Anonymous, will often bring the reply that he wants nothing to do with a 'bunch of drunks'.

2. *Acceptance of Treatment*

Obviously if the patient denies the diagnosis there is no internal reason for accepting treatment. Although he may reluctantly agree to be treated under pressure by his wife or employer, it can be anticipated that when these external forces abate, so will the patient's interest in treatment.

It is important to consider what treatment means to the alcoholic as compared with medical treatment in general. In most illnesses, treatment implies relief, and the more effective the treatment the more prolonged the relief. The alcoholic however may view treatment as a deprivation which he fears he may be unable to endure. It may mean the loss of the very glue with which he is stuck together. Effective treatment implies the permanent loss of the substance which to most alcoholics is apparently life's most precious offering. Many such patients will give up wife, family, friends and job before they will seriously consider giving up alcohol.

PROGNOSIS

Do alcoholics ever get well? If so, which among them stand the best chances? An answer is not possible without defining the term 'recovery' in the context of alcoholism. The latter is a chronic, relapsing disease and cure, in the sense of a regained ability to drink socially, is almost unknown. Having passed into the stage of compulsive drinking, the alcoholic must abstain totally for the rest of his life.

We have found that no 2 alcoholics are alike, but they can be broadly divided into 4 recognizable types.

1. *The Alcoholic with a Good Previous Personality*

This is the so-called normal alcoholic with no deep-seated personality maladjustments. This group represents approximately 60 - 70% of the alcoholics who submit themselves for treatment, and have the best prognosis. About 80% make a

successful recovery and remain totally abstinent for periods of 1 year or longer.

This type of alcoholic is usually an intelligent, educated and comparatively successful person in the age-group 35 - 55. The manifestation period (the period extending from social to compulsive drinking) averages 16 - 18 years, but may be longer. They readily admit their disability and are genuine in their wish to recover.

Having commenced drinking they have gradually changed over the years from occasional or social drinkers into regular drinkers, then into heavy drinkers and finally into compulsive drinkers. Quite often, at this stage, psychological and personality disintegration occurs. Readjustment in the majority of cases in this group can often be attained after the patient has ceased drinking.

2. *The Alcoholic with a Neurotic Personality*

In this group the neurosis has preceded the advent of alcoholism. In our experience the prognosis is moderate to poor. Approximately 30% recover, but are prone to frequent relapses before stabilization is finally achieved. Excessive drinking in early adult life is commonly found in the neurotic, and the manifestation period in this group is shorter. Some become alcoholics within 10 years of the commencement of drinking. The psychiatrist or psychologist can play an important role in the readjustment of the neurotic alcoholic.

3. *The Alcoholic with a Psychotic Personality*

The prognosis in this group depends entirely on the treatment of the psychosis. These are not true alcoholics and must be referred to a psychiatrist. They represent a very small percentage of our alcoholic population.

4. *The Alcoholic with a Psychopathic Personality*

The prognosis in this group is extremely poor. This type of patient has a superficial charm, is of more than average intelligence, but prone to unreliability, pathological lying and insincerity. He lacks any sense of remorse and never profits by experience.

Apart from the prognostic value of basic personality assessment, other factors must be taken into consideration. The prognosis, other factors being equal, is good when the patient has a family and job waiting after his discharge. An alcoholic separated or divorced, or a lonely bachelor, finds it more difficult to maintain sobriety. An alcoholic actively seeking help has a better prognosis than one who is more or less forced into having treatment.

APPROACH TO PATIENT

The Castle Carey Clinic is operated by a four-pronged approach.

1. *Information Office*

The superintendent or his assistant interviews relatives, employers or friends, in addition to alcoholics presenting themselves voluntarily. It is at this stage that the concept of alcoholism as a disease entity is outlined to these interested parties.

2. *Inpatient Treatment*

After clinical examination, the patient is admitted to an intake-ward and deeply sedated for 48 hours. For this purpose the following preparations have been found to be the most efficacious:

Paraldehyde. Large doses are often necessary, e.g. 4 drams by mouth. This is often combined with one of the following preparations: (*a*) 2-chlor-9-(3-dimethylaminopropyliden)-thioxanthen ('truxal'), 50 mg., by intramuscular injection, or (*b*) perphenazine ('trilafon'), 5 mg., by intramuscular injection.

Several authorities in the field of alcoholism disapprove of paraldehyde, maintaining that it prolongs the withdrawal period and causes addiction. We have not found this to be the case in the vast majority of our patients.

'Tapering off' with alcohol is not advisable, since the patient must reconcile himself to the idea that alcohol must never be taken again.

It is usually during this period, or shortly afterwards, that withdrawal symptoms may be manifested, especially after a drinking bout of long duration. Extreme psychomotor agitation or delirium tremens may be both distressing and dangerous, and we have found the drug of choice to be chlordiazepoxide ('librium'), 100 mg. intramuscularly, repeated for a further 2 doses at hourly intervals, if necessary. Epanutin, gr. 1½ *t.d.s.*, is given if there are any signs of seizures.

After the initial 48 hours of deep sedation the patient is allowed to 'surface' and moved into a general ward. He is given a high-protein diet supplemented by vitamins by mouth, and tranquillizers have great value at this stage in relieving tension or anxiety. The following have been found of great value for this purpose: Meprobamates, chlordiazepoxide and promazine.

Barbiturates are seldom given in view of the danger of addiction. During this period, insomnia is often troublesome. Triclofos ('tricloryl') is a valuable hypnotic. By the time the patient is discharged on the 15th day, medication in the form of tranquillizers has been stopped.

3. *Outpatients Department*

This exists for 3 types of individuals:

(*a*) Alcoholics who do not require admission as inpatients.

(*b*) All inpatients from the Pretoria area are required to follow-up their initial treatment by a further 15 days as an outpatient. The treatment consists of the intramuscular administration of high-dosage Vit. B. Co. and the occasional exhibition of a tranquillizer. We have found chemotherapy of little value. 'Antabuse' is only given to a well-motivated alcoholic who requests it.

(*c*) The 'dry drunk'. This is a term used by Alcoholics Anonymous for members who achieve sobriety but who on occasions are restless and without peace of mind. Clinically, one or more of the following symptoms are experienced during the 'dry period' preceding a bout: irritability, restlessness, depression, and insomnia. Its recognition and treatment often helps to ward off a drinking bout. Patients are warned of these significant symptoms and advised to attend the outpatient department if and when they occur. Chlordiazepoxide has proved to be the drug of choice during these periodic manifestations.

4. *Individual and Group Therapy*

(a) *Group discussion classes.* Each morning the patients attend a group class where suitable tape recordings are played, followed by a discussion on various aspects of alcoholism. We have a wide variety of such tapes which precede animated opinions and discussions.

Bi-weekly evening sessions consisting of a course of lectures attended by in- and outpatients with their relatives and friends are conducted by the superintendent or his assistant. It is of paramount importance to integrate the family of the alcoholic, especially the spouse or mother, into the broad therapeutic plan. The family must be given the same insight into the problem of alcoholism as the patient. It has been stated by J. D. Frank that no man is an island, and the degree and permanence of change in any individual will depend in part on corresponding changes in those close to him and on support from the wider milieu.

(b) *Individual psychotherapy*. Being without the aid of a psychiatrist or psychologist, a 'home-spun' type of psychotherapy has been evolved, which has proved to be extremely useful in the handling of alcoholics. We have found that the large majority of alcoholics are not good candidates for intensive psychotherapy and respond better to the more supportive type. If, however, a deep-seated psychoneurosis or psychosis is suspected, such patients are referred to the Mental Health Society for further investigation.

At this point, a word must be said for the fellowship of Alcoholics Anonymous, whose assistance has proved most invaluable. Its members have become associated with 2 very favourable views in the public mind. Firstly, they are making a sincere effort to maintain sobriety, and secondly, they are helping others with similar problems to their own. These ideas are so firmly implanted in the minds of many, that an active member of Alcoholics Anonymous may no longer be considered an alcoholic but an A.A.

The gradual realization by families, employers and the

public at large, that an alcoholic is a sick man and worthy of saving, is reflected by the steady increase in the number of inpatients treated at the Castle Carey Clinic (Table I).

TABLE I. NUMBER OF PATIENTS TREATED

	Men	*Women*	*Total*	*Duration of treatment in days*
1958	245	—	245	7–10
1959	196	—	196	10
1960	219	—	219	10–14
1961	271	—	271	10–14
April 1962–March 1963	279	54	333	10–14
April 1963–March 1964	326	72	398	15
Total:	1,536	126	1,662	

As we look forward to future planning for the clinic, serious thought must be given to providing new premises. The present building which has served well these 7 years is rapidly coming to the end of its useful life and earnest consideration must be given to a new building for the clinic which has become a symbol of hope and help for so many alcoholic patients throughout the Republic.

It is a pleasure to pay tribute to the Superintendent, Mr. A. J. Pienaar, upon whose shoulders have rested for so long the responsibility for the growth of Castle Carey; the nursing and other members of the Clinic who have so willingly co-operated in achieving the aims of SANCA; and the numerous ex-patients who have proved that success can be attained.

REFERENCE

Kiessen, M. D. (1961): Quart. J. Stud. Alcohol, November.