TOWARDS UNDERSTANDING THE ALCOHOLIC

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The Alcoholic, Distinct from Other Problem Drinkers

The large group of problem drinkers can be subdivided into a number of subgroups of which the main ones are: the heavy drinkers—who use alcohol excessively but rarely get drunk, are not addicted to alcohol, and do not develop physical pathology; the drunkards—who are also not addicted to alcohol and do not develop physical illness, but usually drink until they are drunk; the 'hobos'—an excessive form of drunkards; the alcohol-addicts—who do not like to be drunk but cannot feel happy without alcohol, and do not develop physical illness as a result of taking alcohol; and finally the alcoholics—they are the only group that develops physical pathology owing to the consumption of alcohol, e.g. cirrhosis of the liver, pancreas deficiency, cerebral atrophy, delirium tremens, etc. This pathology, called alcoholism, is recognized by the various physical symptoms it produces, such as tremors, disturbances of coordination, memory blackouts, disturbances of cerebration, disturbances of liver function, etc., and is caused by a changed reaction of the tissues to alcohol. Partly owing to the disturbed cerebral function, and partly as a result of the interaction with his environment, the alcoholic also develops behaviour disturbances.

Differences in Various Countries

Whereas the physical symptoms of alcoholism remain virtually the same in every country, the behaviour disturbances vary greatly from country to country, as they are determined by the environment and influenced by the educational, social and spiritual standards prevailing and the drinking patterns of the specific society.

Thus in France, for instance, an alcoholic will not perhaps distinguish himself in his behaviour from his fellow countrymen, but will only be recognized by the gradual and progressive development of physical symptoms such as liver failure, whereas in South Africa the behavioural disturbances will be far more prominent and eye-catching than the physical symptoms. In this paper only the South African behaviour patterns will be discussed.

ADDICTION

Whether all pre-alcoholic personalities are abnormal, is a debatable point; just as debatable as whether all pre-depressive personalities are abnormal. Experience shows that all types of people can become alcoholic and also from all strata of society. Thus alcoholism is known to occur in mentally retarded persons, in neurotics, in psychopathic personalities, and also in 'normal people'. Most alcoholics will have some minor personality aberration before they develop alcoholism, although I have seen alcoholism—with enlarged liver, tremors and personality change—in well-adjusted individuals who have never been drunk but have partaken of regular sundowners in moderation. I will not discuss the symptoms as they present in the markedly abnormal pre-alcoholic personalities, but will confine myself to the larger group of moderately psychologically disturbed personalities.

Addiction to the effects of alcohol seems to play a part in all alcoholics, but the degree of addiction can vary from very mild—not stronger than the 'normal' addiction of people to tea, cigarettes, hunting, motoring, etc.—to addiction as strong as we know it in morphine addicts. However, every alcoholic is also subject to a secondary addiction which only develops if he starts drinking. The first drink creates a craving for more, stronger than any craving he had before, and this is progressive with his alcohol intake. As this did not occur in him before he became alcoholic, and as it only starts with the first drink, it is feasible to ascribe this to the changed tissue response which characterizes the alcoholic. It may be compared to the compulsion to go on drinking sea-water which overtakes the thirsty man on a dinghy in the ocean once he relieves his thirst by drinking from the sea.

PSYCHOLOGICAL SYMPTOMS

Disturbance of Cerebral Function

The changed tissue reaction to alcohol and the damage this does to the nervous system produces symptoms of psychological behaviour which often border on the psychotic. Thus we find unwarranted aggressiveness, irresponsibility, an unrealistic approach to life, emotional outbursts, reversals in emotional attachments and reversals in spiritual and social values, etc. These symptoms arise during a drinking bout and usually persist for days, sometimes weeks, after the last drink has been taken. These symptoms, caused by the toxic encephalopathy, make it necessary for the alcoholic to be admitted to a clinic, and the encephalopathy has to be cured before the cooperation of the alcoholic in his cure can be achieved.

Secondary Psychological Symptoms

The secondary addiction to alcohol and the disturbance of cerebral function (other than drunkenness), present the alcoholic with his biggest problem. He cannot understand either, as he is not aware of his altered physical reaction to alcohol and the poisonous effect this has on him. He is only aware of the fact that, no matter how hard he tries, he cannot control the amount of alcohol he consumes, and he is aware that he behaves in a way foreign to himself and unacceptable to his environment. He is also aware of the progressive resentment and rejection by his environment. He looks for an explanation and is faced by the choice of either discrediting himself or blaming society. For years he has not been the man who would do the things he now does, making it difficult for him to choose the former. The rejection he feels from society makes him favour the second choice, namely, to blame them. He attacks, blames and rejects not only society, but also the values he has learned from them and in which he previously believed. He loses faith in mankind, in God, in right and wrong and eventually withdraws to a position of isolation and selfrighteousness. With this, he forfeits the satisfaction of many of his needs, becomes disgruntled and has to find substitutes or relief, usually in the form of alcohol. He

cannot escape the progressive physical destruction however, and the fact that he has lost control over his drinking. Through this, his selfrighteousness collapses and he is forced to look for help.

REHABILITATION

In the process of his disease the alcoholic has lost virtually everything he had built up before. Like everyone else he had chosen a course in life by which he hoped to satisfy his daily needs as well as his ambitions. For this he needed skills, earning capacity, power over his environment—especially over people, through his charm, his respectability, his dignity, his reliability, etc. He needed confidence in himself, and he needed a course to follow through life which he found in his set of values and his faith. He also needed and developed defensive mechanisms to protect him from threat and attack. Most of this has been shattered by alcoholism and, in addition, he has lost his health. In order to live a full life again, he will have to recover these basic necessities of life, but he cannot hope to take over where he left off. He will need to build a new defensive system, new dignities, new values, find new confidence and faith and develop new skills. This is a Herculean task even for the unhandicapped person, if it has to be done alone. Many alcoholics never achieve this and remain stranded after the first step to recovery—giving up alcohol—has been achieved. They are forced to live a life of poverty as far as ego-satisfactions are concerned, giving up many ideals, ambitions, hopes and suppressing many desires. Their chance of relapse is great.

It is our duty, as doctors towards our patients and as a society towards its members, to help in this rehabilitation. For this we need a team: a doctor who can diagnose the disease, treat the acute intoxication, and assist in regaining lost health; a psychologist; a psychiatrist; a minister and a lay therapist—often an alcoholic who has found the road back—who together can help the person rebuild what he has lost and live a full life again.

Great progress has been made in the last decade towards achieving this ideal of total rehabilitation of the alcoholic. First of all we have learned to distinguish the alcoholic from the large group of problem drinkers, characterized as he is by his physical pathology. Secondly, we have come to appreciate that we are dealing with a fairly homogeneous group of sick people, with similar pathology, similar symptomatology, similar therapy and similar problems. We have found an answer to the question of their cure—they must never drink alcohol again. We have also found answers to many of their problems of psychological, social and spiritual rehabilitation. In the clinics of SANCA these answers are put to work, and new answers for the many open questions are sought. The outlook for these sick people is far more rosy than it was a number of years ago. Much, however, has still to be done. Follow-up and long-term psychotherapy are still very inadequate. Family counselling is still in its infancy, as is family rehabilitation. Public education and prevention of alcoholism are still wholly inadequate. Further research is urgently needed but greatly handicapped by inadequacy of statistics and confusion with other types of problem drinkers.

If there is one plea I would like to make to my colleagues, it is this: let us not confuse the alcoholic with the other problem drinkers. For them, as yet, we have no answer, no definite therapy, no specific symptomatology and no prognosis. Confusion arises if we diagnose the alcoholic on his behaviour pattern, his excessive drinking, his maladjustment, etc., rather than on the clinical manifestations of his disease.