ALCOHOLISM TREATMENT IN TRANSITION

Edited by
Griffith Edwards and Marcus Grant

ROUTLEDGE LIBRARY EDITIONS
ALCOHOL AND ALCOHOLISM

ROUTLEDGE

ROUTLEDGE LIBRARY EDITIONS:
ALCOHOL AND ALCOHOLISM

Volume 9

ALCOHOLISM TREATMENT IN TRANSITION

ALCOHOLISM TREATMENT IN TRANSITION

Edited by
GRIFFITH EDWARDS
AND
MARCUS GRANT

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published in 1980 by Croom Helm

This edition first published in 2024
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-1-032-59082-0 (Set)
ISBN: 978-1-032-61504-2 (Volume 9) (hbk)
ISBN: 978-1-032-61524-0 (Volume 9) (pbk)
ISBN: 978-1-032-61517-2 (Volume 9) (ebk)

DOI: 10.4324/9781032615172

Publisher's Note
The publisher has gone to great lengths to ensure the quality of this reprint but points out that some imperfections in the original copies may be apparent.

Disclaimer
The publisher has made every effort to trace copyright holders and would welcome correspondence from those they have been unable to trace.

ALCOHOLISM TREATMENT IN TRANSITION

Edited by
Griffith Edwards and Marcus Grant

CROOM HELM LONDON

Croom Helm Ltd, 2-10 St John's Road, London SW11

British Library Cataloguing in Publication Data

Alcoholism treatment in transition.
1. Alcoholism – Treatment – Congresses
I. Edwards, Griffith II. Grant, Marcus
III. Alcohol Education Centre IV. University
of London. *Addiction Research Unit*
616.8'61'06 RC565

ISBN 0-7099-0423-1

Typeset by Leaper & Gard Ltd, Bristol

Printed in Great Britain by
Biddles Ltd, Guildford, Surrey

CONTENTS

INTRODUCTION

The purpose of this book is to aid a process of re-thinking alcoholism treatment. Such a process is clearly underway in many parts of the world. A volume such as this can be useful in the modest role of abetting a re-thinking, while it would be far too ambitious for any book at present confidently to say, 'These are now the answers'. Anyone looking for closed and definitive pronouncements, anyone seeking a book which proclaims, 'This is now the way to treat alcoholism', had better quickly go elsewhere.

Alcoholism treatment is very definitely in transition, abandoning old certainties, searching for new syntheses – and that is the only position which we would definitely care to take. These chapters might at best be seen as similar to contributions to one of those seminar series where people feel safe enough to speak their minds and search horizons without striking postures, and where there is a spirit of criticism without nihilistic excess, and a true commitment to a search for understanding. At the end of such a series the participants can sometimes feel that movement and shape can be seen in what was previously a rather amorphous set of ideas. We would hope that those who read this book may enjoy such sense of participation in rewarding adventure.

The contents have been ordered in terms of a number of sections, and the first of these is entitled 'Transition as Challenge'. For any individual, institution, or clinical and scientific endeavour, the experience of transition can be good or bad, handled well or negatively and with fright. It can be characterised by a desperate hanging on to old positions, by a mad flight after new fancies, or it can be just a sort of falling to bits. How transition can be used creatively is the subject of these four chapters.

The second section deals with the question, 'Does Treatment Work?' It is here perhaps that the path between optimism and pessimism is most difficult honestly to steer. The question certainly has to be disarticulated into asking what works for whom, and when. And the third section therefore logically takes as its title 'Towards better questions'.

Whatever the treatment, there is also the treatment system. Study of this system ignores the real material if we are only willing to entertain the assumption that the system is a rationally determined 'health care

delivery system', an organisation man's disembodied dream. The organisation of alcoholism treatment is a social happening in its own right, subject to its own evolutionary forces. It is these questions which are here examined.

What though is treatment, and what are we actually treating? Anyone coming into this field from outside might be excused a sharp comment or two on what sometimes looks more like chronic muddle than transition. The debate on what we mean by the key word 'alcoholism' is never ending, but old models of understanding are breaking down and no longer serve us too well. The next section therefore deals with 'Models in Transition'.

The brief final section borrows as its title a phrase which Aubrey Lewis employed to describe the general state of enquiring minds – a state which he saw as being properly characterised as 'Between guesswork and certainty'. This chapter attempts to sum up what others have, as it were, contributed to the seminar.

One issue, not discussed elsewhere in this book, deserves some comment here. The process of re-thinking alcoholism treatment has profound implications for the way we educate and train those whom we expect to do the treating. Most education presumes a happy consensus from which enquiry can logically proceed. The challenge of a subject which is genuinely in transition is that no such consensus is apparent. The excitement is that education itself becomes the process of re-thinking.

There is more to this than giving extra work to the curriculum planners, asking them to develop courses which take account of the changing views of alcohol problems. It cannot be ignored, indeed it is stressed in several of the chapters in this book, that treatment is not a hermetic activity. There is far more to treatment than making sick people well again. A growing part of the treater's responsibility has to do with communicating relevant information to the public at large and in particular to those sections of the public known to be at higher risk. The re-thinking is, therefore, not the prerogative of the treaters. It becomes, through their efforts, part of a larger public debate, which they can stimulate and encourage. Health professionals involved in alcoholism treatment play a crucial role, for example, in the shift we are seeing towards a greater openness to social policy changes, to self-monitoring and to new, pragmatic approaches to treatment.

That openness needs to be reflected in an acceptance in pre- and post-qualification training that the re-thinking involves crossing some traditional boundaries between disciplines. What emerges from this

book, above all else, is the imperative need for all those involved in treating alcoholism to become actively and continually involved in developing the skills of themselves and their colleagues. At times of transition, more of us can afford to stand still and watch the patients pass by. Since transition is a process, so too training is best seen not as an end in itself, but as a movement, careful and adventurous, from the guesswork towards the certainty. Thus, education and training become an integral part of the process of re-thinking which this book is seeking to assist.

The general shape of this book was determined by contributions to a conference held at the Institute of Psychiatry in April 1979, jointly organised by the Alcohol Education Centre and the Institute of Psychiatry. Most of the original papers have been substantially revised and some additional material has been added. Generous financial backing was provided by the Department of Health and Social Security (UK), the Addiction Research Foundation (Toronto), the National Institute on Alcoholism and Alcohol Abuse (USA) and the World Health Organisation (Geneva). The planning of the meeting was jointly shared with those organisations and the Royal College of Psychiatrists (London), while the International Council on Alcohol and Addictions helped with publicity for the meeting. The original input of ideas was therefore very international and in particular invited an awareness of the need to make the connections between science, clinical care and governmental concerns.

We would particularly draw attention to the fact that this book contains a discussion of alcoholism treatment in the Third World (Chapter 12). That only one chapter deals directly with the problems of that large segment of the globe might be seen as insufficient, but that chapter at least stands as a reminder that the West does not hold the monopoly of problems, and insensitively exported Western solutions will increasingly be rejected as inept and unwanted. Neither should we indulge in the presumption that Europe and North America are for ever the innovators and teachers. A better world sharing of thinking on what are certainly shared problems, could provide an immensely beneficial corrective to insularity.

Acknowledgements

Our thanks are due to the various national and international organisations already named, and we would like personally to thank Dr Alan Sippert (DHSS), Dr Frederick Glaser (ARF), Dr Robin Murray (Royal College of Psychiatrists), Dr D.L. Davies (AEC) and Dr Lee Towle (NIAA) for a fund of ideas which lay behind the planning of the conference and hence the book.

On the organisational side we must particularly thank Miss Nina Little. Mrs Joyce Oliphant, Mrs Julia Polglaze and Miss Beryl Skinner skilfully undertook the secretarial work. Dr David Hirst kindly provided us with the index.

And finally we wish as editors to thank the contributors to this book who have shown such patience and good nature, and who have, we believe, responded magnificently to the challenge we set them.

Griffith Edwards
Marcus Grant

Part One

TRANSITION AS CHALLENGE

1 THE DOCTOR'S DILEMMA

George E. Vaillant

Introduction

For anyone who both treats alcoholism and engages in related research, there exists a dilemma. Much of the evidence is not there to support his treatment. Confidently to persist, is he a fool, or a knave or a sensible man? How can he retain open-mindedness without losing the confidence to deal with the next patient who is certainly expecting his help? This chapter represents an effort to resolve that dilemma.

Thomas Szasz[1] would have us believe that alcoholism, like the dilemma, is a mythical beast. Unfortunately, sometimes mythical beasts are endowed with real horns. One horn of the dilemma is that Szasz, Al-Anon and the best follow-up research instructs would-be care-givers that they are powerless over alcoholism. To try too hard to *cure* an alcoholic is to break one's heart and follow-up studies suggest that elaborate treatments may be no better than brief sensible advice.[2] The other horn of the dilemma is the fact that to ignore a chronic malady as painful to the individual, as damaging to his health, as destructive to the family and as refractory to will power, to motivation and to common sense as alcoholism – for doctors to ignore such a malady – is unconscionable. What are we to do?

My own knowledge of this dilemma began ten years ago. I was asked by the relatives of an alcoholic friend for help. The friend, aged 55, was quietly drinking himself to death. He had exhausted the patience of probably the wisest family doctor in Boston; he had frustrated the staff at perhaps Boston's finest teaching hospital; and he had managed to spend several weeks in an excellent Boston psychiatric hospital as a 'bipolar depression' without noticeable improvement. His relatives pointed out that I was considered knowledgeable about addictions. What or whom could I suggest? I called a few very senior colleagues and then reported back that no one on the faculty of my medical school was expert in the treatment of alcoholism and that, as best I knew, modern medicine had little to offer.

The Cambridge-Somerville (CASPAR) Programme

Shortly afterwards, as part of the trend in both America and England to acknowledge the enormity of the alcohol problem, a comprehensive alcohol treatment programme began at the Cambridge-Somerville Mental Health Center. Since Cambridge and her sister city, Somerville, contained an estimated 20,000 alcoholics, the decision was made to redeploy present services so as to offer much less intensive help to many more people. Thus, the single staff member who, by appointment, used to offer therapy and counsel to these 20,000 souls was replaced by a much better staffed walk-in clinic. Caught up in the historical moment and because Boston and Harvard had been found wanting, my friend turned to this public clinic. He found hopeful paraprofessionals who were willing to meet him where he was, who discussed alcoholism *as if* it were a disease – neither a psychological symptom nor some vague unnamed problem waiting to be understood. The clinic staff invited him to groups that they led, in order to discuss his problem with other alcoholics. In part, these groups were designed as stepping stones between a walk-in clinic in a municipal hospital and eventual use of the cheaper, more accessible resources of Alcoholics Anonymous (AA). But my friend had often previously pointed out that for him Alcoholics Anonymous was not a viable alternative. He was no joiner; he rarely went to church; he was an artist; and he was much too sophisticated, both socially and intellectually, to get involved. After two years of clinic contact in the acceptable 'medical' environment of the Cambridge Hospital, my friend found his way into AA. Two years later he became a group chairman and to the best of my knowledge has been sober for the last seven years. His family relationships and health have been gradually restored.

Supported by the generous infusion of government funds into community-based mental health programmes for the treatment of alcoholism, I too was caught in the historical moment. Two years after I had told my friend that I knew of no treatment for alcoholism, I joined the staff at Cambridge-Somerville Mental Health and Retardation Center as a psychiatric consultant to the alcohol programme which had been developed there by Hilma Unterberger, the Center Assistant Director. This programme was designed on a medical model based in a general hospital, with an internist as a director. The programme includes round the clock walk-in counselling to patients and relatives, it includes 'wet' and 'dry' shelters, groups, immediate access to detoxification and to medical and psychiatric consultation. The programme offers alcohol

consultation to the medical, surgical and psychiatric wards, provides halfway houses for men and women and a comprehensive alcohol education programme to an entire city school system. At present, we see 1,000 *new* clients a year, carry out 2,500 detoxifications (50 per cent directly from the police) and have 20,000 outpatient visits a year. Annually the programme costs about a million dollars and, including our education personnel, our staff is around 80. No one is turned away because of multiple relapses, poor motivation, poverty, criminal history or skid row membership. At the same time, because skilled and hopeful consultation is always available, the rich have come as well as the poor.

In joining this programme, I changed too. My training had been at a famous teaching hospital that from past despair posted an unwritten sign over the door that read 'Alcoholic Patients Need Not Apply'. I had then worked for years at a community mental health centre that in spite of a firm commitment to meet the expressed mental health needs of the community, ignored alcoholism – which, after all, was untreatable and would overwhelm the clinic. At Cambridge Hospital, I learned how, for the first time, to diagnose the illness and to think of abstinence in terms of one day at a time. Instead of pondering the sociological and psychodynamic complexities of alcoholism, while at the bedside I learned how to keep things simple. (If the over-simplification inherent in Jellinek's disease model works mischief in research, too much doubt and vagueness wreaks havoc in the clinic.) My capacity to interview alcoholics improved. Every time I went, in keeping with clinic policy, to AA meetings – which was monthly for seven years – I took medical students and residents along. To me alcoholism became an exciting, fascinating disease. Students and registrars – if not senior consultants – were converted to the idea that alcoholics *should* and could be treated in the general hospital. It seemed perfectly clear to me that by meeting the immediate individual needs of the alcoholic, by using multi-modality therapy, by disregarding motivation, by turning to recovering alcoholics rather than to PhDs for lessons in breaking self-detrimental and more or less involuntary habits, and by slowly moving patients from the general hospital into the treatment system of AA, I was working for the most exciting alcohol programme in the world.

But here is the rub. What alcoholism has failed to borrow is from *medical* understanding of chronic relapsing disease – the first principle of which is to discover the natural history of the disease in question. Therefore, in our clinic we have continued to follow our first 100 in-patients every year since 1971. (The cost has been less than $2,000 a year.) Originally the patients had been hospitalised for an average of

eight days. After detoxification these gamma alcoholics (almost all had required 500 mg or more of chlordiazepoxide during withdrawal) were exposed to two or three discussion groups, to educational films, to didactic lectures on alcoholism, and to counselling by staff members, many of whom themselves belong to AA. On discharge they were offered an unlimited invitation to a continuing programme of twice a week staff-led discussion groups. As the years passed, a majority have returned to the clinic for counselling or detoxification or halfway house placement or help with welfare and family counselling. Initially, we created a control group from patients rejected because our beds were full, but after a few months, this seemed pointless. Our treatment network was sufficiently widespread so that, eventually, controls reapplied and were accepted into our treatment system.

Table 1.1 shows our treatment results. After initial discharge only three patients *never* relapsed to at least a brief period of alcoholic drinking and there is compelling evidence that our treatment results are better than the natural history of the disease. The death rate of three per cent a year is appalling and, it might be added, rather inconsistent with a mythical affliction and quite consistent with the metaphor 'disease'. Granted that after seven years the number of abstinents has steadily increased, that 56 per cent have at some point been abstinent for six months and that a small number have returned to social drinking – the financial costs have been considerable. Some of the patients who have continued to drink alcoholically have – over seven years – received as many as 200 detoxifications; 36 per cent have been detoxified at least ten times.

In Table 1.1 the outcome of the CASPAR (Cambridge and Somerville Program for Alcohol Rehabilitation) patients are contrasted with two year follow-ups of [4] treatment programmes that analysed their data in a comparable way and admitted similar patients and[3–6] with three studies of equal duration that purported to offer no formal treatment.[2,7,8] Each treatment population differs, but the studies are relatively comparable; and in the hope of averaging out major sampling differences, the studies have been pooled. Costello,[9] Emerick,[10] and Hill and Blane[11] have reviewed much larger numbers of disparate outcome studies and documented roughly similar proportions of significantly improved and unimproved. Obviously, abstinence or controlled drinking is not the only treatment goal but it is the variable that will be singled out in this chapter.

Our treatment programme was open-ended; a majority of the active drinkers continued to return to our clinical programme, and

Table 1.1: Comparison of Selected Two Year Follow-up Studies

	CASPAR Treatment	Three Pooled 'No Treatment' Studies**	Four 'Treatment' Studies**
N followed original sample	100/106	214/245	685/963
Length of follow-up	2 yr	2-3 yr	2 yr
Abstinent/social drinking	20%	17%	21%
Improved	13%	15%	16%
Trouble/dead	67%	68%	63%

* These are studies by Orford and Edwards,[2] Kendell and Staton[7] and Imber *et al.*[8] Because at one year there was no difference between Orford and Edwards' treated and control population and because at two years their report did not clearly separate the two populations, all 85 of their subjects on whom they had two year follow-up are included.
** These are the studies by Belasco,[3] Bruun,[4] Robson *et al.*[5] and van-Dijk-Koffeman.[6]

Table 1.2: Long-term Follow-up of Treated and 'Untreated' Alcoholics

	CASPAR Treatment	Myerson Mayer[15]	Bratfos[12]	Goodwin[16]	Voegtlin[13]	Lundquist[14]
N followed original sample	100/106	100/101	478/1179	93/123	104/?	200/200
Length of follow-up	7 yr	10 yr	10 yr	8 yr	7 yr	9 yr
Abstinent/ social drinking	33%	22%	12%	26%	22%	27%
Improved	6%	24%	25%	15%	13%	<20%
Trouble/dead	61%	54%	63%	59%	65%	53%
Dead	25%	20%	14%	5%	?	22.5%
Gamma alcoholics	95%	100%	87%	c75%	?	c 75%

improvement continued.

Therefore in Table 1.2 CASPAR results at seven years are compared with the five rather disparate follow-up studies in the literature which are of similar duration but which looked at very different patient populations. Once again our results parallel the natural history of the disorder. Bratfos,[12] Voegtlin[13] and Lundquist[14] report follow-up of treated middle-class alcoholics. Myerson and Mayer[15] who followed a skid row population and Goodwin *et al.*[16] who followed alcoholic felons report data from essentially untreated populations. Certainly, it is unfortunate that there are *no* more careful long-term (more than six years of follow-up) studies of alcoholism in the world literature, and it can be legitimately argued that there are alternative ways of summarising the findings from each study in Table 1.2. Nevertheless, the similarity of data in Table 1.1 and Table 1.2 are heuristically useful and underscore the fact that over time large numbers of alcoholics remit and that large numbers of those who do not remit die.

The Natural Healing Forces in Alcoholism

In 1976 Gordis[17] editorialised for the *Annals of Internal Medicine* that 'The treatment of alcoholism has not improved in any important way in 25 years and alcoholism is becoming more prevalent . . . Only a minority of patients who enter treatment are helped to long-term recovery. The majority is made up of those who relapse soon and often and those who are lost to follow-up'. Alas, we are forced to agree. The best that can be said for our exciting treatment effort is that we are certainly not interfering with normal recovery process. How can I, a clinician, reconcile my enthusiasm for treatment with such melancholy data?

I must remind you of the second horn of my dilemma. The problem of alcoholism is too immense, the pain it causes too severe and the demands it places on the health care delivery system are too pervasive to tell government bodies that it is useless to fund large scale treatment programmes. It is not a step forward to say that alcoholism is the sole responsibility of families, of the church and of the police. It is not progress for hospitals again to hang out signs that read 'Alcoholics Need Not Apply'. Therefore, if treatment as we currently understand it does not seem more effective than natural healing processes, then we need to understand those healing processes. We need also to study the special role that health care professionals play in facilitating those processes. What alcohol treatment is failing to borrow is the study of

medical response to chronic relapsing disease.

Let us look *first* at what the patient brings to his own cure. Consider tuberculosis as an analogy. In 1940 Cecil's[18] well-known textbook of medicine advised 'Since there is no known specific cure for tuberculosis, treatment rests *entirely* on recognition of the factors contributing to the resistance of the patient'. In saying this Cecil's medical textbook did not recommend that the government and doctors get out of the business of treating tuberculosis, nor did it suggest that, because genes and socioeconomic factors were more important than contagion, tuberculosis was really *just* a social problem not a medical disorder. Rather it suggested that doctors learn more about natural healing processes. Let us return to alcoholism.

In concluding an exhaustive review of alcohol treatment programmes, Baekland[19] wrote, 'Over and over we were impressed with the dominant role the patient, as opposed to the kind of treatment used on him, played both in his persistence in treatment and his eventual outcome'. Similarly, Orford and Edwards[2] in introducing their pessimistic control study of treatment wrote, 'In alcoholism treatment, research should increasingly embrace the closer study of "natural" forces which can be captured and exploited by planned, therapeutic intervention'.

In an effort to meet this need, let me describe preliminary results from a naturalistic, longitudinal study of alcoholism. What happens to alcoholics as they occur in nature rather than when they are viewed through the distorting, self-serving lens of the clinic? How do alcoholics get well if left to themselves?[20] A group of 456 inner-city 14 year old youths were selected by chance in 1940 with the important proviso that they *not* be seriously delinquent. In this sense they differ from the prospective studies by Robins[21] and the McCords.[22] These men have been prospectively followed, without significant attrition, until the age of 47. During the course of 35 years of follow-up 110 of these Boston men at some time have developed 4 or more symptoms of alcohol abuse as defined by DSM III.[23] Of these 110 men, 68 could be described as alcohol-dependent, or gamma alcoholics; 69 exhibited seven or more of Cahalan's[24] symptoms of problem drinking. Some were identified as alcoholic by clinicians and others were not. Out of these 110 men with multiple symptoms of alcohol abuse, 49 have achieved at least a year of abstinence and 22 men have been able to return to social drinking. Thus, compared with the studies already reported, the findings of this follow-up study suggest that if we study alcoholics long enough, 10-25 years, a very significant fraction of them – perhaps over half – recover.

Table 1.3 illustrates that very few of the 49 abstainees from this

naturalistically derived community sample were initiated during exposure to 'treatment'. Only one abstinence in three began during some kind of formal treatment. Many men claimed to have maintained abstinence without any treatment at all and available clinic records support this assertion. For many men, Alcoholics Anonymous *had* played a significant role. But the path into this organisation was often through friends rather than clinic referral.

Table 1.4 suggests that if we follow the advice of Orford and Edwards,[2] and look at natural healing factors, an interesting pattern emerges. First, in order to facilitate the long-lasting abolition of any

Table 1.3: 'Treatment' Experiences that were Associated with Periods of Abstinence or of Social Drinking of a Year or More

	Abstinent Men N = 49	Returned to Social Drinking Men N = 22
'Professional' Treatment		
Psychotherapy	8%	5%
Antabuse	4%	0%
Halfway house	6%	5%
Alcohol clinic/hospital	30%	0%
Other Treatment		
Effective confrontation	61%	50%
Will-power	49%	23%
Alcoholics Anonymous	37%	0%

Table 1.4: 'Natural' Healing Factors that were Associated with Periods of Abstinence or of Social Drinking of a Year or More

	Abstinent Men N = 49	Returned to Social Drinking Men N = 22
I Substitute Dependence	53%	5%
II Behaviour Modification		
External control	24%	41%
Medical consequences	49%	27%
III Social Rehabilitation		
New love object	32%	18%
IV Increased Hope/Esteem		
Increased religious involvement	12%	5%
Alcoholics Anonymous	37%	0%

enduring habit, it is important to provide a substitute for the proscribed habit. Thus, 53 per cent of the 49 abstinent men found some substitute for alcohol (e.g. food, marijuana, gambling, meditation, three packs/day of cigarettes, compulsive hobbies etc.). Secondly, to change a habit, the individual must be reminded continuously that change is important; thus, in over half of the cases some form of behavioural modification occurred that served repeatedly to remind the men that they were unable to drink. Often they developed an unpleasant medical complaint instantly made worse by alcohol. Thirdly, for reasons not fully understood, it is helpful to replace habitual dependence upon drugs with unambivalent human relationships – not therapy. Thus, a third of the men claimed that their abstinence was facilitated by a new and rewarding personal relationship. Finally, the person's sense of hopelessness and helplessness about the possibility of change must be removed. Thus, more than half of the 49 abstinent men turned to religion or Alcoholics Anonymous for hope and for help. Indeed, Alcoholics Anonymous combines all four of the categories in Table 1.4.

Out of 49 men with a year or more of abstinence, there were 21 men who have experienced sustained community abstinence for more than three years and who are *still* abstinent. If these men are considered separately, then compulsory external control was of no use nor was antabuse or psychotherapy. However, for 71 per cent of these 21 *sustained* abstinences and for 87 per cent of the 15 men who had been gamma alcoholics, either AA *or* two or more of the natural healing factors played a significant role. Such findings suggest that recovery from alcoholism should not be called 'spontaneous' or as resulting from hitting some mysterious 'bottom'. Rather such a profound behavioural change is mediated by forces that can be identified and understood by social scientists and harnessed by health professionals.

In this same naturalistically-identified sample of 110 alcohol abusers, 22 men have returned to social drinking. However, only 4 out of 22 were what Jellinek would call a gamma alcoholic. In contrast 40 of the 49 men who became abstinent were gamma alcoholics. As Table 1.3 suggests, it was easier for those who returned to social drinking to change their drinking patterns than it was for the men who became abstinent. Often effective confrontation and will-power seemed treatment enough. Formal treatment of any kind seemed unnecessary. Table 1.4 suggests that substitute dependencies, fresh self-esteem and new people to care about seemed much less important for the return-to-social-drinking men (who were alcohol abusers) than they were for the abstinent men (who were physiologically dependent). External

modification of drinking behaviour patterns, however, was useful, but this modified behaviour often resulted in 'controlled' rather than 'spontaneous' social drinking. For example, these non-gamma alcoholics learned to drink only selected beverages in selected environments during selected time periods. In summary, different factors seem important to recovery at different stages of alcohol dependence.

But what is meant by 'stages of alcoholic dependence'? Obviously, alcoholism is a relative label and represents a continuum. The men I am calling 'alcohol abusers' experienced an average of six of Cahalan's eleven symptoms of problem drinking; the men I call 'gamma alcoholics experienced about nine of Cahalan's symptoms *and* met the DSM III criteria for alcohol dependence. In contrast a heavy social drinker (4-7 ounces of 80 proof liquor daily) would have experienced only two or three of Cahalan's symptoms and be excluded from the compass of this chapter.

What the Therapist Can Add

Let us turn now from the patient's role to the role of the treatment professionals in the recovery process. Throughout history, physicians, faced with the unknown evil of disease they can neither comprehend nor cure, have played archaic but invaluable roles. In his classic monograph *Persuasion and Healing*, Jerome Frank,[25] Professor of Psychiatry at Johns Hopkins University, has offered us a transcultural model for healing that is non-specific for disease or patient; but Frank's model maximises both the relief of suffering and – of special importance in alcoholism – maximises attitude change. Frank acknowledges the paradox that demand for therapy may seem increasingly insatiable at the very time of mounting complaint that such therapy may represent expensive fraud. What feeds such demand is not the patient's need for cure as much as a need to elevate morale. First, alcoholics feel defeated, helpless and unable to change. If their lives are to change, they need hope as much as symptom relief. Secondly, alcoholics often have an ingrained habit that is intractable to reason, threat or will-power. To change a maladaptive habit, be it smoking or getting too little exercise or drinking too much alcohol, we cannot 'treat' or compel or reason with the person. Rather, we must change the person's belief system and then maintain that change. Time and time again, both evangelists and behaviour therapists have demonstrated that if you can but win their hearts and minds, their habits will follow. In other words, if we can but combine the best placebo effects of Lourdes with the best

attitude change inherent in the evangelical conversion experience, we may be on our way to an effective alcohol programme. Frank's views will be described in general terms and then illustrated with four relatively successful alcohol programmes.

Jerome Frank's prescription for an effective 'placebo' therapy, for a modern day Lourdes, has as its goal the raising of the patient's expectancy of cure and his reintegration with the group. At Lourdes, pilgrims pray for each other, not for themselves. This stress on service counteracts the patient's morbid self-preoccupation, strengthens his self-esteem by demonstrating that he can do something for others and cements the tie between patient and group. Such therapy involves the sharing of suffering with a sanctioned healer who is willing to talk about the patient's problem in a symbolic way. The sanctioned healer should have status and power and be equipped with an unambiguous conceptual model of the problem which he is willing to explain to the patient. (Within our medical model this is the strategy of Jellinek's disease concept.) Enhancement of the patient's self-esteem and the reduction of anxiety are the inevitable consequence. The common ingredients of such a programme include group acceptance, an emotionally-charged but communally-shared ritual and a shared belief system. Such a ritual should be accompanied by a cognitive learning process that 'explains' the phenomenon of the illness. The point is that if one cannot cure an illness, one wants to make the patient less afraid and overwhelmed by it.

Jerome Frank's prescription for attitude change is initially interrogation by and confession of sins to a high status healer. This process should involve indoctrination, repetition, removal of ambiguity and the opportunity for identification. It has been demonstrated that the patient's active participation in such a process 'increases a person's susceptibility especially if the situation requires him to assume some initiative'[25] for his own attitude change. In the Stanford Heart Disease Prevention Program, internist John Farquhar and his colleagues[26,27] have examined different modes of reducing smoking, altering diet and increasing exercise. In their efforts to reduce thereby coronary risk in large populations of patients, they found that explanation of risk and rational advice by physicians is less useful than systematic indoctrination using mass media and peer support groups. However, as Jerome Frank writes, 'The greatest potential drawback of therapy groups is the tendency not to supply sufficient support, especially in early meetings, to enable members to cope with the stresses they generate'.[25] One of the functions, then, of the medical care system is to facilitate the transition of the isolated patient to group membership. Finally, in

order to maintain attitude change, rehearsal of these group rituals and the group support that they engender must be sustained after clinic discharge.

Table 1.5 offers support for Frank's prescription. The table reflects the early treatment results reported by the Shadel[13] clinic using emetine aversion, by the Menninger[28] clinic using antabuse and group therapy, by Beaubrun[29] using an imaginative combination of indigenous paraprofessionals and medically sanctioned Alcoholics Anonymous, and by the Sobells[30] using behaviour modification. Each programme employed the newest method of its decade, was led by competent investigators, and led to results that were clearly superior to those usually reported. Because they were adequately controlled the Wallerstein and the Sobell studies are most convincing. Nevertheless, history has not been kind to these individual treatment methods; and, thus far, none have truly met Mark Sobell's[31] criteria for credibility: 'The foundation of validating successful treatment lies in replication'.

What, then, did emetine aversion conditioning in the 1940s, antabuse coupled with group therapy in a world-famous clinic in the 1950s, the use of AA coupled with indigenous calypso singing, ex-alcoholics in the 1960s and behaviour therapy to return to controlled drinking in the 1970s have in common? They all maximised the placebo effect of

Table 1.5: Two Year Follow-up Results of 'Special' Treatment Programmes Compared with Results from 'Routine' Treatment Programmes

	Four Pooled Treatment Studies*	Emetine Aversion	Antabuse	AA	Behaviour Modif.
		Shadel 1949[13]	Wallerstein 1956[28]	Beaubrun 1967[29]	Sobell 1976[30]
N followed/ original sample	685/963	300/?	40/47	57/57	20/20
Length of follow-up	2 yr	2 yr	2 yr	2 yr	2 yr
Abstinent/ social drinking	21%	60%	53%	37%	35%
Improved	16%	5%		16%	50%
Continued trouble	63%	35%	47%	47%	15%

* These are the studies cited in Table 1.1[3-6]

medical treatment and effected significant attitude change. As sanctioned powerful healers, each investigator brought hope and provided a rational explanation of mysterious suffering and then created a framework for sharing that suffering with others. In the nineteenth century, Sir William Osler[32] wrote to a friend of his who had been treating tuberculosis, 'That is a fine record . . . I'm afraid there is one element you've not laid proper stress upon – your own personality. Confidence and faith count so much in these cases'. Because the clinicians in Table 1.5 brought the newest techniques of their decade to bear, they not only brought hope but conveyed assurance of their own power to cure. The Menninger Clinic in the 1950s was world renowned and the Sobells' elaborate research unit at Patton State Hospital was an impressive stageset filled with scientific gadgetry. In each programme the illness of alcoholism was carefully explained to each patient and although these explanations differed, they were consistent with the medical knowledge of each era. Although each patient was made responsible for his future involvement, alcoholism was represented as a disorder, not a symptom or as chaos. For example, each of Shadel's[33] patients received ten rules. Rules number 3 and 4 were, 'Do not look on alcoholism as a personal weakness. Remember that alcoholism is an illness . . . sensitivity to alcohol is inborn and you will always have it.' Beaubrun[29] wrote, 'In my culture where gamma alcoholism prevails the most helpful thing which the therapist can say to the alcoholic is that his problem is an illness. There is a world of difference between therapeutic and research orientations in this respect. The therapist knows that the semantic distinction between "addiction" and "disease" can make all the difference to his patient's sobriety. It is the distinction between a criminal and sick person.' Secondly, consistent with altering ingrained behaviour, all four treatments maximised attitude change in an emotionally charged setting. These programmes indoctrinated each patient into a coherent – if differing – ideology.

In each case a daily ritual was prescribed. For example, Wallerstein[28] wrote, 'In maintaining this sober state outside the hospital, the more compulsive the character of the patient and the more he could ritualise the antabuse ceremony itself, the better his prognosis.' Shadel's patients had a sign, 'There is one thing I cannot do' which they were to hang by the mirror while they shaved. Sobell's patients were given a wallet-sized Do's and Don't's card to keep with them at all times and after leaving the hospital. Beaubrun's patients had to continue to go to AA several times a week.

Rather than trying to alter attitude by threat or rational advice, each

programme altered attitudes by affecting self-esteem. Sobell's patients highly valued the mastery involved in their return to controlled drinking. They were shown videotapes of themselves drinking in control and out of control. Shadel's[33] rules number 7 and 9 were 'Develop other outlets' and 'Get your strength for living from a desire to help yourself and others and not from the bottle. Help other alcoholics to master their problem.'

As they were encouraged in group activities, a comradeship developed among the patients. Wallerstein's[29] antabuse patients stayed in a psychodynamically-oriented hospital for three months and attended therapy groups as well as took antabuse. Shadel wrote, as each alcoholic came into his clinic environment, 'It is interesting to see how the gang of old patients goes to work on a new patient', and Shadel's patients were encouraged to continue groups after leaving. As Beaubrun[29] put it, 'It was not enough to tell a patient to attend a meeting; someone was sent to bring him to the first few meetings until he got accustomed to the new group.'

The success of Alcoholics Anonymous and its reasonable facsimiles which are continuously being revised, is probably due to the fact that it conforms so well to the natural healing principles that have been outlined earlier in this chapter. First, in AA the continuous hope, the gentle peer support, and the exposure to truly successful people provide a ritualised substitute for drinking, a source of identification and a substitute for lost drinking companions. Like the best behaviour therapy, not only do AA meetings go on daily, especially on weekends and holidays, but like any well-conceived programme of behaviour modification, AA provides strategies to combat unwitting relapse. Obviously, belonging to a group of caring individuals who have found solutions to the typical problems that beset newly sober alcoholics, alleviates social vulnerability. And, finally, the opportunity to identify with helpers who were once equally as disabled and to help others stay sober fits in well with Jerome Frank's general prescription for a therapeutic group process.

Resolution of the Dilemma

Let me now attempt to resolve my dilemma. *First*, recognition of our limited ability to alter the course of alcoholism paradoxically may lead to improved care not chaos. Modern surgery took a giant stride forward when it realised that wound-healing fared best by natural

methods, that wound healing could be often slowed but never hastened by surgical intervention. Modern medicine began towards the end of the nineteenth century, it gave up bleeding patients and abandoned virtually its entire pharmacopoeia. Today, psychiatry has a lesson to learn from the fact that schizophrenics have a better prognosis in underdeveloped countries than they do in developed ones.[34] It is important that one of the few conclusions that Emrick[10] drew from his study of 384 alcohol follow-up studies was that it may be easier for improper treatment to retard recovery than for proper treatment to hasten it.

Secondly, I believe that we must remain alert to the limitations of our alcohol treatment programmes. Otherwise national health schemes may suddenly regard as cost ineffective *all* alcohol treatment, rather than just long hospital stays. The 70 per cent improvement rate originally promised in the Rand Report will become dangerous if clinical staff and legislators discover that such hopeful results are a cruel cheat – an illusion produced by attrition, by cross-sectional design and by ignoring the law of initial values. Unless we are careful, doctors and public funding sources may withdraw the support we have grown to expect. Thus, honesty is its own reward. Remembering the first step of Al-Anon, 'And we admitted that we were powerless over alcohol' protects us from maintaining the guilty illusion that if we just try harder and harder, we can cure the alcoholic. Indeed, a major task of my role as psychiatric consultant to an alcohol programme is to remind the staff that they are not to blame for their patients' relapses. As guilt is alleviated, so hope returns.

Thirdly, we have much to learn from how medicine until 1950 learned to cope with tuberculosis. We do not wish to spend either our natural resources nor our own time on just a few alcoholics. Rather, we want to reach as many patients as possible and we never want to ignore the problem. Not surprisingly, the results reported by Kissin and Rosenblatt[35] suggest that openly ignoring alcoholics on a waiting list produced an improvement rate of only four per cent, far worse than naturalistic studies in the literature. As Martin Seligman[36] reminds us, hopelessness kills.

Fourthly, at the same time that Ambroise Paré gave us his humble epigram 'I dressed him, God healed him', he had the wit to invent the surgical ligature to stop haemorrhage. In 1978 the Cambridge-Somerville Mental Health Center provided medical and social assistance to *twice* as many alcoholics as the entire Connecticut Department of Mental Health provided in 1965 to a catchment population that was *ten times* as large. By providing consultation, detoxification, welfare and shelter,

I have no doubt that we stop haemorrhage.

Fifthly, as Table 1.6 illustrates, at Cambridge Hospital if we have not cured all the alcoholics who were first detoxified over seven years ago, we have increased their likelihood of attending Alcoholics Anonymous. The table contrasts our results with those from the naturalistically-derived sample from the same urban area. The comparisons are of the record of our first 106 admissions over seven years with the record of the 110 alcohol abusers in the naturalistically-derived inner-city sample. Of the inner-city sample, 20, or 41 per cent, of the 49 abstinent men became abstinent in part through AA. Each of these 20 men attended an average 300 meetings. After one year of the CASPAR programme, five of our patients achieved an abstinence that had begun through regular attendance in AA. After seven years, 21 patients, or four times as many attained an abstinence that began in part through AA. In the seven years, these 21 patients – 65 per cent of all those stably abstinent – had attended an average of 600 meetings. But in emphasising the belief of *our* programme in AA, I do not wish to suggest that AA is the *best* answer; there are many paths to recovery in alcoholism. We need to understand what is common to all of them. Our treatment programme was designed to respond to the needs of all of the estimated 20,000 alcoholics in our catchment area. We have tried to spread our resources. To concentrate upon 20 or even 200 souls would not do. Therefore, like Dr Blenkinsop in George Bernard Shaw's *Doctor's Dilemma*, we have depended on greengages, as it were. Alcoholics Anonymous is free, readily accessible, consistent with natural healing forces. Our aim was to encourage its use. In that, we succeeded.

Table 1.6: Use of Alcoholics Anonymous Over Time in Treated and 'Naturalistic' Samples

	Inner-city	CASPAR	
N followed/original sample	103/110	106/106	100/106
Length of follow-up	10-25 yr	1 yr	7 yr
Abstinent or social drinking	51%	15%	33%
Improved	17%	19%	6%
Continued trouble or dead	32%	66%	61%
Per cent of those abstinent who became abstinent through AA	41%	31%	65%
Average number of meetings/ abstinent AA attender	300	NA	600

Benjamin Kissin[37] warns us that, 'Perhaps negative results should be reported even more cautiously, since almost everyone tends to view positive ones with a jaundiced eye and to take negative ones at their face value.' If our patients at seven years of follow-up have not fared as well as the inner-city sample at 20 years follow-up, our patients were at a more advanced stage of the disease when they came to us. Besides, the Samaritan role is not to be sneezed at – especially in incurable disease; when large benefits are not forthcoming, patients will be especially grateful for small ones.

Finally, I return to the treatment of alcoholism both with hope and with confidence. I shall continue to hope that our governments and our medical colleagues will continue to regard alcoholism just as worthy of medical treatment and large-scale expenditure of public funds as they regarded tuberculosis in 1940. I would not want to return to the day when due to therapeutic despair great teaching hospitals once again put up signs that read 'Alcoholics Need Not Apply'.

Acknowledgement

This work was supported by the Grant Foundation, Inc., the Spencer Foundation and a research grant (AA-01372) from the National Institute of Alcoholism and Alcohol Abuse.

Notes

1. Szasz, T.S. (1972), 'Bad Habits are Not Diseases', *Lancet*, vol. 2, pp. 83-4.
2. Orford, J. and Edwards, G. (1977), *Alcoholism* (Oxford University Press, Oxford).
3. Belasco, J.A. (1971), 'The Criterion Question Revisited', *British Journal of Addiction*, vol. 66, pp. 39-44.
4. Bruun, K. (1963), 'Outcome of Different Types of Treatment of Alcoholics', *Quarterly Journal of Studies on Alcohol*, vol. 24, pp. 280-8.
5. Robson, R.A., Paulus, I. and Clarke, G.G. (1965), 'An Evaluation of the Effect of a Clinic Treatment Program on the Rehabilitation of Alcoholic Patients', *Quarterly Journal of Studies on Alcohol*, vol. 26, pp. 264-78.
6. van Dijk, W.K. and van Dijk-Koffeman, A. (1973), 'A Follow-up Study of 211 Treated Male Alcoholic Addicts', *British Journal of the Addictions*, vol. 68, pp. 3-24.
7. Kendell, R.E. and Staton, M.C. (1966), 'The Fate of Untreated Alcoholics', *Quarterly Journal of Studies on Alcohol*, vol. 27, pp. 30-41.
8. Imber, S., Schultz, E., Funderburk, F., Allen, R. and Flamer, R. (1976), 'The Fate of the Untreated Alcoholic', *Journal of Nervous and Mental Disease*, vol. 162, pp. 238-47.

9. Costello, R.M. (1975), 'Alcoholism Treatment and Evaluation: In Search of Methods', *International Journal of Addictions*, vol. 10, pp. 251-75.

10. Emrick, C.D. (1975), 'A Review of Psychologically Oriented Treatment of Alcoholism. II. The Relative Effectiveness of Treatment Versus No Treatment', *Journal of Studies in Alcoholism*, vol. 36, pp. 88-109.

11. Hill, M.J. and Blane, H.T. (1966), 'Evaluation of Psychotherapy With Alcoholics: A Critical Review', *Quarterly Journal of Studies on Alcoholism*, vol. 27, pp. 76-104.

12. Bratfos, O. (1974), *The Course of Alcoholism: Drinking, Social Adjustment and Health* (Universitetsforlaget, Oslo).

13. Voegtlin, W.L. and Broz, W.R. (1949), 'The Conditional Reflex Treatment of Chronic Alcoholism. X. An Analysis of 3,125 Admissions Over a Period of Ten and a Half Years', *Annals of International Medicine*, vol. 30, pp. 580-97.

14. Lundquist, G.A.R. (1973), 'Alcohol Dependence', *Acta Psychiatrica Scandinavica*, vol. 49, pp. 322-40.

15. Myerson, D.J. and Mayer, J. (1966), 'Origins, Treatment and Destiny of Skid-row Alcoholic Men', *New England Journal of Medicine*, vol. 275, pp. 419-24.

16. Goodwin, D.W., Crane, J.B. and Guze, S.B. (1971), 'Felons Who Drink: An 8 Year Follow-up', *Quarterly Journal of Studies on Alcohol*, vol. 32, pp. 136-47.

17. Gordis, E. (1976), 'What is Alcoholism Research?' (Editorial), *Annals of International Medicine*, vol. 85, pp. 821-3.

18. Cecil, R. (1940), *Textbook of Medicine* (Saunders, New York).

19. Baekland, F., Lundwall, L. and Kissin, B. (1975), 'Methods for the Treatment of Chronic Alcoholism: A Critical Appraisal', in Gibbons, R.J., Israel, Y., Kalant, H., Popham, R.E., Schmidt, W. and Smart, R.G. (eds.), *Research Advances in Alcohol and Drug Problem*, vol. 2, chapter 7 (John Wiley & Sons, London).

20. Glueck, S. and Glueck, E. (1950), *Unraveling Juvenile Delinquency* (The Commonwealth Fund, New York).

21. Robins, L.N. (1966), *Deviant Children Grown Up: A Sociological and Psychiatric Study of Sociopathic Personality* (Williams and Wilkins, Baltimore).

22. McCord, W. and McCord, J. (1960), *Origins of Alcoholism* (Stanford University Press, Stanford).

23. American Psychiatric Association (1980), *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edn (Washington, D.C., APA, DSM III).

24. Cahalan, D. (1970), *Problem Drinkers: A National Survey* (Jossey-Bass, San Francisco).

25. Frank, J.D. (1961), *Persuasion and Healing: A Comparative Study of Psychotherapy* (Johns Hopkins University Press, Baltimore).

26. Farquhar, J.W., Maccoby, N., Wood, P.D. *et al.* (1977), 'Community Education for Cardiovascular Health', *Lancet*, vol. 1, pp. 1192-5.

27. Farquhar, J. (1978), 'The Community-based Model of Life Style Intervention Trials', *American Journal of Epidemiology*, vol. 108, pp. 103-11.

28. Wallerstein, R.S. (1956), 'Comparative Study of Treatment Methods for Chronic Alcoholism: The Alcohol Research Project at Winter VA Hospital', *American Journal of Psychiatry*, vol. 113, pp. 228-33.

29. Beaubrun, M.H. (1967), 'Treatment of Alcoholism in Trinidad and Tobago, 1956-65', *British Journal of Psychiatry*, vol. 113, pp. 643-58.

30. Sobell, M.B. and Sobell, J.C. (1976), 'Second-year Treatment Outcome of Alcoholics Treated by Individualized Behaviour Therapy: Results', *Behaviour Research and Therapy*, vol. 14, pp. 195-215.

31. Sobell, M.B. and Sobell, L.D. (1973), 'Alcoholics Treated by Individualized Behaviour Therapy: One-year Treatment Outcome', *Behaviour Research and Therapy*, vol. II, pp. 599-618.