Reports of Societies

THE CURE OF ALCOHOLISM

A report by a special correspondent on a paper read at a meeting of the Society for the Study of Addiction on August 26 by Mr. Francis T. Chambers, jun., of the Institute of the Pennsylvania Hospital, Philadelphia.

The problem of alcoholism is not new. Chronic alcoholism and delirium tremens were described in Indian medical lore in 1400 B.C., and, according to Dr. H. Pullar-Strecker, the Roman lawyer Ulpian nearly 2,000 years ago urged that alcoholics should be treated as sick people. But it took centuries for this sensible view to gain ground, and it was not until 1860 that the first inebriates' institution in the world was founded in America, by Joseph Turner.

There are two factors about chronic alcoholism which make the problem difficult. The first is the prevalent misconception in the minds of laymen and even among many of the medical profession that the condition is incurable and that the chronic alcoholic is a hopeless person who cannot be reclaimed. The second is that we know little or nothing about the cause of alcoholic addiction, a psychopathological condition which must be distinguished from heavy drinking or intemperance. The Americans are more alive than we are to the problem. According to Gardner, alcoholism ranks as "Public Health Problem No. 4." There are in the United States many hospitals, clinics, special out-patient departments, and rehabilitation centres for the alcoholic. Patients are admitted to the special alcohol wards of the larger general hospitals, and according to statistics of work done in America there are 4,000 beds specially set aside for the treatment of the chronic alcoholic. Accordingly special interest attaches to a report from America on the treatment of alcoholism.

Antabuse, Alcoholics Anonymous, and Psychotherapy

Mr. FRANCIS T. CHAMBERS addressed the Society for the Study of Addiction, at the premises of the Medical Society of London, 11, Chandos Street, W.1, on "An Analysis and Comparison of Three Measures for Alcoholism: Antabuse, Alcoholics Anonymous, and Psychotherapy."

Mr. Chambers is a lay associate in therapy of the Institute of Pennsylvania Hospital, a well-known figure in the psychotherapy of alcoholism, and lectures to young psychiatrists connected with the University of Pennsylvania and to the Fellows working at the Institute of the Pennsylvania Hospital. In 1938 he collaborated with Professor Edward A. Strecker, who held the chair of psychiatry at the University of Pennsylvania, in writing *Alcohol: One Man's Meat,* which presented a positive treatment plan and had the effect of stimulating a more optimistic approach to the problem.

Prior to 1935, the lecturer said, the approach to the problem had been a negative one. By and large, at this period, most treatment consisted in the facilities offered by rest homes and "cures," where the whole emphasis was placed on sobering a man up. Temporary sobriety having been achieved, he was then discharged with little or no understanding of himself or his problem. At the same time as Strecker and Chambers's book was published the Alcoholics Anonymous movement became active in America, and this had contributed a great deal of help for many alcoholic addicts who could not have received help in any other way. In 1949 "antabuse" (tetraethylthiuramdisulphide) was introduced in the United States for controlled study, and in 1951 it was released to the medical profession. It was defined as the drug that builds a "chemical fence" round the alcoholic.

In sequence, then, declared Mr. Chambers, they could see three positive approaches, each of which had been met by great optimism on the part of the public. This optimism had become tempered by the sobering fact that each one of these approaches had, along with successes, many failures. This did not mean that antabuse should be discarded as a treatment measure because there are failures—and sometimes fatal failures; nor did it mean that those who fail to respond to the Alcoholics Anonymous movement indicate that this is not a helpful measure; nor again did it mean that psychotherapy should be discarded because it, too, has its failures.

"The Chemical Fence"

The lecturer first analysed antabuse as a treatment measure. Quoting recent work on the subject by Strecker, Lathbury, and Martensen-Larsen, he discussed cases where treatment by antabuse had been followed by psychotic reactions. He also referred to the work of Dr. Erik Jacobsen, of Denmark. This authority had written recently that the effective deprivation of alcohol without adequate psychotherapy could be just as dangerous as the untoward effects of antabuse. In the same article Dr. Jacobsen had reported 17 deaths following treatment with antabuse among 10,000 patients; of this total, 5 deaths were sudden and unexplained.

Briefly, then, there were three contraindications to the use of antabuse, said Mr. Chambers. First, there were those who refused this treatment; secondly, those who might develop a psychotic reaction following the treatment; and, thirdly, those to whom the treatment might be fatal. "Let me add a fourth risk, perhaps the most important—namely, that the indiscriminate use of antabuse on a group of patients most apt to respond to psychotherapy might interfere with, or even block, their potential accessibility to psychotherapy." On the other hand, medical literature was full of successful results obtained by the administration of antabuse. Many patients made a much better adjustment when careful treatment was followed by psychotherapy.

Hit Bottom First

Mr. Chambers followed with an analysis of the Alcoholics Anonymous movement and the twelve steps in their programme of recovery. In the foreword to their book *Alcoholics Anonymous* the authors remark that they wish to show other alcoholics "precisely how we have recovered." In their words, "the only requirement for membership is an honest desire to stop drinking." The lecturer's experience with members of this group had been that the successful men and women were those who had made A.A. the most important thing in their lives. They devoted a tremendous amount of time to this work at great inconvenience to themselves. They were willing to be called out to administer to one of their group who had fallen, or to call on some drunkard in order to persuade him to seek their help. Most of those who became members had gone downhill quite far. In fact, many A.A. members said you had to "hit bottom" before you were accessible to their movement. These men and women, owing to their abnormal drinking lives, had by and large lost their normal friends and their contacts with society. They were lonely, isolated by their addiction problem. To be welcomed again in an uncritical group, where their past alcoholic history could be worn as a badge of honour, provided they recovered, must give them a tremendous emotional lift in re-establishing contact with other human beings. "All of us who are interested in the vast problem of mental hygiene owe a debt of deep gratitude to the circumstances that presented this movement at this time. The group is keeping many men and women sober who otherwise would be cluttering up our gaols and our mental hospitals. They are relieving psychiatrists of an already intolerable load, and, most important, this approach is keeping many men and women from destroying themselves and crippling their families irretrievably."

About ten years ago Mr. Chambers had been asked to read a short paper, "Emotional Immaturity in Alcoholics," at the Philadelphia General Hospital. This was followed by a talk given by one of the key men in Alcoholics Anonymous. This man began his talk by agreeing with Mr. Chambers that all alcoholics were emotionally immature; hence they needed Alcoholics Anonymous to compensate for the deficiency of emotional maturity. This

pointed out to Mr. Chambers the outstanding difference between the approach of A.A. and the psychotherapeutic approach—namely, that the former accepted the emotional immaturity and supplied a crutch for it, whereas psychotherapy attempted to supply insight into the emotional immaturity, and helped the patient towards emotional growth and maturity, as a necessary adjunct to abstinence.

Leisurely Personality Diagnosis

Psychotherapy might include a great many different approaches and various techniques. The lecturer outlined briefly the method which he and his colleagues had found practical and effective with a certain group of patients. He asserted that the first and often neglected step in the treatment of pathological drinking is a personality diagnosis. This diagnosis should be avoided during the intoxication symptoms and withdrawal symptoms. Even after a state of sobriety had been reached, the physician should delay opinion as to the best method of treatment until he had had ample opportunity to study the personality of his patient. Personality problems presented by patients varied enormously, as did the underlying causes for their addiction. "We have found," said Mr. Chambers, "that the germ of alcoholism reaches far back into childhood, and that most patients are suffering from unconscious feelings of guilt and rejection coming, usually, from these childhood experiences. We are beginning to see more clearly that drinking alcohol in itself did not create their problem. Rather it was their neurotic insecurity which created their addiction. We see in the paranoid patient a tendency to project his personality discomfort outward, in the psychoneurotic a tendency to project personality discomfort inward, and in the alcoholic a tendency to reach for a drug to anaesthetize his personality discomfort. In the abnormal drinker, emotional immaturity plus the addiction problem preclude emotional growth. The alcoholic, when intoxicated, is on an infantile level. When sober, he is a very uncomfortable child in an adult body in an adult world."

Correspondence

Because of the present high cost of producing the Journal, and the great pressure on our space, correspondents are asked to keep their letters short.

Admission of Poliomyelitis Cases to General Hospitals

SIR,—Dr. A. H. Gale, in a comprehensive and well-balanced contribution to this problem (August 30, p. 516), presents the evidence of obvious danger that cannot be honestly refuted. He thereby rightly questions the wisdom of the views of your contributor who answered a question on the subject ("Any Questions?" August 9, p. 349) and who favoured the admission of poliomyelitis cases to general rather than to infectious diseases (I.D.) hospitals. That writer, while expressing concern for the welfare of the patient as his sole reason, is, I trust, free from any taint of self-interest in his advocacy.

In addition to the cases of apparent cross-infection in general and other hospitals referred to by Dr. Gale, there have been a number of cases of poliomyelitis affecting nursing staff of general or special hospitals. This is in contrast to the rarity of such an event in the I.D. hospitals.

I had not seen the criticized opinion until Dr. Gale's letter drew my attention to it, and I wonder if it did not also escape the notice of some of my I.D. hospital colleagues with vast experience of tracheotomy, for they, with me, will be surprised to learn that only in the general hospital can this emergency be coped with. I know that the race of tracheotomists is fast dwindling with the disappearance of diphtheria and cannot be brought up to strength. I am also aware that the type of tracheotomy advocated recently for bulbar poliomyelitis in American literature is not that normally practised by I.D. hospital staff. There was an implication, however, that we are isolated from our surgical colleagues. In fact, the grouping of our hospitals under the N.H.S., which ran parallel with the rise in poliomyelitis incidence, has left us far from isolated from the laryngologist, thoracic surgeon, or anaesthetist, who may be required to make up the team dealing with the more complicated of the bulbar cases. The main difficulty, as I see it, may lie in convincing the experts called in that perhaps a planned tracheotomy or bronchoscopy may be needed.

As this hospital (probably with other of the larger I.D. hospitals) has given training in respirator (breathing machine) technique and nursing to the nursing staff of the more advanced of the large general hospitals in London, it is with some surprise that we read that the skill required to deal with respiratory paralysis is only rarely to be met in the I.D. hospital, but is never lacking in the general hospital. Most of the larger I.D. hospitals are to-day fast becoming I.D. units within a general hospital plan, whether within the same curtilage or in the same group. Structurally, with well-separated pavilions and open corridors, they are admirably suited to such development with safety. Conversely, the large, many-floored blocks of the average general hospital with internal corridors and common passenger or patient lifts are far from ideal for the purpose of nursing medical cases of an infectious nature whether of notifiable or non-notifiable classification.

I contend that a normally practised aseptic technique (so seldom carried out as routine by staff in the medical wards of the average general hospital) is most important in prophylaxis of known or unsuspected infections. Of probably much greater importance is *the structure of the I.D. hospital plan with its emphasis on free, even uncomfortably free, ventilation of wards and corridors and the proper spacing of buildings.*

Finally, I quote from an article by Mr. H. J. Seddon, the orthopaedic surgeon (*Practitioner*, 1948, **160**, 175): "A surgeon called upon to deal with patients suffering from poliomyelitis will be faced with an important question of hospital policy; if the disease is epidemic the answer is of paramount importance. Should a patient suffering from poliomyelitis, or suspected to be suffering from it, be admitted in the initial stage to a fever hospital or to an orthopaedic hospital? It is generally agreed that the responsibilities of the orthopaedic surgeon begin as soon as paralysis is present, and for this reason many favour immediate admission to an orthopaedic hospital. There are, however, certain practical objections. The suspected case may be found, after all, to be suffering from some other condition, such as meningitis or rheumatic fever; an efficient fever hospital is in a better position to treat or place cases of this kind. In established poliomyelitis, barrier nursing is desirable for a period of about three weeks. In fever hospitals such measures are common form; in orthopaedic hospitals they are not, and the structure of the hospital is often unfavourable for efficient isolation. . . . For all these reasons, therefore, the most sensible plan is first to admit poliomyelitis patients to a fever hospital. . . ."—I am, etc.,

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SIR,—I feel that the reply to the question about admission of poliomyelitis cases to general wards ("Any Questions?" August 9, p. 349) is somewhat misleading. The impression created is that if a patient suffering from poliomyelitis is admitted to a general hospital he is more liable to be nursed by staff experienced in the handling of such cases, particularly in regard to respiratory and bulbar paralysis. This is quite the reverse of the position as it exists. In the fever hospital, the ward sisters and staff nurses will have had extensive experience in the use of the respirator, whereas in the general hospital they will have had little, if any, such experience. The same applies to tracheotomy cases. Resident medical staff accustomed to the management of these patients will also be available. In fact, fever hospitals experience great difficulty in getting general or orthopaedic hospitals to accept patients while still, to any extent, dependent on a respirator. Consequently they have to retain such patients for long periods, sometimes years after they have ceased to be infectious. The limited amount of physiotherapy which is beneficial in the early stages of poliomyelitis is also, so far as I am aware, generally available in fever hospitals.