

'A UNIT FOR THE TREATMENT OF ALCOHOLISM'

(An evaluation of the response of alcoholics
treated by a specialised clinic)

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PREFACE

In 1963 the Nuffield Provincial Hospitals Trust enabled a unit for the treatment of alcoholism to be opened in Edinburgh. The treatment regime of this clinic is described in the thesis.

This study has two principal aims. The first is to describe the attributes of a sample of patients referred to the clinic. The second is to evaluate the prognosis of these alcoholics, one group of which were admitted to the unit while the other received out-patient therapy alone. Particular emphasis is placed on detecting these characteristics of patients which appear to influence their response to treatment.

The findings should improve selection of patients so that therapy can be more exactly tailored to the individual, and assist in the future planning of the alcoholism treatment programme.

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CONTENTS

<u>CHAPTER</u>		<u>PAGE</u>
I	Introduction: Review of literature.....	1
II	The treatment of alcoholism: Review of therapies.....	31
III	Method.....	50
IV	Evaluation of treatment response.....	58
V	Source of referral.....	78
VI	Demographic and background data of the sample.....	87
VII	History of alcohol usage.....	119
VIII	Attempted suicide in alcoholics.....	142
IX	Clinical evaluation of the patients.....	148
X	Evaluation of the quality of involvement in treatment response.....	163
XI	The influence of the spouse on treatment response.....	182
XII	Psychological evaluation.....	191
XIII	Summary and conclusions.....	203

APPENDIX I - Patients excluded from the study

APPENDIX II- Data sheets and psychological tests

APPENDIX III-Examples of follow-up letters

BIBLIOGRAPHY

CHAPTER I

INTRODUCTION

SECTION 1 -

The extent of the problem:

The true prevalence of alcoholism in Great Britain is unknown. Experience in specialised units indicates that the number of alcoholics desiring treatment far outnumbers the services available. Clearly the illness presents a major public health problem, but the extent of morbidity due to alcoholism can only be guessed.

Field studies in the community require to be conducted so that we have a meaningful estimate of the prevalence of alcohol addiction. A recent survey, that may be taken as a model for future work of this kind, was reported by Bailey et al (1965)⁽¹⁾. In an urban residential area of Manhattan they found the prevalence of problem drinking to be 19/1,000 persons over 20 years of age with a sex ratio of 3.6 men to 1 woman. A similar study is now being carried out in London, Edwards (1966)⁽²⁾.

Most estimates of the extent of the alcoholism problem have been arrived at by deductive methods. The Jellinek formula is probably the best known estimator of the incidence of alcoholism and Jellinek himself has been critical of its accuracy⁽³⁾. The estimate is derived from the number of deaths due to cirrhosis of the liver and the percentage of these that are known to arise from alcoholism. In addition it is necessary

to know the incidence of cirrhosis amongst alcoholics and it is recognised that the frequency of physical complications in alcoholics varies from time to time and between different countries. Using the technique the World Health Organisation estimated (in 1952) that there were 350,000 alcoholics in Great Britain⁽⁴⁾.

Some impressions of the seriousness of the problem may be derived from examining the social and medical complications of alcoholism. Lipscomb (1959)⁽⁵⁾ outlined the agencies that an alcoholic may confront at some stage in his illness. Among these were general and psychiatric hospitals, religious and other social agencies, and the courts in relation to drunk arrests, traffic accidents, crime and divorce. All of these could provide data which would reflect the extent of alcohol addiction in the community.

General practitioners, who may be regarded as being closest to the situation obtaining in the community, arrive at surprisingly low estimates when asked to enumerate the number of alcoholics in their practice. Unlike a disease such as typhoid which is recognised by patient and doctor alike as serious and notifiable, alcoholism is rarely reported by the patient and may not be recognised by the doctor. Parr (1957)⁽⁶⁾ sent a questionnaire to 480 general practitioners concerning the number of patients suffering from alcoholism in their practices. 369 doctors replied and the overall estimated incidence of alcoholism in England was "1.1 per thousand males over the age of 15". The male:female ratio was 2.2 : 1.

Many of the practitioners who took part in the study commented 'that those alcoholics who were known were reluctant to admit it to the doctor and that those who admitted it were often unwilling to go for treatment'. It is important to keep this observation in mind when considering data derived from hospitalised alcoholics. The World Health Organisation estimate for the incidence of alcoholism in England was nine times greater than the figure given by general practitioners. A survey in Scotland detected an incidence of alcoholism amongst men of 1.37/1,000 in rural areas and 0.78/1,000 in urban. For women the incidence ⁽⁷⁾ for the same areas was 0.15/1,000 and 0.2/1,000.

The number of alcoholics referred or admitted to hospital can be obtained with relative ease. What remains uncertain is the relationship between these hospital figures and the number of alcoholics in the population. Clearly it would be wrong to assume that a study based on alcoholics attending hospital reflected the parent population. Errors in selection arise even when alcoholics are being looked for in the general hospital as the physician's preconception about the alcohol addict determines those he selects for referral, Blane (1963) ⁽⁸⁾. Wolff et al (1965) ⁽⁹⁾ have shown that alcoholism is more likely to be diagnosed by general physicians when the man is socially derelict than amongst those who are better integrated socially when they are reluctant to make the diagnosis. In the group of physicians studied they also observed a preference for

TABLE 1
Alcoholic Admissions in Scotland

Male first admissions in the Regional Board Areas of Scotland:
Rates per 100,000 total population.

	1962*	1963*	1964
North	76	92	105
North East	17	19	42
East	32	32	34
South East	16	22	19
West	28	41	41
All Scotland	27	36	38

(* Estimated rates based on 7 month period)

diagnosing physical problems and a tendency to overlook psychosocial aspects of the patient. This reluctance to diagnose alcoholism except in the 'down-and-out' is at variance with the social features of 2,000 alcoholics attending as out-patients at alcoholism clinics. ⁽¹⁰⁾ . Of these, more than half were living with their wives, 74% were living in an established household, 62% had been employed for the previous 3 years and 80% had been living in the town of present residence for at least 2 years.

Depending on the type of service offered and the criteria used for admission the features of the hospitalised alcoholic will vary considerably. In Scotland as in the rest of the British Isles and Ireland there has been an increase in recent years amongst admissions to mental hospital with the diagnosis of alcoholism or alcoholic psychosis. Between 1959 and 1962 the proportion of alcoholic admissions to total admissions increased by 50% in Scotland⁽⁷⁾. More recent figures indicate that this upward trend continues.⁽¹¹⁾ (See Table 1.)

Convictions for drunkenness in Scotland show a similar tendency to exceed those for England and Wales. In Scotland in 1962 for a population of approximately 5 million there were 15,066 while England and Wales with a population of 46 million had 80,798 similar convictions⁽¹²⁾. Research in Scotland should have this relatively high incidence in mind as a close examination of the Scottish alcoholic may reveal clues to such regional variations. Many variables, psychological, diagnostic,

social, political, historical, geographic and climatic have been considered to explain Scotland's unfavourable position in this respect. It seems likely that many factors interact to produce conditions where alcoholism may flourish.

SECTION 2 -

Definition of Alcoholism:

Except for its chronic or terminal phase where the clinical features are relatively stereotyped the definition of alcoholism presents considerable problems. Practical experience in an alcoholism clinic suggests that at present non-addicted drinkers are rarely referred. It seems likely that the diagnosis is most often made by the patient himself or by significant persons in his environment. A definition of alcoholism which disregards the mental and social implications of the illness would be too narrow and would exclude from consideration many of these patients who benefit most from treatment.

With this in mind there has been an emphasis on social aspects of alcoholism in recent definitions. Studies with alcoholics should state clearly the definition which is being applied Keller (1960)⁽¹⁾. The definition used by the staff of this unit was that recommended by the World Health Organisation Alcoholism Subcommittee (1952)⁽²⁾.

"Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments. They therefore require treatment."

This definition provides a framework within which the disease can be examined more closely. As early as 1919 Wingfield⁽³⁾ differentiated species of addiction. He made the following 4 distinctions:

1. 'Pseudo dipsomania' - by this was implied the drinker who experienced no craving until he had a drink - "once he has taken one drink the patient drinks in great excess".
2. 'True dipsomania' - which is distinguished from the above by the occurrence of "spontaneous craving".
3. 'Chronic sober alcoholism' - the patient drinks regularly to excess for a long period but is usually not intoxicated.
4. 'Chronic inebriate alcoholism' - in which the sufferer is chronically intoxicated.

This classification clearly distinguishes the bout drinker from the inveterate drinker. Jellinek⁽⁴⁾ after a detailed study of alcoholism suggested the following major categories of alcoholism:

1. 'Alpha': Here there is a purely psychological reliance on alcohol to relieve emotional or bodily pain. There are no withdrawal symptoms or signs of a progressive process.
2. 'Beta': Physical effects such as polyneuropathy, gastritis and cirrhosis arise without physical or psychological dependence. Such cases arise out of social

custom or poor nutrition.

3. 'Gamma': Here there is a progression from psychological to physical dependence, with the occurrence of loss of control, increased tolerance, withdrawal symptoms and craving (terms which he defines in detail). He also felt that in these alcoholics some form of metabolic adaptation to alcohol had occurred.
4. 'Delta': This category possessed all the features of the Gamma type with the exception of 'loss of control'. In these patients there is an 'inability-to-abstain' for even a few days without withdrawal symptoms developing. He comments that in this form of alcoholism there is a relative absence of social and psychological problems.

In this study I shall be primarily concerned with Gamma and Delta alcoholism. Chafetz⁽⁵⁾ doubts the usefulness of such classifications and states "Although Jellinek's study of alcoholism definitions is scholastically valuable, it perpetuates the trend to categorise alcoholics into static groups. We feel that it is more important to visualise alcoholism as arising from multiple and varied components which overlap". Nonetheless it seems useful to look for species within the genus alcoholism as these species may well prove of differing clinical importance and show different responses to treatment. Jellinek⁽⁴⁾ makes clear that Alcoholics Anonymous cater solely for the Gamma alcoholic and that by their standards the other forms would pass unrecognised.

SECTION 3 -

Aetiology:

With psychiatric illness it is unhelpful to think of single causes. Even when the necessary cause has been identified as with the bacillus in tuberculosis it is clear from the widespread prevalence of this organism and the relative rarity of the disease that other causes are at work. It would be true, but of little practical value to say that drinking alcohol was a necessary cause preceding the development of alcoholism. It is apparent that a concept of multiple causation is required in examining the aetiology of alcoholism. At present a number of hypotheses exist which endeavour to explain the development of alcohol addiction. The relative significance for the clinician of the various hypothetical causes is examined in the following section.

Cultural influences:

Drinking habit is influenced by such factors as ethnic group, religion, climate and prevailing agriculture. Several studies have examined the role allotted to alcohol in different cultures^{(1),(2),(3),(4)}. Chafetz comments "that alcoholism appears relatively uncommon in cultures where it is integrated into the culture"⁽¹⁾. It does appear that a way of life which has a place for alcohol consumed at certain times and in moderation leads to a rational use of alcohol. Certain groups such as

Italians⁽³⁾ and Jews⁽⁴⁾ appear to have evolved an attitude to alcohol which curbs excessive drinking. Chafetz's view does not appear to take into account countries such as France⁽⁵⁾ where alcohol ingestion in large quantities is regarded as an integral part of the diet and seen by the populace as health-giving.

There is some evidence that a cultural expectation of strict abstinence may restrict the amount of drinking but in attaching emotional significance to alcohol it may thereby become a symbol of rebellion against established custom and give rise to pathological drinking amongst those who do take alcohol. Straus and Bacon⁽⁶⁾ observed that colleges which had a formal prohibition on drinking had fewer drinkers but that those who did drink tended to do so excessively.

Knowledge of the prevailing drinking pattern of the general population and of the various social segments within that population is useful in identifying populations at risk. Studies such as Riley and Marden (1946)⁽⁷⁾, Mulford (1964)⁽⁸⁾, and Bailey et al (1965)⁽⁹⁾ assist in identifying these target populations. Bailey found the most vulnerable sub-groups in the population were widowers and divorced or separated persons of both sexes. Men in all studies appear to have a greater incidence of alcoholism than women. Bailey concluded that religion seemed less associated with alcoholism prevalence than race although Jews revealed an exceptionally low rate of 2 per 1,000. In an analysis of socio-economic variables in

this same study which was conducted in Washington Heights district of New York there appeared to be a concentration of alcoholics amongst those with least education (none to some grade school, 33 per 1,000; high school graduate, 24; college graduate, 13). This contrasts with Mulford's observation that the highest incidence of heavy drinkers were to be found amongst those with a college education and relatively high status occupation.

Research that pinpoints susceptible groups is useful, and may provide clues as to aetiology, and yet, cultural and social factors can only assist us in predicting populations which will produce many alcoholics; they give little assistance in understanding why any particular individual becomes addicted. It may be hypothesised that a drinker in a heavy drinking group who becomes addicted would be less deviant than the alcoholic in teetotal surroundings. This has not been tested. It is hardly surprising that those most exposed to alcohol are most likely to use it excessively.

The excessive number of alcoholics in Scotland has given rise to speculation on the cultural influences which bring this about. Primrose⁽¹⁰⁾ in a study of psychological illness in a highland community considered that alcoholism was "not looked on as an illness in that culture, nor is it condemned by the community who are more likely to treat the matter as a joke". In this community he found an incidence of 10/1,000.

Biological influences:

While cultural influences play an undoubted part in an individual's disposition toward excessive drinking it remains true that only at most 5 - 6%⁽¹¹⁾ of the people in a given culture will become addicted to alcohol. What is it about these people that engenders pathological drinking?

The possibility that alcoholics are in some way biologically distinct from birth has been considered by certain authors and has been extensively reviewed by Jellinek⁽¹¹⁾. One such concept has been that of alcohol allergy. This point of view is adhered to by Alcoholics Anonymous. This theory has not been substantiated and no evidence of phenomena comparable to the allergic response have been detected in alcoholics⁽¹²⁾.

Endocrinological aetiologies have been considered as the underlying biological disturbance in alcoholics. Smith⁽¹³⁾ suggested a disorder of the pituitary-adrenal axis as the critical pathology in his patients and was impressed by the similarity between delirium tremens and an Addisonian crisis. The argument surrounding the view that a primary pituitary deficiency exists in alcoholics which in turn is associated with adrenal hypofunction is reviewed by Jellinek⁽¹¹⁾ who quotes the criticisms of Wexberg⁽¹⁴⁾: "nowhere in the literature have facts been brought out to support this theory. It would require studies of large numbers of young alcoholics,

and the establishment of a premorbid metabolic type, which in follow-up studies would show a significant correlation with alcoholism." This has not been done. It seems likely that these theories have been most useful in highlighting the undoubted strain which alcoholism as a disease places on the adrenals and that the hypofunction observed is effect rather than cause.

It has been considered that the potential alcoholic possesses an idiosyncratic metabolism which is genetically determined or has its origins in nutritional deficiencies. The impetus for such theories is mainly derived from animal experiments.

Williams (1947)⁽¹⁵⁾ hypothesised that genetic factors were significant determinants in the development of alcoholism. He arrived at this view chiefly from experiments in which certain rats showed a preference for ethyl alcohol. He suggested that an inherent enzymic defect rendered an individual unable to utilize certain nutritional elements and that alcohol was taken in an attempt to augment this deficiency. Since then several attempts have been made to breed 'drinker strains' of rats^{(16),(17)}. In reviewing these experiments Mendelson and Mello (1964)⁽¹⁸⁾ detect a tendency to equate preference for alcohol and addiction. They criticise earlier experimenters for failing to establish criteria which should be observed before an animal may be regarded as truly addicted and attempt to define such criteria themselves.

The presence of an increased voluntary intake of alcohol in rats deprived of vitamin B complex appeared to support the hypothesis that a specific deficiency might determine subsequent preference for alcohol⁽¹⁹⁾. However later experiments^{(20),(21)} made clear that the craving in these deprived animals was not specific for alcohol and that the same animals showed a preference for a sugar solution when given the choice. The idea that a dietary deficiency may produce a specific craving of this kind is no longer tenable. However Alexander⁽²²⁾ has pointed out that the evidence that dietary deficiencies may influence subsequent food choice remains, and he likens this to the psychoanalytic concepts of early deprivation having an influence on subsequent oral behaviour.

The presence of a predisposition to alcohol addiction in animals has not been proved. In man there is no evidence of such predisposition. Although a familial trend to develop alcoholism has been demonstrated the pattern is not such as to suggest a genetic transmission.

It is difficult to believe that a defect is present ab initio otherwise addictive drinking would be observed from the outset of the alcoholic's drinking career. This picture is rarely encountered clinically. In considering the metabolism of the alcoholic it is impossible to differentiate cause from effect. A recent study⁽²³⁾ on the effects of experimentally induced chronic intoxication in ten alcoholics detected an

increased rate of alcohol metabolism in alcoholics after 14 days of whisky ingestion. This observed change may represent in part, the biochemical basis of metabolic and behavioural tolerance seen in the chronic alcoholic. The evidence available suggests that some form of metabolic change occurs after years of excessive drinking. This is the 'adaptive cell metabolism' postulated by Jellinek⁽¹¹⁾ and requires more detailed study before its nature is understood.

SECTION 4 -

Psychodynamic formulations:

Psychological factors in the aetiology of alcoholism have probably received more detailed examination than any others.

No one personality type can be defined as pre-alcoholic. Diethelm⁽¹⁾ having reviewed the literature concluded "there is not sufficient evidence to support the claim that specific personality types predispose to alcoholism". However recurring themes may be detected in the writings of those who have studied the personalities of alcoholics. Search for a basic alcoholic personality has been hindered by the difficulty of separating the characteristics of alcoholics that may be the result of alcoholism from those that may be the cause of or at least precede pathological drinking.

The theories advanced by psychoanalysts have for the most part been based on more or less incidental observations of individual cases. Such intensive study of an individual anamnesis is extremely useful in that it indicates the path by which an individual became an alcoholic. Freud⁽²⁾ stressed the importance of oral character traits in the alcoholic and held the view that the mood change produced by alcohol was potent in allowing the patient to return to an earlier form of adaptation so that he could become passive and dependent. Alcohol would also enable the patient to free himself from the

constraints of reality and of his own inhibitions. Later in his writings Freud arrived at the concept of a link between homosexuality and alcoholism⁽³⁾. Most men in our culture drink in the company of other males and it has been suggested that this behaviour in itself indicates fear of, or disappointment, with women. Certainly sexual disorders appear to be common amongst alcoholics⁽⁴⁾.

Fenichel⁽⁵⁾ agreed with Freud that the pre-morbid personality of alcoholics was commonly dominated by oral traits. He comments - "the reasons for reverting to alcohol are either the existence of external frustrations, that is states of misery one would like to forget and to replace by pleasurable fantasies, or internal inhibitions, that is, states in which one dare not act against super ego without such artificial help". He also stressed the importance of depressive moods and likened bout drinking to manic-depressive mood swings - when addiction can be seen as "the last means to avoid a depressive breakdown".

Although he does not explicitly state so, it appears that Fenichel is differentiating the patient who drinks to gratify his oral personality and the man who uses alcohol to escape from external anxieties or the inhibitions of an hypertrophied conscience. This distinction is more clearly made by Knight⁽⁶⁾ who after a detailed study of 30 cases described two types of addict, those in whom the oral incorporative urge predominates, he called these 'essential alcoholics'; the other

form who drank excessively to cope with stress he termed 'reactive alcoholics'. Chafetz⁽⁷⁾ more recently has arrived at a very similar conclusion. He describes the 'alcohol addict' as suffering from a gross disturbance of personality and the 'reactive alcoholic' as having a relatively normal personality prior to the onset of his alcoholism. He appears to qualify this notion of normality by stating that such patients "utilise alcohol to excess when overwhelmed by some external stress".

Rado^{(8),(9)} detected in the alcoholic's personality a defect in ego development whereby the omnipotent megalomania of the infant had not matured to a more realistic self evaluation. When passively obtained gratification is not forthcoming the frustrated patient develops a 'tense depression' and is in these circumstances particularly susceptible to the pleasure-giving effect of a drug. He suggested that alcohol intoxication allowed a regression to a very early quasi-orgastic sensation involving the whole alimentary tract.

Alexander⁽¹⁰⁾ in a review of psychodynamic formulations of alcoholism, discriminates between two distinct predisposing factors - the desire for regressive gratification and the escape from stress. Of the former he comments "in drinking the patient achieves the bliss of an oral-dependent situation". The stress from which the drinker seeks to escape may arise from "inferiority feelings arising from excessive inhibitions,

never expressed resentments and sexual cravings".

Several authors^{(11),(12)} have commented that the alcoholic has a low tolerance for frustration. This concept does little more than restate the problem in different terms. The predisposed personality can not tolerate certain 'frustrating' situations, the exact nature of these situations being specific to each patient's problem area or level of fixation. In reviewing psychological theories of the aetiology of alcoholism Jellinek⁽¹³⁾ quotes Higgins⁽¹⁴⁾. "A predisposed person (and the predisposition may represent fixations at various levels of personality development) is confronted with a difficult life situation; the 'difficult life situation' may or may not be one which has as its primary component an 'oral threat'; an attempt is made through drinking to handle the anxiety aroused by this conflict. The drinking may serve as a defence through various channels; it may bring diminished awareness of internal and external stress, or it may facilitate defences previously inhibited."

Most authors appear agreed that alcohol reduces anxiety and it is interesting in view of this to consider the observed effect of alcohol on alcoholics. In an experiment⁽¹⁵⁾ in which alcoholics were given alcohol over a period of time psychological testing revealed increased anxiety as more alcohol was taken. This suggests that the anxiety-reducing effect of alcohol may no longer obtain when the addictive

phase is entered. These patients did however display ego alien activities during intoxication. Ten men were observed and a marked deterioration in their behaviour patterns appeared with the emergence of 'psychopathological symptoms'. Two subjects exhibited overt passive-aggressive behaviour towards other members of the group in the form of lying and minor theft. One subject tried to get into bed with other subjects. Three became suspicious and showed moderate paranoid tendencies. It is understandably rare to have an opportunity of observing the effects of alcohol directly in a controlled environment. The fact that these patients were subjects in an experiment would undoubtedly influence their behaviour.

In recent years attempts have been made to place the somewhat speculative psychological concepts of aetiology on a more scientific foundation. In such studies those features of the alcoholic personality which differentiate him from those around him are described and the resultant hypothesis tested. The most effective means of contrasting the alcoholic and his neighbour has often proved to be by focusing on critical life experiences which have occurred significantly more often in those who subsequently drink pathologically.

Knight (1937)⁽⁶⁾ suggested that the disorder of personality commonly observed in alcoholics is produced by the constellation of an over-protective and indulgent mother with a weak or inconsistent father. As a result of this the child does not learn self control and reacts to every frustration

by becoming intensely angry. Zwerling⁽¹⁶⁾ in a detailed analysis of 46 alcoholics concluded that a number of interacting processes were at work varying in severity and prominence from case to case but that a disordered mother-child relationship was a common denominator in all his patients.

To detect the influence of early life experiences the most satisfactory approach is to follow a known population from its childhood until alcoholics appear within it. A paradigm of such a project is McCord and McCord's⁽¹⁷⁾ longitudinal study of 255 delinquent boys. At the start of the investigation the average age of the sample was 9 years. Subsequently 29 boys became alcoholic. The criteria for the development of alcoholism were a membership of A.A., hospitalisation on account of alcoholism, known as alcoholic by social agencies or had two court convictions for drunkenness. The personalities of the pre-alcoholic boys could be significantly differentiated from those of their peers not destined to become alcoholic. They appeared more likely to reject their mothers and were cool and indifferent towards siblings. They conformed to community patterns, had fewer abnormal fears and seemed self confident. They tended to display unrestrained aggression more often than the others and were hyperactive and disturbed by sex anxieties. McCord postulates that this manly, fearless, self sufficient and aggressive nature conceals feminine traits which are culturally undesirable. With the passing of childhood traits of dependency and passivity emerge. "Heavy drinking

widely recognised as masculine behaviour allows him to enjoy simultaneously those dependency needs which are otherwise being suppressed."

In the same study 83 of the fathers were found to be alcoholic and the authors compared their characteristics with those of 105 non deviant fathers. The alcoholics appeared unable to show affection, were not leaders in their household and were erratic as disciplinarians. They tended to feel victimised by society and to compensate for this by feelings of grandiosity. They frequently showed unrestrained aggression and their homes were unhappy with frequent problems arising due to unemployment.

There is general agreement that the sons of alcoholics are significantly more anxious and depressed as children (18) and are conspicuously susceptible to alcoholism themselves (19). It is thought that the mode of transmission is by example. A family tradition of attaching undue emotional significance to alcohol becomes established and it seems that the child who observes his father attempting to solve problems by drinking will identify with this pattern.

(19)
Aronson and Gilbert examined this influence by contrasting each of 41 boys whose fathers were alcoholic with three boys from a matched randomly selected population. On 21 of 36 items in a questionnaire concerning characteristics commonly reported in the alcoholic the alcoholics' sons differed

significantly from the others by possessing such characteristics.

Parental loss or separation in childhood has been regarded as having a lasting and harmful effect on personality development. Compared with other parental influences death or prolonged separation are relatively 'hard' facts and their occurrence has been the subject of detailed study in psychiatric patients.

Munro⁽²¹⁾ has recently focused on the danger of inferences drawn from data which has been inadequately controlled. He found that 19.5% of subjects in a psychologically normal population had lost a parent by death before their 16th birthday.

Hilgard and Newman⁽²²⁾ found no increased incidence of childhood parental loss in alcoholics with the notable exception of those who were young (20 - 39 years). They suggested that the young adult years revive traumata associated with parental death in childhood and reveal latent ego defects.

Although on account of the absence of adequate controls the findings must remain conjectural, certain studies of experiential data in the lives of alcoholics have offered some interesting clues to aetiology. In a study of 50 alcoholics Bleuler⁽²³⁾ commented that only 10 had been reared in favourable circumstances; 30 had experienced a broken or disturbed home life and 12 had suffered the death of a parent before the age of 20. Wahl⁽²⁴⁾ analysing the case histories

of 109 male alcoholics observed that 37% had lost a parent by death or permanent separation before the age of 15. Both of these authors examined the quality of the patients' relationship with parents and it is quite likely that this variable is more significant than the occurrence of separation but it is much more difficult to measure and is open to retrospective distortion on the part of the patient. In the quoted studies, 60% of Bleuler's and 80% of Wahl's patients had unsatisfactory relationships with parents and Knight's review of 30 male alcoholics concluded that in most cases a possessive mother and a remote and inconsistent father are to be found in the lives of alcoholics.

Navartil⁽²⁵⁾ in a survey of 600 male alcoholics observed that nearly 30% of the patients were last children which contrasted with the expected figure of 22.8%. When there was a sibship of 3 or 4 then the sibs appeared equally likely to develop alcoholism. When there were only two the younger was twice as likely to become addicted, a situation which also applied to those when the sibship was 5 or more. Others^{(22),(26)} have not found such a trend. Smart (1963)⁽²⁶⁾ did not find any correlation between position in sibship and alcoholism but observed that a significantly greater number came from larger families.

Summary of aetiological factors:

It has been demonstrated that social and other environmental factors influence profoundly the individual's attitude towards drinking. Although such determinants are important in establishing the prevalence of alcoholism in the community they do not explain the path by which the individual drinker becomes an addict. The case for biochemical idiosyncrasy in the alcoholic has not been established. It does seem likely that the alcohol addict metabolises alcohol differently from his fellows but the genesis of this difference has not been explained. While no single personality type can be termed pre-alcoholic there is some evidence that certain types are more susceptible than others. The increasing interest in the life experiences of alcoholics has produced some contradictory findings but certain distinguishable patterns have been detected particularly in the study of parental influences on the developing personality.

SECTION 5 -

Follow-up studies:

In the alcoholism literature relatively little has been written on the effectiveness of treatment. In psychiatry the evaluation of therapies is complicated by the multiplicity of variables involved, the majority of which are outwith the control of the observer. The notion that improvement is a unitary concept has rightly been criticised^{(1), (2)} and it has been suggested that change within selected areas of life experience may be a more significant measure of treatment response. With alcoholism the psychiatrist is fortunate in that the criterion of abstinence is relatively easily established while the more subjective aspects of improvement remain difficult to assess. Chafetz⁽³⁾ points out that abstinence alone is insufficient and that improved well-being comes only when intrapsychic readjustment has occurred. None the less, it seems reasonable to suppose that until the alcoholic has learned to abstain further psychological change can not occur. For this reason alcohol intake following treatment seems the best available index of change.

Follow-up studies are hampered by the arbitrary nature of their duration. The ideal follow-up period should be for life. If we wish to know the quality of a patient's response to treatment an intensive study over a short period of time may be more informative. Pfeffer and Berger (1957)⁽⁴⁾ stressed

the importance of providing adequate means for maintaining contact with patients after discharge. This is a crucial problem both for research and treatment. It becomes increasingly difficult to contact patients as time elapses.

In this section attempts to assess treatment response are reviewed.

Harper and Hickson⁽⁵⁾ assessed the progress of 84 chronic alcoholics 2 to 5 years after treatment (in this case treatment entailed sedation, vitamins, modified insulin and some form of psychotherapy). The in-patient stay varied between a few weeks to six months. 16 patients were much improved (abstinent or one lapse), 25 were improved and 22 unchanged, 15 were dead. They found no relation between age or sex and treatment response.

In surveying the effectiveness of a specialised unit for the treatment of alcoholism Glatt⁽⁸⁾ observed that within 2 to $4\frac{1}{2}$ years of discharge one third of his patients were sober, one third had relapsed but were improved and another third had lapsed more than three times and were no better. In his series 90 per cent of those who lapsed did so within six months. It appeared that older, socially stable, married patients from classes I and II had the best prognosis.

Davies et al (1956)⁽⁷⁾ arrived at similar findings in a follow-up of fifty alcoholics treated within the Professorial unit of the Maudsley Hospital. All these patients had received individual psychotherapy and the offer of assistance from

Alcoholics Anonymous together with the prescription of Antabuse. Duration of stay varied between 3 weeks and 10 months. 36 per cent. of these patients remained abstinent for the greater part of the two year period of study, 42 per cent. were improved but drinking, and 20 per cent. were unchanged. In analysing their data they arrived at the following profile of the "patient with favourable outcome: intermittent drinker of good previous personality with satisfactory work record, with close personal ties to at least some one person, married, seeking help for the first time, rating 1 or more for social stability (Straus and Bacon scale) who continues to accept the aid afforded by Disulfiram and Alcoholics Anonymous". Like Glatt they observed that the majority of patients who resume drinking do so within 6 and nearly all of these within 3 months of leaving hospital. They point out that "predictions made six months after discharge based on the patient's behaviour during that time would result in a prognostic misclassification of less than 20 per cent. of all the cases in the series". More recently Gerard and Saenger (8) studied the interval between intake and follow-up as a factor in the evaluation of alcoholics and arrived at a similar conclusion.

(9)
In an assessment of the first 83 alcoholics treated at the clinic described in this study 54 per cent. of the patients were abstinent six months after treatment although a number of these had brief lapses not lasting more than a week.

20 per cent. of the patients were regarded as improved but drinking. A quarter of those studied showed no improvement. Again it was found that six months provided a good indication of drinking status at 18 months after their treatment began. Like Davies⁽⁷⁾ this study found that compulsive addicts responded better than regular restrained addicts. It was observed that those patients whose conscience structure was judged 'harshly self-critical' had a uniformly poor outcome.

This section is not primarily concerned with a discussion of the relative merits of treatment methods, but the controlled evaluation of response to different forms of therapy conducted by Wallerstein⁽¹⁰⁾ requires mention at this stage. (It is discussed in detail later). In a follow-up study of 2 years duration he found that the best response occurred in the group treated with milieu therapy plus antabuse where 53.2 per cent. improved. He also observed that 75.6 per cent. of those who had one home and lived most of the time with either parents or wife benefited from treatment whereas only 16.6 per cent. of the socially unstable group did so. It was also noted that older patients responded better than younger. A psychiatric assessment had been made of all the patients and those with a compulsive character structure appeared to have the best prognosis. It is interesting that certain personalities appeared best suited to specific therapies - this is an area which has been inadequately explored.

Several other authors ^{(11),(12),(13)} have agreed that social stability and particularly the attitude of the spouse are closely correlated with treatment success. This seems particularly true when the spouse is taking an active part in treatment. ⁽¹⁴⁾

Lundquist ⁽¹⁵⁾ found prognosis most favourable amongst patients who are married, over 40, have their own home and have no previous admissions to hospital for alcoholism. He found that 2 years after discharge 16 per cent. of 96 patients were much improved while 51 per cent. were relatively unchanged or in institutions. The importance of age as a predictor of outcome is uncertain. While most have found that older patients have the best prognosis, a report ⁽¹⁶⁾ from the Apolinar Clinic in Prague found no significant difference between response in different age groups.

In a recent Scottish study Vallance ⁽¹⁷⁾ assessed the progress of 68 male alcoholics over a two year period by comparing this with their condition during the two years prior to admission. Only three cases were abstinent for the whole of the follow-up period and almost 80 per cent. had started to drink again within six months of discharge. 56 per cent. were readmitted at least once during the two years. In discussing his findings he stresses the poor results obtained when alcoholism is treated by the 'first aid approach' currently employed in mental hospitals throughout Britain.

CHAPTER II

THE TREATMENT OF ALCOHOLISM

SECTION 1 -

Review of treatment methods:

The recognition of alcoholism as a disease entity has effected a change in attitudes towards the alcoholic and with this, new treatment endeavours have occurred.

While many societies have used alcohol in an integrative way in their culture, it is equally apparent that they have repeatedly become aware of its destructive properties and have attempted to eradicate these. Plato declared in Laws - "To drink to the degree of drunkenness is not becoming anywhere, except perhaps in the days of festival of the god who gave men wine for their banquets". The death penalty was enforced in Sparta for soldiers who were unable to fight because of drunkenness. In England at the time of the industrial revolution gin at first assisted the worker to tolerate the misery of urban life but at the same time it destroyed his health and impaired his working capacity. Prompted by such circumstances temperance movements were organised and legislation introduced to tax alcohol and restrict its hours of sale.

At the close of the 19th Century a series of statutes in English law known collectively as "the Inebriates Acts" made

provision for special institutions for "habitual drunkards"⁽¹⁾. This legislation appeared to recognise that drunkenness did, in some way, differ from other offences. The Acts were rarely enforced, probably because insufficient appropriate reformatories or retreats were provided.

Throughout the first half of this century attention was chiefly directed at the social consequences of drunkenness. Temperance societies highlighted the evils of drink and rarely concerned themselves with the social and psychological precipitants of excessive drinking (this was inevitable in view of the prevailing therapeutic nihilism and absence of effective treatment). The chief concern of the community was the protection of others from the antisocial behaviour of the alcoholic. During this period psychiatrists were chiefly concerned with the management of the late manifestations of chronic alcoholism such as Korsakof psychosis or delirium tremens⁽³⁾.

In 1935 the American Medical Association passed a resolution that alcoholics were to be regarded as valid patients. In the same year Alcoholics Anonymous was founded in Ohio. At first, serious attempts at treatment were made by only a minority of doctors or by the sufferers themselves and it was several years before public concern was aroused.

From the Yale Center of Alcohol Studies came the concept of out-patient clinics for the treatment of alcoholism. At first the Yale Plan Clinics in Hartford and New Haven,

Connecticut functioned as centres of guidance and referral for alcoholics. R. G. McCarthy (1944) rapidly became aware of the dearth of referral facilities and treatment itself was added to the clinic's programme⁽⁴⁾. Treatment was on an out-patient basis and groups of patients were formed primarily for didactic therapy.

In addition to the above clinics 1944 also saw the foundation of the National Council on Alcoholism in U.S.A. This organization has contributed enormously to developing public awareness and understanding of alcoholism. The chief aim of the council was to disseminate the facts about alcoholism as widely as possible. "Alcoholism is a disease and the alcoholic a sick person. The alcoholic can be helped and is worth helping. This is a public health problem and therefore a public responsibility."⁽⁵⁾ Increasing concern about alcoholism as a public health problem has given rise to the development of government and local authority programmes to combat it. In U.S.A. the funds devoted to state alcohol programmes have increased⁽⁶⁾ yearly.

Voegtlin and Lemere⁽⁷⁾ in a survey of treatment approaches used up to 1942 were forced to conclude that "advances in therapy had not kept pace with advances in the knowledge of pathology, psychodynamics and aetiology of chronic alcoholism."

The meagre success of individual psychotherapy and psychoanalysis in treating alcoholism coupled with the effectiveness demonstrated by Alcoholics Anonymous inclined psychiatrists

towards employing group psychotherapy in helping alcoholics. Pfeffer (1949)⁽⁸⁾ reported improvement in four of six alcoholics whom he had treated with intensive group psychotherapy - meeting twice weekly for a year. All these patients had not responded to the earlier efforts of Alcoholics Anonymous and individual psychotherapy. He postulated that "the alcoholic is unable to tolerate the intense transference feeling in individual therapy but in the group he achieves a level of intensity of transference that is therapeutically useful and yet within the encompassment of his low anxiety tolerance".

In 1948 Martensen-Larsen⁽⁹⁾ reported the treatment of 83 alcoholics with tetraethyl thiuram disulphide (Antabuse) a drug which sensitised the patient to alcohol. Subjects who drank alcohol after taking 0.5 to 1.5 g. of the drug developed characteristic symptoms of flushing, headache, dyspnoea and nausea: at the same time marked peripheral vasodilation, hypotension and tachycardia were observed⁽¹⁰⁾.

'Antabuse' was rapidly incorporated into treatment programmes for alcoholics. At first⁽⁹⁾ the unpleasant symptoms of the Antabuse/alcohol reaction were used as a deterrent by urging the patient to take the drug daily even when he was drinking. Physicians experienced in the use of Antabuse came to recommend the drug as an aid to total abstinence, so that rather than having to decide whether or not to drink many times each day the alcoholic need only make the decision once each morning by taking the Antabuse. Antabuse used in this way

gave an alcoholic a feeling of security when faced with daily anxieties. It was made clear to each patient that he alone was responsible for taking Antabuse and that the patient's spouse or employer should avoid becoming responsible for its administration ⁽¹¹⁾. There is agreement that Antabuse is only an aid to sobriety and that it must be used in conjunction with other forms of social and psychological assistance ^{(12),(13),(14)}.

Several attempts have been made to utilise the principles of conditioning to instill an aversion to alcohol in patients. In reviewing conditioning therapy Voegtlin and Lemere ⁽¹⁵⁾ point out that only well integrated and highly motivated patients are likely to respond to this approach. Clearly when treatment is made distasteful to the patient he must be very desirous of cure before submitting to it. Reports on the effectiveness of this form of therapy vary between 51% abstinent 1 to 7 years after ⁽¹⁶⁾ (Thimann) and the near total ineffectiveness of treatment in patients who are less well motivated ⁽¹⁷⁾. This suggests that the attitude of the patient may be more relevant to treatment response than the actual conditioning technique.

Aversion to alcohol produced by unpleasant reactions induced by emetics or by muscle relaxants such as curare has achieved less popularity amongst psychiatrists in Western Europe and U.S.A. than in Poland and Russia ⁽¹⁸⁾. Psychiatrists

are understandably reluctant to submit patients to painful and unpleasant procedures. Some physicians have favoured electric shock as the unconditioned stimulus as this can be timed more accurately than the onset of nausea and is probably less unpleasant. This technique was originally employed by Kantorovich⁽¹⁹⁾ and has returned to prominence recently⁽²⁰⁾. In evaluating any form of conditioning it is difficult to differentiate the effects due to the technique itself and those attributable to the relationship between patient and therapist. This of itself does not detract from a treatment approach of proven effectiveness. Chafetz⁽⁶⁾ comments "that aversion therapy can alleviate guilt for some patients so that they can give up alcohol, or experience a punishing episode for relief". The problem is to detect which patients.⁽²¹⁾ Wallerstein offers the interesting finding that the patients who responded best to aversion therapy were depressed and that the experience had allowed them to unburden their guilt and self-criticism and "externalise their aggression".

Hypnosis as a treatment for alcoholism has proved disappointing. Wallerstein treated a number of alcoholics with group hypnotherapy⁽²¹⁾. The result did not compare favourably with other methods but he was impressed that passive dependent personalities responded best to this technique.⁽²²⁾ Edwards found no difference in treatment response between matched groups, one of which received standard in-patient care and the

other individual hypnosis in addition to this standard regime. Wallerstein (1957)⁽²¹⁾ has made an interesting contribution to the problem of selecting the most effective alcoholism treatment regime. In his study 178 male alcoholics were randomly allotted to four treatment groups. All were treated in semi-closed wards and remained in hospital 60 to 90 days. The first group were treated with Antabuse. Group 2 received conditioning therapy (unfortunately using a faulty technique). Group 3 experienced hypnotherapy and Group 4 was designated 'milieu therapy' which involved hospital routine with an extra group discussion each week. All four groups had one discussion group weekly and all were allowed free access to the resident doctor for individual consultation if desired.

Follow-up was conducted over a two-year period, the patients being assessed for sobriety, social, economic and intra-psychic adjustment. The Antabuse group fared best with 53.2% improvement. In the conditioned reflex group the depressed patients seemed to respond best and those with passive dependent personalities showed favourable response to group hypnotherapy. The milieu therapy group had 26% improvement with no particular trend for the improved cases to cluster among patients assigned to one or other personality configuration.

Of patients who had lived most of their time with parents or wives 75.6% benefited from treatment. Of those who were socially unstable only 16.6% responded favourably. The older

patients appeared to have a better prognosis and patients diagnosed as compulsive characters showed the highest improvement rate of any personality pattern. The group categorised as 'schizophrenic reactions' showed least improvement.

In the conclusion of the monograph Wallerstein makes it clear that no one treatment which can be designated 'the best' has yet been found. "The Antabuse therapy program emerged as the most helpful to the most patients, yet an important corollary conclusion was that the group of patients not helped by Antabuse constituted almost half of those to whom it was administered. Moreover, the number of patients helped with conditioned reflex therapy, with group hypnotherapy and with milieu therapy was sizeable enough to preclude the blanket prescription of Antabuse as the optimal mental hospital treatment of the chronic alcoholic."

(23)

In 1952 Glatt opened a unit for the treatment of alcoholism at Warlingham Park. Daily group therapy was integrated within a ward routine that involved much interaction between patients who were responsible for much of the day to day organisation of the ward, and extensive use of Alcoholics Anonymous both during the three months in-patient stay and after discharge. The 'group therapy' offered was unorthodox in that each patient was expected to prepare a 'life story' which he would read to the group once during his stay and this account would form the basis for subsequent discussion. In a review of this treatment approach Glatt states -

(23)

"the period of after-care is probably the most important phase in the therapy of alcoholism". The geographic distribution of the patients attending Warlingham has made follow-up extremely difficult ⁽²⁴⁾ and as in many hospitals the burden has been carried by Alcoholics Anonymous with the additional provision of monthly social reunions of former patients.

The term 'group therapy' has become a collective noun describing a wide range of different treatment techniques. Some, such as that used at Warlingham, are highly structured but essentially non directive. Others favour a more didactic group with discussions on set topics ⁽²⁵⁾. Predominantly inspirational techniques have proved effective with some groups, notably Alcoholics Anonymous and some religious organisations such as the Salvation Army ⁽²⁶⁾. Both Fox ⁽²⁷⁾ and Chafetz ⁽²⁸⁾ have indicated that group therapy to be effective with alcoholics requires some modification of traditional psychotherapeutic techniques. Chafetz ⁽²⁸⁾ states that - "Alcoholism as a preverbal disorder, must be treated by action - by doing for the patient". He stresses that the non directive therapist will be unlikely to retain the patients he treats if he persists in this approach particularly in the early stages of treatment.

He has in another paper ⁽²⁹⁾ stressed the importance of the initial contact with the alcoholic and demonstrated that those patients who are made to feel welcome when they first approach a clinic thereafter tend to remain in treatment.

This diversity of methods which may appear superficially similar emphasises the difficulty of comparing one treatment with another and makes it imperative that each report on a therapeutic technique should state clearly the methods used.

A dilemma which faces all psychotherapeutic endeavour with alcoholics has been highlighted by Agrin ⁽³⁰⁾ in his survey of the Georgian Clinic for the treatment of alcoholism - "The alcoholic can not stay sober until he begins to develop some tolerance of the difficulties in living yet he can not develop this capacity for adequate mature living unless he stays sober." Clearly it is necessary for the alcoholic to be sober before explorative psychotherapy can be effective. Admission to hospital at the outset of treatment allows the patient to achieve sobriety so that he becomes accessible to therapy. This is an advantage of in-patient facilities being available with a service for the treatment of alcoholism. Walton (1961) ⁽³¹⁾ has outlined such a service which has served as a model for the treatment service outlined later in this chapter.

The importance of involving the patient's spouse in the treatment of alcoholism is being increasingly recognised. Gliedman ⁽³²⁾ recommended wives' groups organised concurrently with those for their alcoholic husbands. Alcoholics Anonymous have recognised the importance of relatives by establishing Al. Anon. groups for close relatives ⁽³³⁾. The spouse derives great benefit from exchanging experiences with others in similar circumstances and can develop an understanding of her partner's

illness. In addition some wives may require psychiatric
help in their own right ^{(34),(35)} . Patients whose spouses
take part in active therapy appear to respond better to
treatment ⁽³⁶⁾ .

CHAPTER II

SECTION 2 -

A unit for the treatment of alcoholism:

The unit for the treatment of alcoholism described in this study was formed with the assistance of a grant from the Nuffield Provincial Hospitals trust. The unit is situated within the Royal Edinburgh Hospital and the treatment service commenced in October, 1963. The staff comprised one part-time consultant psychiatrist, a registrar, psychiatric social worker, seven trained nurses, a secretary and a part-time occupational therapist. A consultant physician and psychologist were available for consultation.

The plan of treatment has been out-lined in a preliminary report (1). The majority of referrals came from the city of Edinburgh but approximately 10% came from surrounding districts. No attempt was made to restrict referrals to the hospital's catchment area. In certain circumstances patients referred themselves but the majority came either from their General Practitioner or another psychiatrist. The unit catered for patients of both sexes and all admissions were voluntary.

Factors limiting acceptance for in-patient treatment:

All patients were interviewed by the staff psychiatrists and if alcoholic were offered treatment. The criteria required for admission were that the patient agreed he was alcoholic and could contemplate a life of total abstinence and also that

he possessed some capacity for forming lasting relationships or had shown this in the past. It was also required that he be able to attend the clinic as an out-patient weekly for one year following discharge. Patients who did not fulfill these criteria would be treated as out-patients or referred elsewhere.

The in-patient regime:

This commenced with detailed attention to the patient's physical health. During this phase, which normally lasted less than a week, patients were commonly kept in bed. Phenothiazine drugs (most often Promazine) combined with barbituates were liberally used, the aim being to effect the transition from alcohol to abstinence with as little discomfort due to withdrawal symptoms as possible. After one week most patients had discontinued all sedatives and hypnotics. During this phase attention was paid to each patient's physical and particularly nutritional state. All received parenteral vitamins ('Parentrovite'). When physically able patients entered the second phase of treatment.

The above procedure is often known as 'drying-out', the next phase was more specifically aimed at assisting the patient to develop techniques for maintaining his abstinence. Daily group-psychotherapy was organised with a group analytic orientation ⁽²⁾. The psychiatrist and those nursing staff on

duty attended each group. The aim was to clarify for each patient those personality difficulties which had disrupted his capacity for interpersonal relationships or had given rise to misperceptions of events around him. The patient's history was known in detail by all members of the staff and every effort was made to facilitate the communication of this history to all members of the therapeutic community, patients and staff alike.

The behaviour and reactions of each patient could be observed by all members of the therapeutic community and were open to comment. When the patient's history was known in detail then his behaviour could be seen and understood against the background of his former life. In an atmosphere which was non-judgemental the patient gained confidence in exposing ego-alien aspects of his personality which had caused him suffering. This was of particular assistance to those patients of stern conscience who were ashamed of impulses which they believed unacceptable.

While part of the work of the therapeutic community would be directed to freeing patients from unrealistic anxieties and restrictions, on other occasions it worked to bring a patient to examine closely a reality which he was avoiding. The excessive use alcoholics make of defence mechanisms is well known. Patients would tolerate 'home-truths' about themselves more readily from other alcoholics than they would from

non-alcoholics - Alcoholics Anonymous have consistently stressed this principle.

The nurse played a crucial part in treatment acting as a therapeutic catalyst in facilitating the activities described above in the light of her knowledge of each patient and coaxing neurotic distortions towards reality. Without a team of nurses willing to undertake this, it would not be possible for the ward community to become truly therapeutic. The difficulties experienced by nurses in developing these treatment skills have been described elsewhere (3,4,5).

During each afternoon patients and nurses attended occupational therapy where the explorative process was continued.

The alcoholics remained together all the time and gained detailed understanding of each others' problems and personalities. Relatives were encouraged to visit the Unit each evening and were incorporated within the treatment regime so that they gained a clearer understanding of the alcoholic's problems and found support in talking to other relatives with similar experience of the disease.

An additional function of the treatment staff was to teach patients and their relatives about alcoholism. Regular films about alcoholism were shown and discussed. Patients and their spouses were encouraged to read books on alcoholism available in the Unit library.

The Psychiatric Social Worker interviewed if possible, the closest relative of each patient. Where it seemed that a

detailed analysis of this person's part in the patient's life was necessary, the relative was taken on for case work. Prior to discharge one or more joint interviews between patient, spouse, psychiatrist and Psychiatric Social Worker would be arranged.

It was the policy of the treatment staff that patients should be discharged as soon as they had gained a thorough understanding of alcoholism and techniques to avoid drinking, and had clarified the emotional difficulties which their drinking had concealed. Detailed psychotherapy with the goal of lasting change in the person was the aim of the out-patient group to which each patient was allotted prior to discharge.

The out-patients groups contained approximately 10 members and met weekly with staff psychiatrists as observers and conductors. They were organised as closed groups and met for 1½ hours in the evening once each week. It was important that they were held in the evening so that attendance did not interfere with the patients' jobs.

"To deal with alcoholism solely by abstinence methods and without any analysis is to leave the patient at the mercy of a psychopathological process which he was originally unable to withstand." This view of Glover's ⁽⁶⁾ expresses the dilemma frequently experienced by the alcoholic when he leaves hospital. In becoming abstinent he is deprived of his traditional defence that is, resorting to alcohol. The continuing aim of ongoing

out-patient treatment is to maintain abstinence and at the same time to analyse the psychological difficulties which were masked by intoxication. The out-patient group establishes a repertoire of techniques for avoiding drinking and assists members who feel they are about to relapse or have in fact relapsed. In addition patients report on the problems and anxieties they have experienced during the week and obtain reactions from other group members. Strong feelings about each other develop within the group and are available for analysis. As patients become confident of their acceptance within the group they reveal laboriously concealed aspects of their personality which they believed were unacceptable; they feel free to express new patterns of behaviour both within and outside the group. A group when it is working therapeutically maintains the abstinence of its members and facilitates the development of their personalities.

The out-patient service:

A number of patients were not admitted to the Unit but were offered out-patient treatment from the start. This group comprised;

- 1) patients who were considered suitable for admission but had refused to come into hospital.
- 2) patients who were not accepted for in-patient treatment because they did not fulfill the criteria set-out earlier in this Chapter.

If the patient was physically ill and it was clear that he would require attention in hospital, particularly when severe withdrawal symptoms seemed likely to develop, then he would be admitted elsewhere in the hospital for 'drying-out' and return later to the unit staff for out-patient management. In certain circumstances the patient would be given tranquillisers (commonly Promazine) to assist him during the first few days of abstinence and the General Practitioner's help in dealing with withdrawal symptoms at home was obtained.

Those treated as out-patients were required to attend regularly for individual therapy from a staff psychiatrist. Case work for the family was provided by the Psychiatric Social Worker. The form of therapy offered was adjusted to the patient's capacities and needs and the stage of treatment which had been reached. In all circumstances abstinence was the primary goal. When the patient was no longer drinking exploration of his anxieties and conflicts could be carried out. Throughout it was accepted that alcoholism is a relapsing illness and no patient was refused further treatment because of continued drinking. Many out-patients attended films about alcoholism shown in the Unit and borrowed books from the Unit library. In a few cases patients entered the closed out-patient groups without first experiencing in-patient treatment.

Antabuse (Disulfiram):

All patients who expressed a wish to remain abstinent were offered Antabuse provided physical illness did not contraindicate this. The use of Antabuse was carefully explained to the patient. It was emphasised that by making a habit of taking Antabuse daily the patient simplified the decision to drink or not to drink by only having to make it once each day. The responsibility for taking Antabuse was to be theirs alone and the dangers of drinking within three days of taking Antabuse were explained. To give each patient an understanding of his own individual response to the drug all were given a test dose of alcohol in hospital. This Antabuse-alcohol reaction was given at an early stage of a patient's in-patient stay. Those who were out-patients attended hospital on one morning for their test dose.

Patients took 0.5G Antabuse daily and on the day of the reaction were given 2 oz. of whisky. During the hours following the reaction the patient was in bed and the nurse who attended throughout made quarter hourly pulse, respiration and blood pressure readings. It was felt that the experience was abreactive for some patients and the nurse encouraged them to talk freely about their feelings throughout. Some patients experienced adverse reactions to Antabuse, skin rash, headaches, drowsiness and rarely psychotic episodes. In such circumstances Abstem (Citrated Calcium Carbamide) was used in place of Antabuse.

CHAPTER III

METHOD

The project began on 1st January, 1965. From that time all new patients were subjected to the same evaluative procedure. Included in this study were 50 consecutive admissions and also an equal number of patients who were not admitted. Excluded from the study were eight referrals who, although evaluated by the staff, could not be allotted to either group (these eight are described in detail in Appendix I).

SELECTION PROCEDURE

All patients were assessed by one of the staff psychiatrists who conferred with a colleague before arriving at a clinical formulation and recommendation for treatment. Assessment was based on a detailed psychiatric history with particular emphasis on the diagnosis of alcoholism.

The criteria required for admission were:

1. The patient agreed he was alcoholic.
2. The patient accepted that in the future total abstinence was required.
3. The patient was able to attend weekly as an out-patient for at least a year following discharge.
4. The patient had shown some capacity for forming relationships suggesting that he could utilise therapeutic community techniques.

The evaluation of the patient's capacity to form

relationships within the unit was the most subjective and complex of these criteria. Features which, if prominent in a patient's history, would suggest that he was unsuitable for admission are listed below.

1. The presence from an early age of a persistent inability to adapt to his environment or to form meaningful relationships.

2. Markedly inconstant in his relations with others, revealing an unconcern for the feelings of others, viewing people as objects.

3. Recurrent episodes of inadequately motivated impulsive behaviour not related to drinking.

These attributes would be in evidence before the development of excessive drinking.

Such patients were not admitted because it was felt that the limited treatment facilities should be made most fully available to those whom they were most likely to be able to assist.

Ideally allocation to in-patient and out-patient treatment should have been random. Although this was experimentally desirable it was not regarded as ethically possible. The unit was designed primarily to give a treatment service.

The group who received out-patient treatment alone comprised those who, for the reasons indicated, were regarded as unsuitable for admission. There were patients for whom the



staff had advised hospitalisation and who had declined the offer. In many cases the reasons given were rationalisations of a fear of hospital or a reluctance to recognise that they were addicted, such as inability to leave his work or an assertion that he could manage on his own. Those who remained reluctant were given further appointments and treated as out-patients at the clinic. A number of patients had stopped drinking successfully before the initial interview and did not want to come into hospital until they had tried to maintain abstinence as out-patients.

INITIAL INTERVIEW DATA

Most of the information detailed in the initial interview form (see appendix II) was collected during assessment. In circumstances when a patient was relatively incapacitated as a result of intoxication when first seen it was necessary to postpone data gathering until a second examination.

Definitions of the categories to be examined in the initial interview had been agreed on by the staff psychiatrists. A preliminary study⁽¹⁾ had afforded experience in the use of these categories. In cases where doubts arose the final decision was reached by discussion and represented a consensus opinion of the staff.

The validity of information obtained by interview is always questionable. Factual data is more likely to be reported

reliably than are opinions about attitudes and emotions. Thus, the information collected from the initial interview can be divided into that which is factual and those more subjective opinions which reflect the patient's perception of events.

During the initial interview with each patient, information about the following areas of experience was collected:-

1. Demographic Data
2. Background and parental influence
3. Drinking History
4. Clinical Evaluation: Pattern of Addiction
 Psychiatric Diagnosis

The Psychiatric Social Worker attached to the unit assessed all spouses who were referred to her. During an interview she evaluated the spouses' personality and understanding of alcoholism (see Appendix II). For those spouses whom she selected for case work more detailed assessment and progress reports were obtained.

ASSESSMENT OF TREATMENT EXPERIENCE

The patient's physical state on admission, attitude towards Antabuse and duration of stay were recorded. An attempt was made to assess the quality of each patient's stay in hospital. Progress was evaluated by doctors and nurses on the staff. The number of out-patient attendances, whether for individual or group therapy were also noted. (See Chapter 10)

FIRST EVALUATION OF PROGRESS

Six months after the start of out-patient care all patients were interviewed once again by the author. The period in hospital was not included in the six months time lapse. If the patient was a regular clinic attender at this stage his progress was evaluated at the time of his attendance. In circumstances where contact had been lost with a patient he received a letter from the staff indicating that we would like to see him again as we were interested in his progress and an appointment was offered. Those who did not attend received a second letter stating that the doctor (B.R.) would be calling on them (see Appendix III). Thereafter the patient's home was visited repeatedly until an interview could be obtained. In all cases it was made clear to the patient that the unit would be happy to offer further assistance if this was desired.

At this interview the patient's drinking, work and domestic status were evaluated (see Appendix II).

In all circumstances a second opinion on this self-evaluation was obtained from the patient's spouse or closest associate. When no relative was available a close friend, or the patient's general practitioner, was consulted. When the evaluation from these sources differed from the patient's estimation of his progress the more pessimistic estimate was accepted.

SECOND EVALUATION OF PROGRESS

Six months after the first evaluation those patients who continued to attend the unit were interviewed by the author and again asked about their drinking status. A letter was sent to the remainder asking them about their progress and indicating that we would like to see them again (appendix III). Whenever possible these patients were interviewed once more although in a number of cases the patient's opinion on his progress was based on his written reply to a questionnaire about his progress (appendix III).

In all circumstances a second opinion was obtained from the same persons previously mentioned.

PSYCHOLOGICAL TESTS

The following were employed:

Personal illness questionnaire (Foulds⁽²⁾). This simple questionnaire (appendix II) provided an estimate of the presence or absence of distressing psychological symptoms - that is distressing subjective experiences reported by the patient.

This was administered to all patients at the initial interview and again at the time of first evaluation of progress.

General Punitiveness scale (Foulds⁽²⁾). This questionnaire⁽³⁾ is derived from the Minnesota Multiphasic Personality Inventory. It contains five sub-scales, three (Acting out hostility, Delusional hostility and Criticism of others) concern extra-punitive hostility and two (Self-criticism and Delusional guilt) are intropunitive. All correlations between these scales have been shown to be positive⁽³⁾ indicating the presence of a general punitive factor obtained by adding all five scales.

All patients completed this questionnaire at the time of initial interview and again at the first evaluation of progress. At the time of initial interview, or as soon after as possible, the patient's spouse also completed the questionnaire.

STATISTICAL TESTS

The study was designed to demonstrate the relationship between a number of variables outlined earlier in this Chapter, and the outcome variable: i.e., drinking status after six months.

Kendall's Tau was employed as a test of strength of association between this outcome variable and all other variables. The Atlas computer⁽⁴⁾ was used to calculate the value of Tau for these contingency tables. In each contingency table the outcome variable formed one axis and the descriptive data the other. Those patients treated as in-patients were analysed separately from those who were treated as out-patients.

The value of Tau is an estimate of the strength of the association between outcome and the other variables. The deviation of tau from zero was tested for significance by reference to the normal curve, Kendall⁽⁵⁾. Probability values (two-tailed) were assessed by entering a table of the normal curve with the value of the unit normal deviate given by the test of significance.

CHAPTER IV

EVALUATION OF TREATMENT RESPONSES

The prognostic value of assessment six months after the start of treatment has been discussed in Chapter I. Many follow-up studies have observed that those patients who were improved at six months had a favourable prognosis and that the majority of those who relapsed or abandoned treatment did so within the first few months after leaving hospital. (1,2,3,4,)

All patients in this sample were interviewed six months after their first attendance at the clinic, and in the case of those who were hospitalised, six months after their discharge date. The means whereby each patient was contacted are discussed in Chapter III.

The drinking status of each patient was taken as the chief parameter of treatment response and all other variables in this study have been related to this.

The drinking status of each patient was assessed on the following seven point scale:- (Before firstly placing a patient on this scale corroboration of his own assessment was obtained from his spouse, nearest relative or when neither of these were available from his General Practitioner. When there was a difference of opinion the more pessimistic appraisal of progress was accepted).

Drinking Status:

1. Abstinent throughout the six month period.
2. 1 lapse (drinking for less than one week) but abstinent.
3. 2 or 3 lapses but now abstinent.
4. 4 lapses but now abstinent.
5. Improved - a definite change in quality or pattern of drinking. (More than 4 lapses also in this category).
6. Not improved.
7. Unknown.

Foot-Note:

In all the contingency tables in this thesis when one variable is compared with 'outcome' these seven categories of drinking status are given as the measure of 'outcome' numbered 1 to 7 in the horizontal axis of the table.

Results:

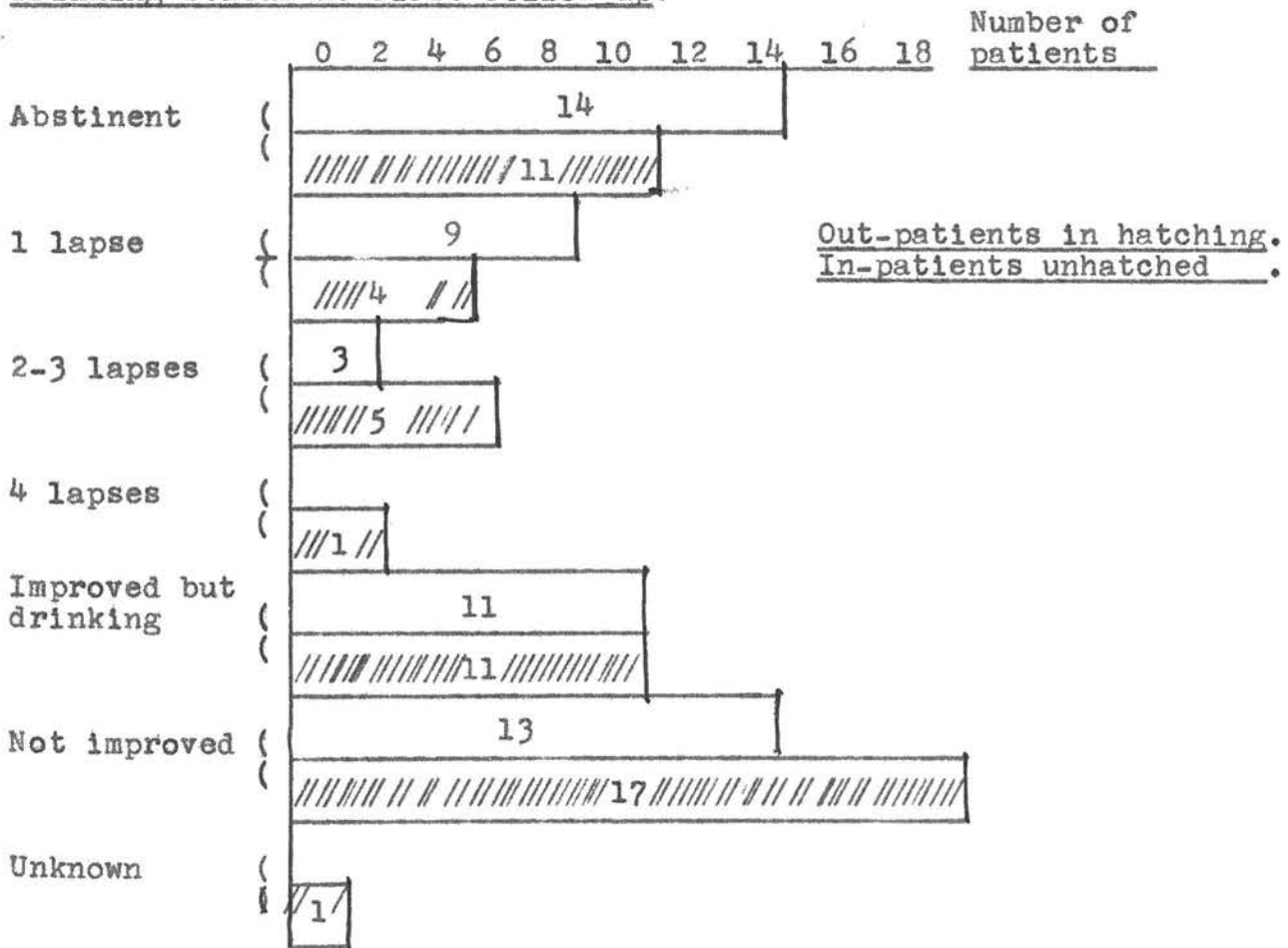
Amongst those admitted to hospital 26 (52%) were abstinent although 12 of these had experienced transient lapses. 13 (26%) were unchanged.

21 (42%) out-patients were also abstinent, and 17 (34%) of these were unchanged. Only one patient in the sample could not be traced six months afterwards.

Table 1 summaries these findings.

Table 1

Drinking status at first follow up:



Discussion:

The in-patient and out-patient groups did not differ significantly in terms of treatment response: (table 2)

Table 2

Relation between treatment group and treatment response

	<u>In-Patients</u>	<u>Out-Patients</u>	<u>Total</u>
Abstinent	26	21	47
Improved	11	11	22
Unchanged	13	17	30
Total	50	49	99

$\chi^2 = 2.12.$ 2 d.f. N.S.

The findings are similar to those observed in a preliminary study ⁽¹⁾ reported by this clinic. That two thirds of the sample had benefitted from coming to treatment and half were abstinent at the time of follow-up suggests that treatment had proved worthwhile particularly if it is recognised that alcoholism is a relapsing illness.

The difference in treatment response shown by the hospitalised and out-patient groups is small. There is a trend in favour of those admitted but the difference is not significant (Table 2). It should be remembered that these were selected groups and that this does not provide evidence of the relative merits of in-patient and out-patient care. Later Chapters will examine closely these factors amongst those treated by the two regimes which are associated with a favourable prognosis. The patient who can make good use of out-patient treatment may differ from the patient who requires hospitalisation at the start of the treatment.

It is interesting that only one patient lapsed four times while 21 lapsed between one and three times in the first six months. It appears that a small number of lapses followed by a return to abstinence are possible. When the number of experiments in drinking increases above three, then it seems less likely that abstinence can be recaptured.

Employment at follow-up;

At the time of follow-up assessment an enquiry was made

into each patient's adaptation to work. Each patient was assessed in terms of the following scale. (A second opinion was obtained from spouse or close relative in support of the patient's own estimate. If their views differed then the more pessimistic judgement was accepted).

1. Working in better job, (a definite improvement in the patient's occupational status).
2. Working in same or similar job with improvement in position (e.g., increased responsibility, promotion).
3. Work unchanged since initial interview.
4. Working in worse job.
5. Not working at initial interview but is now.
6. Not working but had job since initial interview.
7. Not working since initial interview.
8. Not known.

(Housewives in the sample were regarded as working and any change in their efficiency in coping with the house and family was noted).

Results:

The majority of patients (N = 46) were working in the same or in similar job to that which they held at the time of the screening interview. The time interval between referral and follow-up is too short to expect much evidence of change in work status to have occurred. A relationship with drinking status is observed between abstinence and unchanged or improved work status (Table 3).

TABLE 3

The relationship between a patient's work status at six months follow-up and his drinking status at the same time.

	Drinking status at six months							Total						
	In-Patients			Out-Patients										
	1	2	3	4	5	6	7	Total						
Working in better job	-	-	-	-	-	-	-	0	-	-	-	1		
Working in similar or same job improved.	6	-	-	1	-	-	-	7	2	-	-	3		
Working in similar or same job unchanged.	4	7	2	4	5	-	22	7	2	4	6	5	24	
Working in worse job.	1	-	-	1	-	-	2	-	-	-	-	2	2	
Not working at initial interview but is now.	1	-	-	2	1	-	4	-	2	-	1	2	5	
Not working but had job since initial interview.	1	-	-	0	4	-	5	-	-	-	-	2	1	3
Not working.	1	2	1	3	3	-	10	2	-	1	1	2	6	12
Not known.	-	-	-	-	-	-	0	-	-	-	-	-	0	0

Total: 14 9 3 - 11 13 - 50 11 4 5 1 11 17 1 50
 Kendall's tau = 0.3322 Kendall's tau = 0.2989

Unit normal deviate = 2.82785 Unit normal deviate = 2.53035

p < .01 p < .05

Discussion:

The observed relationships between being employed at follow-up interview and being abstinent is significant but there are clearly many cases where an improvement in drinking has not brought immediate change of job status. As would be expected, when progress is viewed over a relatively short period of time, the majority of those seen have made little change in their employment (46%).

The relationship between work status and drinking is complex and will depend largely on the patient's work-record prior to treatment, the nature of his work and the level of functioning demanded, the likelihood of drinking being discovered, and occupational pressures favouring relapse.

It would be wrong to assume that the relationship observed is necessarily causal and in certain cases the improvement of a patient's work status on leaving hospital may have contributed to continued abstinence or the demotion which followed the diagnosis of alcoholism may have precipitated a relapse.

Domestic relationships at follow-up:

The patient's domestic life was considered as part of the estimates of his improvement since the start of treatment. Again the opinion of the person closest to the patient was obtained to verify his assessment and again the more pessimistic opinion was accepted. Change in home situation was rated on a six point scale.

1. Improved with major observable changes - for example husband and wife reunited.
2. Some improvement observed by both partners who agreed that they were much happier. In cases where the patient was not married, agreement that there was an improved relationship with those he lived with.
3. Unchanged.
4. Evidence of deterioration.
5. Major deterioration as evidenced by changes in the life situation such as arrest, break-up of the family or divorce.
6. Not known.

A very close relationship between the patient's domestic situation six months after the out-set of treatment and drinking status at that time was observed. (Table 4)

TABLE 4

The relationship between drinking status and home situation
at follow-up

Home situation at follow-up.	<u>Drinking status at six months.</u>															
	<u>In-Patients</u>							<u>Out-Patients</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Major change	-	-	-	-	-	-	-	0	2	-	-	-	2	-	-	4
Improved	5	1	-	-	1	-	-	7	5	1	3	-	3	1	-	13
Same	7	7	3	-	8	4	-	29	4	3	2	1	5	8	-	23
Deteriorating	2	1	-	-	2	4	-	9	-	-	-	-	-	5	1	6
Major deterioration	-	-	-	-	-	5	-	5	-	-	-	-	1	3	-	4
Not known	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-	0
Total:	14	9	3	-	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = 0.4750
Unit normal deviate = 3.91458

Kendall's tau = 0.4728
Unit normal deviate = 3.98564

p < .001

p < .001

Discussion:

In 52% of patients no significant change had been observed in their home situation. In 24% there had been an improvement and in an equal number a deterioration. As anticipated, patients who were abstinent were much more likely to be enjoying an improved home life than those who were drinking but there were some interesting exceptions as the following examples show:

A 44 year old business man had been an in-patient in the unit and his treatment was complicated by the development of liver failure. Following discharge he remained abstinent and attended his out-patient group regularly. During the final year of his addiction he had involved his company in excessive debts and was declared bankrupt.

He had been separated from his wife for 12 years. She suffered from a personality disorder and had herself received much psychiatric treatment. The patient now lived with his mistress who was also his business partner.

Since abstaining he had found his relationship with her extremely strained. She drank heavily herself, a habit he had over-looked when he was drinking and she continued to coax him to drink his usual gin and tonic when he came home from work saying she felt lonely drinking on her own. He admitted that he felt no love for her, yet planned to marry her when the divorce from his first wife was completed. He claimed that he was so indebted to her for the assistance she had given him in his business that he could not let her down. Throughout the six months their relationship deteriorated progressively and there were regular arguments, usually ending in her becoming very drunk.

A 56 year old director of a painting and decorating firm had been treated in the unit and had subsequently attended his out-patient group. He had suffered from the loss-of-control pattern of addiction. During the six month period of follow-up he had one lapse which lasted for a weekend and was then arrested with the help of tranquillisers from his General Practitioner.

Although sober he was most unhappy. Normally he was an overconscientious inhibited man and alcohol had enabled him to express himself more freely - particularly it allowed him to display the anger he felt towards his brother (a partner in the business) and his wife. Since abstaining there had been continued unhappiness at home, his wife nagging him and criticising him for past failures. His daughter had left the house because of these rows.

In both these examples it was clear that the patient had been confronted with an unpleasant situation which he had previously dealt with by drinking and had not yet developed new techniques for improving his domestic life.

A further example illustrates the desperate measures another patient adopted to solve a stressful situation in which he would previously have taken alcohol.

A 49 year old exciseman had been treated in the unit and had thereafter attended his out-patient group regularly. He had remained abstinent for six months. He suffered from the inability-to-abstain pattern of addiction. He appeared to be a placid, easy-going man who was extremely self-critical. His childhood had been marred by his father's alcoholism but he characteristically denied any resentment towards his father for mistreating him. He had wanted to go to University but in view of the family hardships entered customs and excise when he could "earn money quickly and not be a burden to mother." This passive acceptance of other people's needs had characterised his whole life.

He had been married for 26 years and they had one grown up daughter who had recently married. The patient's wife appeared extremely competent and managing but subsequent experience in case work showed that she was unable to tolerate not having her own way. The relationship between them appeared loving but it only remained so on the condition that he allowed her to treat him like a child and constantly reassured her that he was happy.

Four months after discharge he attempted suicide by turning on the car engine and closing the garage doors. He was discovered by his wife before he came to any harm. On the day before this gesture he had been telling his wife that he was unhappy at work

and his employers had changed his department. His wife had told him he should not get angry. When she brought her husband to the clinic she said "I am upset that he should even contemplate such a thing and leave me all alone." It seemed clear that the growing resentment the patient felt towards his wife and employer could no longer find expression in alcohol and he had been forced to express his feelings by a suicidal gesture.

The following history demonstrated psychological deterioration despite a reduced alcohol intake:

A 27 year old alcoholic who was separated from his wife took his own discharge from the unit, having been an in-patient for seven weeks. He failed to attend his out-patient group but was seen periodically on an individual basis. He suffered from loss-of-control alcoholism. His personality was markedly immature with a failure to resolve his maternal dependency - this latter had been the disruptive force in his marriage.

Six months after discharge he was visited in his own house as he had not responded to letters requiring him to visit the unit. The patient cautiously opened the door having ascertained that the caller was a friend. He explained that he was afraid that the police were after him.

During the months after discharge he had twice committed theft during drinking bouts and had been caught on both occasions and fined. No attempt had been made to pay either fine, instead he had abandoned his job and retreated to his flat. He no longer drank but became increasingly depressed.

The flat was littered with empty tins of instant coffee and unwashed dishes - gas and electricity had been cut off some weeks previously.

He was depressed and could make no plans for coping with his problems. It was clear that he was waiting for others to take action. He did not accept the suggestion that he should return to the unit.

A few weeks later he took an overdose of aspirins and went straightaway to his mother who lived nearby. In this way he once more enacted his infantile expectation that his mother would care for him and solve his problems. She had him admitted to the regional poisons centre where he made a rapid recovery. The mother then arranged for him to return to the unit.

This progression illustrates how the patient's basic conflict persisted even when drinking was much reduced.

Drinking status 1 year later:

The prognostic validity of a six month assessment has already been discussed. This sample was re-assessed six months after the first follow-up so that the stability over time of the six month drinking status could be established. Identical ratings to those employed in the first occasion were used and the patients view was checked against the opinion of others closely connected with him. Any episodes of drinking in the second six month period were noted - for example a patient who had a lapse of less than one week in the first six months would be rated (2) for the first six months; if he was entirely abstinent in the second six months he would be rated (1) for the second six months.

30 of those patients who had been hospitalised and 19 of those who had been treated as out-patients were still in contact with the unit when their progress was reviewed at one year. The remainder had to be contacted once more by letter. It was possible to interview most of these patients personally but for seven their opinions on drinking status at one year was based on a written reply to a postal questionnaire(appendix II). Six of these had been out-patients and on the basis of their replies were rated as Abstinent 1, One lapse 2, Improved 2, Not Improved 1. One former in-patient was rated as not improved. For these patients their own opinion was corroborated by that of their General Practitioner.

Thus(21) 42% of those treated as out-patients and (24) 48% of those originally treated as in-patients were abstinent one year later. This is very similar to 42% and 52% respectively observed at six months. As before the in-patient group fared only fractionally better than the out-patient.

Table 6 shows the relationship between drinking status noted at these two times more clearly.

TABLE 6

Relation between drinking status at 6 months and drinking status at 1 year

<u>Drinking status at 1 year</u>	<u>Drinking status at six months</u>															
	<u>In-Patients</u>							<u>Out-Patients</u>								
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
1	8	2	-	-	-	-	-	10	8	1	1	1	-	-	-	11
2	1	3	-	-	1	-	-	5	3	2	2	-	2	-	-	9
3	3	3	2	-	-	-	-	8	-	-	1	-	-	-	-	1
4	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	0
5	1	-	1	-	5	-	-	7	-	-	1	-	3	1	-	5
6	1	-	-	-	4	12	-	17	-	1	-	-	6	15	-	22
7	-	-	-	-	1	1	-	2	-	-	-	-	-	1	1	2
<hr/>																
	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
	Kendall's tau = 0.6872							Kendall's tau = 0.7673								
	Unit normal deviate = 5.91150							Unit normal deviate = 6.50458								
	p < .001							p < .001								

Discussion:

Assessment at six months has been shown to be a valid prediction of status in terms of drinking at one year. Of 14 patients from the hospitalised group who were abstinent throughout the first six months, 12 were abstinent at the end of the next six months although four of these had lapsed briefly in that time. Amongst the out-patient groups all 11 who were abstinent at six months were again abstinent six months later although 3 had experienced transient lapses. The grave prognostic significance of being unimproved after six months is clear, only one of the 30 patients so rated showed significant improvement in the second six month period. This improvement occurred in a patient who became more actively involved in treatment after the six month interview although he did not succeed in abstaining for any length of time.

Those who were regarded as improved in terms of their drinking status are of particular interest as they form the group in which categorisation is most difficult. Of 22 patients who had been so classed at six months, 10 were placed in the unimproved category at the end of the year. Three were now abstinent and 8 were again clearly improved in their drinking status. After one year it is too early to speak of return to normal drinking but it will be interesting to follow this small group who appear to have regained some control of their drinking without being abstinent, as it is suggested by several

(5,6,7,)
authors that return to normal drinking is possible for a small number of alcoholics. Also it is clear that as time passes the distinction between those who are improved and those who have not changed becomes clearer. Of those 16 patients who have abstained throughout the year all but three maintained regular contact with the unit. These three were a Chemist who had suffered from a depression and had been treated in the unit for inability to abstain alcoholism. He did not attend his out-patient group but came occasionally to visit the unit especially when he was feeling very depressed. The other two abstainers who did not maintain regular contact were both out-patients. Both were old, aged over 60 years, one a retired police officer maintained abstinence as he felt it his duty to look after his invalid daughter throughout the year. This role assisted this aged widower in maintaining his sobriety and give him a sense of purpose. The other patient did not attend the unit after his first visit stating that he had made up his mind to stop drinking and that he knew he would not relapse. Since abstaining his work record had improved and his domestic life was much happier. His wife, mother and General Practitioner all confirmed that this improvement had been maintained throughout the year. It seems that with the rare exception of those patients who used the unit to confirm a resolution already made that those patients who attended regularly made the most striking improvement. This relationship will be discussed in more detail

in a later Chapter.

Those patients who lapsed during the first six months but abstained throughout the second period form an interesting group. The two patients in the hospitalised sample who did this both indulged in transient experiments with alcohol, reported this to their out-patient group and thereafter remained abstinent. The three who were not admitted had all originally lost contact with the unit. One young alcoholic came twice and was not seen again until the time of his 'follow-up' appointment. He had lapsed briefly twice and had then become involved in a newly formed young alcoholics group of A.A. At the end of the year he was an active member of this group and abstinent. He was now working regularly and had moved into better accommodation where his wife was much happier.

Another patient stopped coming after three out-patient appointments but returned to the clinic after a lapse of one week. On the second occasion he became a regular attender and was able to establish a limited but sober life. He was not working and acted as housekeeper to his aged father. A further patient who had been treated for alcoholism elsewhere on numerous occasions was treated as an out-patient with some improvement. He abstained for three months and then started drinking again. At first he was able to control this but inevitably his condition deteriorated so that he was admitted to the general mental hospital suffering from delirium tremens. After three months as an in-patient receiving supportive psychotherapy, considerable

progress in improving his social situation had been made and he was able to go out and work from hospital. At the end of the year he was abstinent.

All these patients had found successful forms of treatment not necessarily from the unit.

Summary:

In this Chapter the progress of the alcoholics has been evaluated six months and one year after the start of out-patient treatment. A close relationship between drinking status after six months and after one year has been shown. It has been demonstrated that abstinence is usually accompanied by an improvement in work status and domestic relationships although some interesting exceptions were observed. In the following Chapters factors in the patients history will be examined which correlate with his treatment response.

CHAPTER V

SOURCE OF REFERRAL

The distribution of the 100 patients by source of referral is shown below. (Table 1)

TABLE 1

Distribution of patients by Source of Referral

<u>Source of referral</u>	<u>All referrals</u>	<u>Treatment Offered</u>	
		<u>In-Patient</u>	<u>Out-Patient</u>
General Practitioner	61	26	35
Psychiatrist	26	17	9
Hospital Consultants(other)	7	3	4
Self	3	2	1
Other	3	2	1
Total:	100	50	50

The majority of patients were referred by their General Practitioner. Amongst those who had come to the Unit at the request of another psychiatrist were nine patients seen at the Edinburgh regional poisons centre ⁽¹⁾ where they had been admitted following a suicide attempt.

Those three who were self referrals form an interesting group in that all were abstinent one year later although one of these had experienced a transient lapse.

Two of the self referrals had learned of the Unit through their affiliation with Alcoholics Anonymous. They retained contact with Alcoholics Anonymous throughout their treatment, thereby obtaining support from both sources. The third

referral had been told of the existence of the Unit by a psychiatrist whom he had consulted about anxiety symptoms in the previous year. Alcoholism had been suspected at that time but the patient only admitted that he could not control his drinking at a later date when he referred himself to the Unit.

Those whose referral has been designated 'other' comprised one woman referred by her husband who was himself a doctor; a patient brought by a friend who was himself being treated at the Clinic and one referral from the Court.

That only one referral should be from the Court is interesting and his case may help to illustrate a concept of alcoholism which remains prevalent.

A 45 year old unmarried unemployed man of no fixed address, who had been convicted on several occasions on charges of being drunk and disorderly, was referred from the Court after the Police missionary had spoken for him on this same charge. He was a Romany who had lived an itinerant life with his parents until they died. Since that time, for the past fifteen years, he had lived in lodging houses in the cities of Scotland. He had not worked since 1938. Although he had suffered from delirium tremens on several occasions, he did not think he was alcoholic. Asked if he had ever received treatment he replied, "No, except perhaps thirty days in prison." He indicated that he had never had any specific treatment for alcoholism, insisted that he was not alcoholic and would not agree to hospital admission.

He gained considerable support from a religious organisation in the City and when I visited him both six months and one year after the first referral he was living in their community for alcoholics. During that time he had twice been arrested for drunken behaviour. The following extract from a letter written to the Unit gives some indication of his attitude towards alcohol:

"I believe that the alcoholic is gutless and full of self-pity. Satan has him as a Robot and his biggest and highest hurdle is becoming a man again ... The only way is to ...have

Christian Fellowship giving Christians insight to pray for him and his deliverance from sin. And when alcohol (Satan) starts controlling man instead of man controlling alcohol (Satan) it becomes a great sin to indulge".

In view of the frequency with which alcoholics recount incidents of law-breaking ^(1,2,) and arrest, it is surprising that only one alcoholic was detected by the Courts in the time of this study. It is also interesting that the patient was himself a caricature of the 'down-and-out' alcoholic. This, suggests that many alcohol addicts are passing through the courts without being recognised. Further research is required to clarify why this should be. This patient's problems also highlight the plight of a section of the alcoholic community for which this unit could provide little. Provision for this kind of patient has not been made in Edinburgh. A similar problem has recently been discussed by Edwards et al (1966) ⁽³⁾.

Alcoholism had been diagnosed first by Consultants in General Hospitals in seven of the patients in this study. The diagnoses which had brought them into hospital are listed below.

Initial Diagnosis:

Pneumonia	-	2 patients.
Hepatitis	-	2 patients.
Peripheral Neuritis		1 patient.
Diabetes	-	1 patient.
Anxiety symptoms	-	1 patient.

The patients with pneumonia had both concealed the problem of their alcoholism until the enforced abstinence of hospitalisation precipitated delirium tremens. The presence of alcoholism was suspected in the diabetic because of his difficulty in keeping to the recommended diet and the frequency with which he would appear at the clinic under the influence of alcohol.

Drinking status on first attendance:

The majority of referrals had been drinking on the day of the initial interview. This does not imply that the majority were for this reason incapacitated; patients had taken one or two drinks either to control withdrawal symptoms or to give them courage to come to hospital. Table 2 shows the relationship between drinking status on first attendance and outcome six months later.

TABLE 2

Relation between drinking status when first seen and drinking status at follow-up

<u>Drinking status on first attendance.</u>	<u>Drinking status at six months</u>															
	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Drinking	5	5	1	-	4	5	-	20	-	2	-	-	4	11	1	18
Sober under 1 week	5	3	1	-	4	4	-	17	6	-	1	-	3	2	-	12
Sober over 1 week	4	1	1	-	3	4	-	13	5	2	4	1	4	4	-	20
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = 0.0270

Kendall's tau = -0.3587

Unit normal deviate = 0.22120

Unit normal deviate = -2.94616

N.S.

p < .01

While no significant relation between drinking status at the time of the first interview and treatment response can be observed for those who were admitted, a highly significant relationship obtains for those treated solely as out-patients. Those who were drinking up to the time of the interview have a poor prognosis. All but 2 of the 18 in this category were drinking six months after the interview and the majority were unimproved.

Discussion:

It seems likely that a patient who has decided to seek treatment will endeavour to be as sober as possible within the limits of his addiction at the time of his interview. This finding suggests that few patients who had been unable to abstain on the interview day could attain sobriety with the assistance offered. The assistance offered such patients commonly took the form of advice concerning the necessity of abstinence and a supply of tablets containing phenothiazine sufficient to minimise withdrawal symptoms for the first few days of abstinence. The patient would be given an appointment to return to the unit after this period. Commonly the General Practitioner would be informed of the procedure and his help enlisted. Even with this assistance very few attained abstinence; it was particularly difficult for patients in lodging houses as they would commonly be offered alcohol by well intentioned friends who had observed that they were developing

"the shakes".

It is likely that there are diverse reasons for the relative failure of those who drink on the day of their first interview. The motivation for treatment in these cases may be less than in the others, or they may well have expected admission and perceived an out-patient regime as rejection. Some patients may have failed to recall the instructions given at the interview because they had been drinking, although it did not seem from subsequent interviews that any patients had failed to understand the instructions imparted on the first occasion.

The finding suggests that a more intensive treatment for the abstinence syndrome was required for these patients. This might take the form of more detailed supervision of the withdrawal phase at home or the provision of 'drying-out' facilities within a unit for the treatment of alcoholism.

Suitability for in-patient treatment:

At initial interview 66 of the sample were considered suitable for admission. 16 declined the offer of in-patient care and were treated as out-patients. The remaining 34 were offered out-patient treatment. The criteria required for admission have been outlined in a previous chapter. (3)

Those who were offered admission and yet declined, did so for various reasons - some did not realise the seriousness

of their problem, others felt that the social stigma of hospital admission would damage their reputation and their career. In some cases refusing admission was but one facet of the patient's extensive employment of denial mechanisms. The following examples illustrate some of the reasons given for refusing in-patient treatment.

A 56 year old married architect who was referred by his General Practitioner was suffering from the inability-to-abstain form of alcoholism. At the time of the initial interview he had already abstained for three weeks. When he was offered in-patient treatment with the aim of gaining further understanding of his addiction and the psychological factors precipitating this he declined. His attitude at this time was summed up in his comment that "the idea of having treatment in hospital is itself a deterrant" and that "there is only one person who can do anything about it and that is myself".

He possessed an extremely restricted and obsessional personality with a conscience structure which frowned on any suggestion of loss of control. He regarded his excessive drinking as evidence of weak will.

He attended the clinic regularly while he remained abstinent, which was for two months, although he remained pre-occupied with what he regarded as the social stigma of alcoholism. He would write 'dentist' in his diary on the day of his appointment with the psychiatrist. He refused to take Antabuse as he regarded this as further evidence of weakness.

When he eventually did relapse he refused to come to the clinic and six months later when visited at his home in response to requests from both his wife and General Practitioner, he was so frightened by the call that he ran to his bedroom shouting "I don't want any help I can manage this drinking myself."

This patient presents a common problem amongst alcoholics who feel threatened when they suspect they are entering a dependency situation which is both longed for and feared. This patient's conscience would not allow him to gratify his dependency needs.

A patient who may be taken as representative of another group of those refusing admission was a 53 year old widow. This woman worked as a secretary, she had two children and a home which she endeavoured to maintain, although it was in a district of the City where the cost of living was beyond her means. She was much concerned with keeping up appearances and regarded the development of loss-of-control alcoholism as a secret which she must keep from those around her, even her own daughter. She refused to come into hospital, but attended regularly as an out-patient. When it was suggested that her daughter visit the Psychiatric Social Worker she detached herself from the clinic and refused to attend further appointments.

At a later visit to her home it became apparent that not only did she deny that she was drinking to the psychiatrist and her General Practitioner, but also she believed that her twenty-one year old daughter who lived with her did not know of her drinking habits.

The extent to which alcoholics utilise denial mechanisms has often been noticed. In many cases this defence is a major factor in preventing the patient from becoming involved in treatment.

A third example illustrated those patients who attend the clinic without any serious desire for treatment.

Thus a 45 year old lorry driver was referred to the clinic; he suffered from the inability-to-abstain form of alcoholism and was offered admission. On the day of first attendance he had lost his job because of repeated absence caused by drinking. He agreed that he was addicted and in need of treatment and arrangements were made for his admission the next day. He did not appear for admission and subsequent appointments met with no response. Finally he was visited at home. He explained that he did not come into hospital on the day suggested because he had obtained another job which had kept him fully occupied. He continued to drink excessively.

It is interesting that this patient's concern centred on the social consequences of his addiction. He did not perceive his addiction as a continuing illness. His treatment aim had been to restore his capacity to work and not to abandon

drinking.

The importance of the initial contact with alcoholics has been stressed by Chafetz⁽⁴⁾. These findings suggest that detailed appraisal of those patients who do not accept treatment is required. Some of the reasons have been suggested by the examples given. Patients who have experienced damaging relationships earlier in their lives may be reluctant to enter into a close relationship with another person. For some, recognising the need for treatment involved admitting the diagnosis of alcoholism which the patient has avoided by the use of denial mechanisms. Alcoholics Anonymous have stressed the importance of reaching 'rock-bottom' before a true understanding of alcoholism is developed in the patient. Evidence suggests that treatment can be most effective at an earlier stage and yet these observations indicate that techniques for keeping patients in treatment and motivated towards abstinence may at this stage present particular difficulties.

CHAPTER VI

DEMOGRAPHIC AND BACKGROUND DATA

Section 1: Demographic characteristics

Sex:

Of the patients studied 84 were male and 16 female - a male/female ratio of 5.3: 1. Table 1 suggests that there is a tendency for female patients to be hospitalised more frequently than men, but the difference is not significant. ($X^2 = 1.9.1$ d.f. N.S.) No relationship between sex of patient and treatment response has been demonstrated.

It has been suggested that husbands leave their alcoholic spouses early in the illness. In this sample no significant difference was observed between the number of males having extant marriages and the equivalent for females (Table 2 - $X^2 = 0.04$ 1 d.f. N.S.). Of the women nine were married, two separated, one divorced, three widowed and two single.

TABLE 1

Patient's sex against drinking status at six months

	<u>In-Patients</u>							<u>Out-Patients</u>								
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Male	11	7	2	-	10	10	-	40	11	3	4	1	9	15	1	44
Female	3	2	1	-	1	3	-	10	-	1	1	-	2	2	-	6
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = -0.0177

Kendall's tau = 0.0575

Unit normal deviate = -0.13728

Unit normal deviate = 0.44690

N.S.

N.S.

TABLE 2

Marital state compared with patient's sex

	<u>Males</u>	<u>Females</u>	<u>Total</u>
Married and living with spouse	48	9	57
Unmarried or separated	36	7	43
<u>Total:</u>	84	16	100

$\chi^2 = 0.04$

1 d.f.

N.S.

Age:

The distribution of the sample by age did not differ between the sexes. (Table 3)

TABLE 3

Comparison of Cumulative Age Distributions of Male and Female Patients

<u>Age group</u>	<u>Female</u>	<u>Cumulative proportions</u>	<u>Male</u>	<u>Cumulative proportions</u>	<u>Difference in proportions</u>
20-29	2	0.125	13	0.155	0.030
30-39	6	0.500	15	0.333	<u>0.167</u>
40-49	4	0.750	23	0.607	0.143
50-59	3	0.937	27	0.929	0.008
60-69	1	1.000	4	0.976	0.024
70 +	0	1.000	2	1.000	0.000

Total $n_1 = 16$ $n_2 = 84$

$$1.36 \sqrt{\frac{n_1 + n_2}{n_1 n_2}} = 1.36 \sqrt{\frac{16 + 84}{16 \times 84}} = 1.36 \times 0.27 = 0.367$$

Kolmogorov-Smirnov $D = 0.167$; value of D needed for the 5% level of confidence is 0.367 therefore the present distributions are not significantly different.

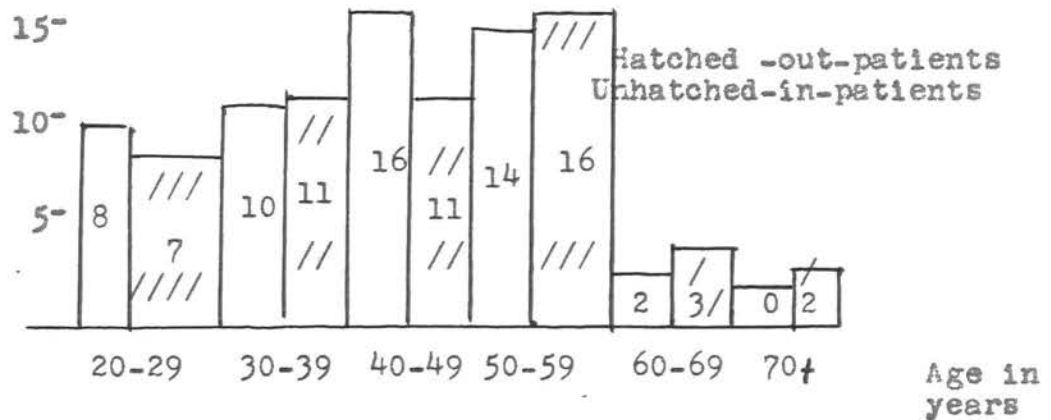
Foot-note: The Kolmogorov-Smirnov test is sensitive to any difference in the distribution from which the two samples were drawn. The differences between the two sample cumulative distributions are determined by subtraction and are given in the last column. The largest of these differences is D . This value is then compared with the critical one obtained by entering the observed values of n_1 and n_2 in the formula shown above. Only if the observed D is equal to or greater than the number computed from the expression may the samples be considered to come from significantly different populations. A detailed discussion of this test is given in Siegel. S. (1956) Non parametric Statistics, McGraw Hill, N. Y.

The distribution of the patients by age is shown in the figure 1. The majority of the patients seen (57) were aged between 40 and 59. 15 were under 30 years. There is little difference in the age structure of in-patient and out-patient populations.

FIGURE 1

Age distribution of the clinic sample

Number of patients:



There is a significant relationship between the age of a patient and his response to treatment. The table (4) shows that this is true for both in-patients and out-patients.

TABLE 4

Patients age group against drinking status at six months

Drinking status at six months

Age	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
20-29	1	-	-	-	3	4	-	8	-	-	1	-	2	4	-	7
30-39	2	2	-	-	2	4	-	10	1	2	1	-	3	4	-	11
40-49	6	2	1	-	3	4	-	16	2	1	1	1	2	3	1	11
50-59	3	5	2	-	3	1	-	14	5	1	2	-	3	5	-	16
60-69	2	-	-	-	-	-	-	2	1	-	-	-	1	1	-	3
70+	-	-	-	-	-	-	-	0	2	-	-	-	-	-	-	2
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = -0.3113

Kendall's tau = -0.2473

Unit normal deviate = -2.64695

Unit normal deviate = -2.13245

p < .01

p < .05

Social Class:

The social class of each patient was determined from the Registrar General's Classification of Occupations (1960). The distribution of the sample by social class is shown in the accompanying figure 2. The in-patient population differed significantly from the out-patient, ($X^2 = 10.98$, 4 d.f. $p < .02$. Table 5). Classes I and II being somewhat over-represented in the hospitalised sample.

FIGURE 2

Distribution of social class of the clinic sample

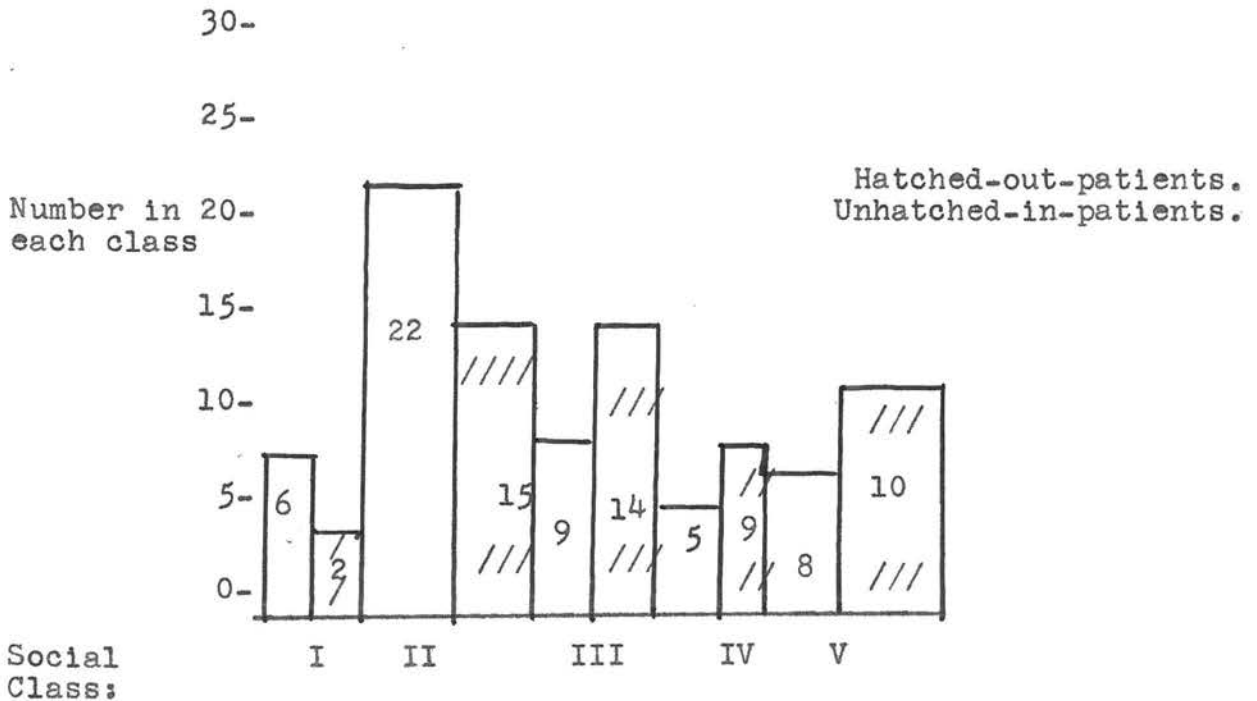


TABLE 5

In-patient and out-patient samples compared by social class

<u>Social Class</u>	<u>Admitted</u>	<u>Not Admitted</u>	<u>Total</u>
I	6	2	8
II	22	15	37
III	9	14	23
IV	5	9	14
V	8	10	18
Total:	50	50	100

$$\chi^2 = 10.98$$

4 d.f.

$$p < .02$$

Patients from Social Classes I and II showed a significantly more favourable treatment response than others. This was true irrespective of treatment groups (Table 6).

TABLE 6

The relationship between patients social class and drinking status at six months

<u>Social Class</u>	<u>Drinking status at six months</u>															
	<u>In-Patients</u>								<u>Out-Patients</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
I	2	1	2	-	1	-	-	6	-	-	1	-	-	1	-	2
II	7	6	1	-	6	2	-	22	9	1	1	-	1	3	-	15
III	2	-	-	-	2	5	-	9	1	-	2	-	5	6	-	14
IV	2	-	-	-	1	2	-	5	-	1	-	1	2	5	-	9
V	1	2	-	-	1	4	-	8	1	2	1	-	3	2	1	10
Total	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

$$\text{Kendall's tau} = 0.2754$$

$$\text{Kendall's tau} = 0.2346$$

$$\text{Unit normal deviate} = 2.33736 \quad \text{Unit normal deviate} = 2.00495$$

$$p < .05$$

$$p < .05$$

Nationality:

By this was meant the country in which the patient had passed the greater part of his childhood, defined as his first fifteen years. All but one of the sample were Scottish. The exception was an Englishman.

Civil Status:

Table 7 summaries the civil status of those in the sample. Of these 70 who were married at the time of referral, 13 were separated from their spouse. Nine of the patients had been married more than once and one had been married three times.

TABLE 7

Civil status of in-patient and out-patient groups compared.

(Figures in brackets are number of alcoholic females)

	<u>In-Patients</u>	<u>Out-Patients</u>	<u>Total</u>
Married	29 (6)	28 (3)	57
Separated	7 (1)	5 (1)	12
Legally separated	1 (0)	0 (0)	1
Divorced	4 (1)	3 (1)	7
Widowed	1 (0)	6 (1)	7
Single	8 (2)	8 (0)	16
Total:	50	50	100

The relationship between civil state and treatment response is shown in Table 8. Amongst those who were admitted to the unit, married patients show a significantly better treatment response than unmarried. This trend is not apparent for those who were not admitted.

Religion:

The majority of the sample were of Protestant religion(88). 10 were Roman Catholic and 2 had no religion. The table (9) indicates a trend towards a more favourable outcome amongst Protestants but the figures do not reach significance.

Patients were asked about their degree of involvement in Church activities. 15 of the sample had attended at least once monthly and 29 had been to Church at least once in the preceeding three years for the purpose of worship which did not include quasi social purposes such as weddings or funerals. No relationship between degree of involvement in religion and treatment response was observed. (Table 10).

TABLE 8

The relationship between treatment response and civil state

Civil State:	<u>In-Patients</u>							<u>Out-Patients</u>							Total	
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6		7
Married	11(1)	5(1)	2(1)	-	6(1)	5(2)	-	29	9	-	4(1)	-	8(2)	7	-	28
Separated	-	3(1)	1	-	2	1	-	7	-	-	-	-	1	3(1)	1	5
Legally Separated	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	0
Widowed	-	1	-	-	-	-	-	1	2	-	-	-	1	3(1)	-	6
Divorced	1(1)	-	-	-	1	2	-	4	-	1(1)	-	1	1	-	-	3
Single	1(1)	-	-	-	2	5(1)	-	8	-	3	1	-	-	4	-	8
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = 0.3363

Kendall's tau = 0.0219

Unit normal deviate = 2.68919

Unit normal deviate = 0.17438

$p < .01$

N.S.

(Figures in brackets show the number who were female)

TABLE 9

The relationship between patient's religion and drinking status at six months

	<u>In-Patients</u>								<u>Out-Patients</u>							
	<u>Outcome</u>								<u>Outcome</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Protestant	14	8	3	-	10	10	-	45	11	4	3	1	9	14	1	43
Roman Catholic	-	1	-	-	-	2	-	3	-	-	2	-	2	3	-	7
No Affiliation	-	-	-	-	1	1	-	2	-	-	-	-	-	-	-	0
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
	Kendall's tau = 0.2353								Kendall's tau = 0.1282							
	Unit normal deviate = 1.84442								Unit normal deviate=0.99582							
	N.S.								N.S.							

TABLE 10

The relationship between degree of involvement in organised religion and drinking status at six months.

	<u>In-Patients</u>								<u>Out-Patients</u>								
	<u>Outcome</u>								<u>Outcome</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	
Church attendance:																	
Frequent Attendance		3	1	1	-	1	3	-	9	2	1	1	-	1	1	-	6
Rare attendance		2	6	1	-	3	1	-	13	3	1	3	-	4	4	1	16
Does not attend		9	2	1	0	7	9	-	28	6	2	1	1	6	12	-	28
Total:		14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
	Kendall's tau = 0.0726								Kendall's tau = 0.1353								
	Unit normal deviate = 0.58907								Unit normal deviate= 1.09263								
	N.S.								N.S.								

Discussion:

Among the aspects of the sample considered in this chapter Age, Social Class and Civil Status stand out as the factors having a significant influence on treatment response.

The observation that prognosis is more favourable amongst older patients has been commented on in other studies ^(1,2,) . Why do young patients show such an unfavourable response to treatment?

The young alcoholic (less than thirty years old) has had less time in which to become addicted than his older counterpart. Thus it seems that he is either physically more susceptible than those who develop addiction later in life and there is no evidence for this. Or he may be relatively more susceptible psychologically and for this reason use alcohol in an extremely pathological way from an early age. If this were the case then a consideration of the underlying psychological disturbance in young alcoholics would be expected to reveal an excess of severe pathology as compared with older patients. As part of the psychological formulation of each patient a diagnosis of psychiatric disorder was made employing the following 5 categories - the number of ^{young} alcoholics in each category is shown:

- Psychoneurotic - 1
- Personality disorder mild - 0
- Personality disorder moderate - 4
- Personality disorder severe - 9
- Psychotic - 1

The following examples may clarify the problems of these young alcoholics with severe personality disorders.

A 26 year old man had been suffering from alcoholism for six years. He had been in mental hospitals on two occasions but had impulsively left both times in the first week of treatment. He said "I can't settle anywhere, I have to be moving around, it is the same with all the jobs I have taken. I get fed-up and argue with the boss, and I just walk out."

He was second in a family of three and there was no history of mental illness. His mother was strictly teetotal. She was exceedingly protective of her son, frequently covering up for him when he was involved in trouble. His father, who was a welder, had died six months previously. He had been a very strict authoritarian man who was bitterly resentful of his son's misbehaviour. At 22 he married a girl of 18, but left her and his child after 18 months. Since then he had been living with another girl but this relationship had broken down recently after the arrival of a daughter.

All his life he had difficulty in forming lasting relationships and his intense emotional involvement with his mother was the only intimate experience he had enjoyed. He had been in prison three times. At school he was a frequent truant. He was reluctant to view himself as an alcoholic although he had frequent amnesias and withdrawal symptoms. He could not envisage giving up alcohol completely, "Alcohol makes things seem brighter," and he was treated as an out-patient. He attended twice. At follow-up there was no improvement and he had been imprisoned once more for robbery and violence.

A 28 year old man recently separated from his wife after two years of marriage, was referred by another psychiatrist who had made the diagnosis of alcoholism. He was the eldest of three siblings and intensely dependent on his mother, in whose eyes he could do no wrong. At an early age he had felt himself to be the man of the house first when his father was in the Army and later when he was imprisoned for embezzlement. He had his first drink when he was sixteen in the R.A.F., and drank heavily from the start. On leaving the Service he worked as a clerk, augmenting his income by petty crime which enabled him to buy drink. He married at 22 but the relationship was unhappy from the start, and his wife left him after two years. He would drink every evening in an attempt to keep away from his wife and avoid sexual relations which had proved unsatisfactory for both partners. His wife accused him of being too childish and

dependent on his mother, unable to remain in one job for any length of time. After his wife left him he attempted suicide which was the reason for his original referral for psychiatric help. He was admitted to the Unit. Although his wife attended the clinic she would not agree to return. After discharge he failed to attend his out-patient group, allowed debts to mount once more and was arrested for breaking into a warehouse. He again attempted suicide and went to his mother to tell her what he had done. After this he returned to the unit as an out-patient but could not maintain a regular attendance and continues drinking.

A 28 year old unmarried girl who had suffered from loss-of-control alcoholism for at least six years and had signs of peripheral neuritis. She was advised to come to the clinic by a friend who had himself been a patient of the clinic for nearly two years. She was an only child, her mother had nearly died at the time of her birth and she felt herself responsible for the absence of any further children. This sense of guilt that she had caused suffering by her birth was fostered during childhood by the role she was expected to play in arguments between her parents. Her father was an alcoholic, the patient preferred him to her mother, who was regarded as cold and indifferent. She recalled feeling insecure throughout her childhood because she felt her parents might separate.

Since leaving school she had failed to remain in any job for any length of time. She became a journalist for a time and then drifted amongst a group of poets and artists, occasionally writing poems herself, which she did not submit for publication. It was in this company that her heavy drinking commenced. At this stage she became involved in successive unsatisfying relationships with men whom she was unable to marry and gained a reputation, she felt wrongly, of being promiscuous. At interview she said, "although I am surrounded by friends I feel constantly alone". She drank heavily, at first because that was the custom of her company but mainly to control the bouts of depression she experienced when she felt she was not achieving what she expected from a relationship. When drunk she was hostile, provocative and abusive. When sober she was demure and reserved and wore a silver cross on a necklace. She seemed unable to reconcile two contradictory aspects of herself. Although she was twice admitted to the Unit there was no improvement in her drinking habits. Nonetheless, she did develop an attachment to her female therapist and has remained in treatment throughout the year.

These three young patients indicate the gross disorder of personality which commonly is found in young alcoholics.

None of those described had been able to form enduring relationships and all were intensely involved in resolving conflicts which had their origins in childhood. There was a tendency for them to have a poor and erratic work record and the criminal record of the two young men is characteristic of many of these patients. Treatment in all three cases proved relatively ineffective although the progress of the girl will be watched with interest as the transference relationship she has established may prove sufficient to maintain the patient in treatment while she acquires skills which enables her to develop relationships which are not self-destructive and do not involve drinking.

Table 11 below shows that a disproportionate number of young people were diagnosed as having a severe personality disorder.

TABLE 11

	<u>Less than 30</u>	<u>Over 30</u>	<u>Total</u>
Severe personality disorder	9	18	27
Other diagnosis	6	67	73
Total:	<hr/> 15	<hr/> 85	<hr/> 100

$$x^2 = 9.7.$$

1 d.f.

$$p < .01$$

It seems that young alcoholics tend to suffer from a crippling personality defect which makes it difficult for them to form lasting relationships and allows them only a precarious

adaptation to society. Treatment of patients with this form of disorder is notoriously difficult and it is made even more complex when an addiction is added to an already formidable problem. The fate of these with gross personality disorders as they grow older is uncertain. It may be that with age these patients develop capacities for coping with life which were not in evidence in youth. The middle aged alcoholics, for whom the diagnosis of mild personality disorder can be made, may in his youth have presented evidence of a gross disturbance that maturation has eliminated. Some of these very disturbed young patients may, on account of anti-social behaviour, be arrested and pass their later life in prisons; others may kill themselves. There are many possible explanations of this excess of severely disordered patients in the young age group, but detailed investigation of this sub-group is required so that a more satisfactory treatment approach can be developed.

The social class distribution of this clinic sample shows the same excess of Class I and II that has been observed in other studies of alcoholism (Table 12)

TABLE 12

Social Class distribution of clinic alcoholics

	<u>I</u>	<u>II</u>	<u>III</u>	<u>IV</u>	<u>V</u>
Percentage of patients in this study.	8	37	23	14	18
Percentage of alcoholics (10) described by Vallance(1965)	5.9	29.4	28.2	4.4	22.1
Percentage of Scottish census (1961)	5	13	51.3	18.3	14.4

The observation that alcoholics from social class I
(2,3,4,) and II have a better prognosis has been made in several studies. It may be that the ability to attain Class I or II occupations demands a personality structure which is in turn able to utilise treatment facilities. Studies which have shown that patients socially nearest to their therapists progress most favourably may also be relevant (5). The patient from Class V may feel that he is not talking the same language as his therapist. A sense of rejection may be engendered in those patients who feel socially alien from the treatment staff.

Patients with extant marriages have a good prognosis. This observation has been made in several other studies (1,2,7,8,) 57% of the patients attending the clinic had extant marriages. This observation is similar to the finding of Straus and Bacon (8) (1951) amongst out-patients attending an alcoholism clinic and Vallance (1965) in alcoholics admitted to a Glasgow psychiatric unit.

It is surprising that marital stability weighs so heavily in favour of patients admitted to the unit and yet is of little significance for those who were treated as out-patients. It may be that the spouse of an in-patient becomes more intensely involved in treatment when the patient is hospitalised than is the case when treatment is offered as an out-patient from the start. A later chapter on the significance of case-work with the patient's spouse adds to this impression. Equally, a marriage which is pathological and itself a cause of drinking

may be assisted if the patient is withdrawn temporarily from the stressful situation and has an opportunity of reassessing his marriage in sobriety and with the aid of a therapeutic environment which will enable him to recognise distortions and misperceptions which have existed in his marital relationship.

Females in this sample did not differ significantly from males in respect of age or marital status. The male/female ratio of approximately 5:1 is similar to that reported in an earlier study by this clinic ⁽⁴⁾.

There is no evidence that the female alcoholic has a poorer prognosis than the male, which accords with the observation of Davies et al (1956) ⁽¹⁾. It has been suggested that women who drink pathologically are more psychologically disturbed initially ⁽⁶⁾ than men of similar habits because excessive drinking is culturally alien for the female. The findings cannot confirm this view. It may be that women who seek treatment are unrepresentative of the population of alcoholic women in the community as women seem particularly reluctant to seek treatment in view of the social stigma attached to alcoholism in their sex.

Religion and nationality do not appear significantly related to outcome. The percentage of Roman Catholics in the sample approximates to that in the City. It is likely that the tendency for those of Protestant religion to have a more favourable outcome reflects the social class and occupational difference of the groups.

Immigrants are often regarded as a sub-culture at risk to alcoholism. No evidence that this situation exists in Edinburgh

can be derived from the present findings. 2.9% of Edinburgh's population are immigrants and it is perhaps surprising that none are represented in this sample.

CHAPTER VI

SECTION 2: Childhood Experiences

Parental Death:

The loss of a parent by death before the age of 16 was not a common occurrence in this sample. Patients had experienced the death of their father in 11 cases, of their mother in 7 and of both parents in 3. Parental death in childhood did not appear to influence treatment response as the table shows (Table 1)

Permanent separation from either parent before the age of 16 for any reason including death occurred in 24 of the patients. The age of the patient at the time of loss is shown in Table 2. No relation between separation and treatment response is demonstrable.

In an attempt to assess the patient's feeling for each parent his attitude towards both mother and father was recorded. This was regarded as being "positive" when the patient expressed a liking for the parent using such phrases as "one of the best", "a fine person" or "someone we all admired". "Negative" when the patient expressed dislike or fear, for instance, "never had any time for us", "he was a big man we were all afraid of him" or "it was best to keep out of her way".

Some degree of mixed feeling is inevitably present in all parent-child relationships and further knowledge of the patient often reveals that what at first seemed a simple positive or

negative has concealed the contrary attitude. However, data recorded here is based on the initial impression. In some cases a patient would be very aware of mixed feelings and made these known at the first interview. Phrases such as "I was afraid of him and yet admired him", "Although she often made you annoyed, you couldn't help liking her".

TABLE 1

The relation between the occurrence of parental death in childhood and treatment response

Drinking status at six months

Loss of parent before 16.	<u>In-Patients</u>								<u>Out-Patients</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Not applicable	10	5	2	-	8	12	-	37	11	4	4	1	8	14	-	42
Mother	2	3	1	-	-	1	-	7	-	-	-	-	-	-	-	0
Father	2	1	-	-	3	-	-	6	-	-	-	-	3	2	-	5
Both	-	-	-	-	-	-	-	0	-	-	1	-	-	1	1	3
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = -0.1635 Kendall's tau = 0.2416

Unit normal deviate = -1.30508 Unit Normal deviate = 1.89163

N.S.

N.S.

TABLE 2

Relation between permanent separation from a parent and treatment response

Permanent separation from a parent.	<u>Drinking status at six months</u>															
	<u>In-Patients</u>							<u>Out-Patients</u>								
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Not applicable	10	5	2	-	8	12	-	37	11	2	4	-	8	14	-	39
Father. 4 and under	1	-	-	-	-	-	-	1	-	1	-	-	1	-	-	2
" 5 - 9	-	-	-	-	-	-	-	0	-	-	-	-	-	1	-	1
" 10 - 15	1	1	-	-	3	-	-	5	-	-	-	-	1	1	-	2
Mother. 4 and under	1	2	1	-	-	-	-	4	-	-	-	-	-	-	-	0
" 5 - 9	1	1	-	-	-	-	-	2	-	-	-	1	-	-	-	1
" 10 - 15	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-	0
Both. 4 and under	-	-	-	-	-	-	-	0	-	1	1	-	1	-	-	3
" 5 - 9	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	0
" 10 - 15	-	-	-	-	-	-	-	0	-	-	-	-	-	1	1	2
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = -0.1648

Kendall's tau=0.1282

Unit normal deviate = -1.33537 Unit normal deviate=1.04098

N.S.

N.S.

TABLE 3

The relation between patient's attitude towards father and treatment response.

Attitude towards Father.	<u>Drinking status at six months</u>															
	<u>In-Patients</u>							<u>Out-Patients</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Positive	4	5	1	-	3	5	-	18	9	-	4	1	5	10	1	30
Negative	6	2	-	-	3	7	-	18	1	3	1	-	3	3	-	12
Ambivalent	3	2	2	-	5	1	-	13	1	1	-	-	1	4	-	7
Non-committal	1	-	-	-	-	-	-	1	-	-	-	-	1	-	-	1
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = -0.0756 Kendall's tau = 0.0862

Unit normal deviate = -0.62317 Unit normal deviate = 0.65317

N.S.

N.S.

The relation between patient's attitude towards mother and treatment response

Attitude towards Mother.	<u>Drinking status at six months</u>															
	<u>In-Patients</u>							<u>Out-Patients</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Positive	8	6	3	-	5	7	-	29	8	2	5	1	9	11	1	37
Negative	5	1	-	-	-	2	-	8	-	2	-	-	1	3	-	6
Ambivalent	1	1	-	-	6	3	-	11	2	-	-	-	1	3	-	6
Non-committal	-	1	-	-	-	1	-	2	1	-	-	-	-	-	-	1
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = 0.1142 Kendall's tau = 0.0182

Unit normal deviate = 0.93335 Unit normal deviate = 0.14658

N.S.

N.S.

which reflected markedly opposing emotions existing towards a parent; would place the patient in the "ambivalent" category. Some patients were placed in a "non-committal" category when their response indicated they could not recall feelings about a parent or were reluctant to talk about a parent in any but the most general terms. Some patients feel at first interview that it is 'bad form' to talk about their parents and spouse. The table demonstrates the frequency of these attitudes and relates them to treatment responses (Table 3). There is no significant relationship between attitude towards parent and treatment response.

Parental Drinking Habits

It seems reasonable to suppose that the emotional significance an individual attaches to alcohol will in part be determined by the parental drinking habits. Patients were asked about a family history of excessive drinking, whether amongst parents or near relatives.

In 38 of the patients no family history of excessive drinking could be found. 35 patients had a father who was an excessive drinker and 10 had a mother who drank in excess. In 3 cases both parents had drinking problems and in 14 patients a drink-problem although not present amongst parents, was reported amongst more remote relatives. Clearly the accuracy of these figures must be in doubt as they depend on how much detail about his family the patient wished to reveal and to a certain extent on the patients' concept of what constitutes a

drink-problem. Nonetheless, they do provide some picture of the familial drinking habits. No relation between excessive drinking within the family and treatment response was demonstrable. (Table 4).

Total abstinence is in our culture, a deviant attitude towards alcohol and in itself may represent an over-valued notion of the significance of alcohol. The relationship between parents who were regarded by the patient as being teetotal and treatment response is shown in Table 5. There is a trend which suggested that the offspring of abstinent parents have a more favourable outcome in treatment.

Siblings:

The number of sibs in the patient's family did not appear to have any bearing on treatment response, (Table 6), neither did the patient's position in the sibship (Table 7).

The distribution of the sample in terms of position in sibship differs significantly from a normal Edinburgh population described by Munro (1966)¹ (Table 8). Although this normal sample can not be regarded as a properly constituted control for the alcoholics in this study it is interesting that there appears to be a preponderance of only, second and penultimate placings in the sibship.

TABLE 4

The relation between familial alcohol excess and treatment response
Drinking status at six months

<u>Excessive drinking</u> <u>in family.</u>	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
None	5	4	1	-	5	4	-	19	2	3	1	1	7	4	1	19
Father	4	3	-	-	4	7	-	18	3	-	2	-	2	10	-	17
Mother	1	-	-	-	1	2	-	4	2	1	1	-	2	-	-	6
Both	1	1	-	-	-	-	-	2	1	-	-	-	-	-	-	1
Other	3	1	2	-	1	-	-	7	3	-	1	-	-	3	-	7
<u>Total:</u>	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
	Kendall's tau = -0.0731								Kendall's tau = -0.1248							
	Unit normal deviate = -0.61183								Unit normal deviate = -1.04977							
	N.S.								N.S.							

TABLE 5

The relation between parental abstinence and treatment response.
Drinking status at six months

<u>Strict abstinence</u> <u>in parents.</u>	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Neither	8	5	2	-	9	10	-	34	5	3	3	-	7	12	1	31
Father	2	1	-	-	-	2	-	5	1	-	1	-	-	-	-	2
Mother	2	1	-	-	2	1	-	6	4	-	1	1	3	5	-	14
Both	2	2	1	-	-	-	-	5	1	1	-	-	1	-	-	3
<u>Total:</u>	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
	Kendall's tau = -0.1903								Kendall's tau = -0.1612							
	Unit normal deviate = -1.54899								Unit normal deviate = -1.30071							
	N.S.								N.S.							

TABLE 6

The relation between number of siblings and treatment response.

Drinking status at six months

<u>Number of siblings</u>	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
None	3	1	-	-	2	2	-	8	-	1	1	-	1	3	-	6
One	4	4	1	-	-	3	-	12	-	2	-	1	3	2	-	8
2 - 3	2	2	2	-	6	1	-	13	8	1	1	-	2	5	-	17
4 - 6	5	2	-	-	-	6	-	13	2	-	1	-	2	4	-	9
7 - 10	-	-	-	-	3	1	-	4	1	-	1	-	1	1	1	5
10+	-	-	-	-	-	-	-	0	-	-	1	-	2	2	-	5
<u>Total:</u>	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau = 0.1460

Kendall's tau = 0.0338

Unit normal deviate = 1.25188 Unit normal deviate=0.29377

N.S.

N.S.

TABLE 7

The relation between position in sibship and treatment response.

Drinking status at six months

<u>Position in sibship</u>	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Only	3	1	-	-	2	2	-	8	-	1	1	-	1	3	-	6
First	5	3	-	-	2	3	-	13	1	-	-	-	4	1	-	6
Second	1	3	-	-	2	2	-	8	3	1	-	-	-	4	-	8
Middle	1	-	1	-	-	1	-	3	3	-	1	-	2	1	-	7
Penultimate	1	-	1	-	3	3	-	8	3	-	1	-	1	3	-	8
Last	3	2	1	-	2	2	-	10	1	2	2	1	3	5	1	15
<u>Total:</u>	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's tau= 0.0779

Kendall's tau = 0.0142

Unit normal deviate= 0.67800 Unit normal deviate=0.12387

N.S.

N.S.

TABLE 8

Sibship position of this sample compared with normal population.

Position in sibship:	Alcoholics	Normal Population (1)
Only	14	13 (7%)
First	19	40 (25%)
Second	16	10 (6%)
Middle	10	37 (23%)
Penultimate	16	12 (7%)
Last	25	51 (31%)
Total:	100	163 (100%)

$$\chi^2 = 18.8. \quad 5 \text{ d.f.}$$

$$p < .01$$

Discussion:

The incidence of parental loss and separation in this sample is very similar to that observed for a psychiatrically normal Edinburgh population. Munro⁽¹⁾ found that by the age of 16, 12.4% of a normal sample had lost a father and 8.1% a mother. This study does not support the view that parental loss is an unduly common experience in the childhood of alcoholics⁽²⁾. Amongst those who have lost a parent before 16 the experience with its attendant effect on the developing personality has not been shown to impair or facilitate the progress shown by a patient.

"The loss of a meaningful relationship with a mother figure is crucial to our understanding of the motivating unconscious drives of the alcoholic"⁽³⁾. This comment from Chafetz is in accord with traditional theories of the pathogenesis of alcoholism^(4,5). Separation is a crude form of deprivation and should the mother surrogate prove attentive the warm maternal relationship may be restored. Before the validity of maternal deprivation in the pathogenesis of alcoholism can be fully established or refuted it would be necessary to be aware of the nuances of emotional behaviour which existed between a patient and his mother in the early years. This study has not touched on the occurrence of maternal illness, depression or pre-occupation with other stressful situations which may have distracted her during the patient's childhood, nor has it described

those mothers who were protective but over-indulging of oral gratifications in childhood⁽⁶⁾. It seems likely that the quality of a child's relationship with a parent or parent-substitute is more important than the occurrence of separation from a parent. Detailed study of incorporated parental images is required but this must be carried out first in a psychiatrically normal population. This study's attempt at obtaining a subjective global estimate of the patient's attitude towards each parent did not reveal any correlation between such an attitude and treatment response.

Hilgard and Newman⁽⁶⁾ suggest that it is only in the young alcoholic that the loss of parent is an important aetiological factor. In this sample only one of those 21 who had lost parents was a young man under 30 years of age. There was no indication in this sample that young alcoholics had suffered excessively in this way.

All seven patients who had lost their mothers in childhood were admitted to the unit. Clinical inspection of these seven revealed that they were all men and appeared to have similar personalities, being markedly self-critical and dependent. Six were married and it seemed clear that these patients had entered into dependency relations with their wives whom they treated as if they were their mothers. As a group they appeared to have a good prognosis.

The finding that a third of the patients had fathers who were excessive drinkers supports the view that the offspring

of alcoholic fathers are more likely to develop alcoholism than the general population ⁽⁷⁾. The parent who drinks excessively may provide a model for subsequent identification. A home in which one parent 'over-indulges' and is criticised by his partner, presents a model which could be incorporated within the developing personality. The struggle between impulse and conscience becomes centred in the question of alcohol indulgence. These suggestions must remain speculative but the family pattern of excessive drinking is one fact that has been observed repeatedly in the background of alcoholics ^(7,8,10).

While excessive drinking in a parent is not of value in predicting treatment response the occurrence of abstinence amongst parents appears linked with a favourable prognosis, although the evidence presented is not conclusive. Several factors can be considered which could contribute to this finding. A patient who abstains may find that he is accepted by his parents so that this reward reinforces his resolve to remain abstinent. It will be easier for a patient to avoid alcohol if he has a circle of friends and relatives who do not drink; with the teetotal parents such a circle is more likely to be available. The occurrence of total abstinence in one or other parent may have provided a model for identification which the patient can recapture during the treatment. More research into the emotional significance of alcohol within differing families and social conditions would be interesting.

It has been suggested ⁽⁹⁾ that birth rank is aetiological significance amongst alcoholics. Navartil found that an excessive number of his patients were last children. This study does not support this view although there is evidence of difference between this sample and a 'normal' sample. Before any definite conclusions could be drawn more detailed control studies are required.

Wahl (1956) ⁽²⁾ found a significantly greater number of alcoholics came from large families. The figures obtained in this study where 52% of the patients came of families of two to six sibs and only 14% were larger, does not support this observation.

CHAPTER VII

HISTORY OF ALCOHOL USAGE

In their drinking career the majority of alcoholics pass through certain recognised phases. These have been described by Jellinek⁽¹⁾ and more recently by Kessel and Walton⁽²⁾. The alcoholic passes from a prodromal phase of excessive drinking to the stage of addiction - perhaps the most striking features of this phase are the occurrence of frequent alcoholic amnesias and the abstinence syndrome. Finally, comes the stage of chronic alcoholism where physical and mental symptoms predominate. It should be stressed that there is variation in the clinical features of alcoholism between different patients. The downward path described for the alcoholic is merely an outline of commonly encountered stages in the disease.

This chapter describes the frequency with which certain landmarks in the history of the alcoholics were met with clinically in this sample. The prognostic value of these features is also discussed.

Age at first drink

All patients were asked if they recalled their age at the time of their first alcoholic drink. The majority could give only an approximate date while some recalled the occasion vividly. For example, a middle aged married man remembered

being teetotal until he was 19. One evening he was jilted by a girl friend whom he had known for two months - he went out after this blow to his self-esteem and got drunk.

Another patient reported that he had been abstinent until as a young man in a dance band he discovered that the leader of the group was a homosexual. He began drinking during the evening so that he could tolerate the journey home with this leader. It appeared that he was drinking to reduce his own homosexual anxieties.

Most of the patients (59) had started drinking between the ages of 16 and 21. As shown in the Table 1, those who started drinking relatively late in life appear to have a good prognosis. This observation applies to in-patients only.

Drinking History

The majority (N=83) of patients had their first drink outwith home and away from their parents.

In Scotland a favourite drink is a 'nip' of whisky and a chaser of beer and many patients drank in this way. When asked to specify the form of alcoholic beverage they most commonly drank, 71 indicated that this was whisky, 14 regarded themselves as predominantly beer drinkers often adding that they had not believed you could become alcoholic on beer alone. 14 favoured spirits other than whisky and only one person drank predominantly wine.

The drinking of cheap wine or methylated-spirit was relatively uncommon. Only 11 had any experience of such drinks and none took them regularly or for preference. This group appeared to have a bad prognosis, neither of the two meths drinkers admitted were improved at follow-up.

All patients were asked how long they had been drinking excessively. The aim of this question was to obtain the patient's own estimate of the time elapsed since he started drinking in excess of what had been his previous drinking habit. Clearly replies would often be distorted and their accuracy was dependent on the motivation of the patient at that time and his own estimate of what constituted excessive drinking. Nonetheless allowing for this subjective element, their answers do provide some indication of the duration of each patient's drink problem.

No relationship between duration of excessive drinking estimated in this way and treatment response was observed amongst hospitalised patients. (Table 2). There does appear to be a trend apparent amongst out-patients suggesting that those with a longer history of excessive drinking have a more favourable prognosis. This trend does not reach significance.

Solitary drinking in this culture is regarded as less socially acceptable than drinking in company. It might be that those who do drink in this culturally deviant way will be more disordered and hence have more difficulty in abstaining. No significant difference in treatment response was observed between those who mainly drank alone (N=28) and those who customarily drank in company (N=72) (Table 3).

TABLE 1

Relation between age at first drink and treatment response.

DRINKING STATUS AT 6 Months

Age at first drink	<u>In-Patients</u>							<u>Out-Patients</u>								
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Younger than 15	1	-	-	-	2	5	-	8	-	2	1	-	2	3	1	9
16 - 21	7	3	2	-	8	7	-	27	9	2	3	1	7	10	-	32
22 - 30	5	4	1	-	1	1	-	12	2	-	1	-	2	4	-	9
31 and over	1	2	-	-	-	-	-	3	-	-	-	-	-	-	-	0
TOTAL	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = -0.3909

Kendall's Tau = -0.0615

Unit normal deviate = -3.21683

Unit normal deviate = -0.40697

$p < .01$

N.S.

TABLE 2

Relation between duration of excessive drinking and treatment response

DRINKING STATUS AT 6 MONTHS

<u>Duration of excessive drinking in years</u>	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
0 - 1	-	-	-	-	-	1	-	1	-	-	-	-	1	1	-	2
2 - 5	7	2	1	-	6	3	-	19	3	-	4	-	5	7	-	19
6 - 10	-	4	-	-	2	5	-	11	1	2	-	1	1	5	1	11
11 - 15	5	3	-	-	2	1	-	11	-	1	1	-	-	2	-	4
16 - 20	2	-	2	-	-	1	-	5	4	1	-	-	1	1	-	7
21 f	-	-	-	-	1	2	-	3	3	-	-	-	3	1	-	7
TOTAL	14	9	3	0	11	12	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = 0.0000

Kendall's Tau = -0.2091

Unit normal deviate = 0.0000

Unit normal deviate = -1.79841

N.S.

N.S.

TABLE 3

Relation between preferred drinking habit and treatment response.

DRINKING STATUS AT 6 MONTHS

	<u>In-Patients</u>								<u>Out-Patients</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Drinks in company	8	6	2	-	7	10	-	33	8	4	5	1	10	10	1	39
Drinks alone	6	3	1	-	4	3	-	17	3	-	-	-	1	7	-	11
TOTAL:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = -0.1266

Kendall's Tau = 0.1602

Unit normal deviate = -0.98007

Unit normal deviate = 1.24516

N.S.

N.S.

Alcoholic Amnesias

(1)

Jellinek regards the occurrence of frequent amnesias following drinking as an early feature of the development of alcohol addiction. All patients were asked whether they had experienced such a 'blackout' defined as 'loss of memory following consumption of alcohol not sufficient to cause drunkenness.' This final clause excluded those who had amnesia following a drinking spree when the patient had been so drunk as to be unaware of his surroundings at the time. In a true alcoholic amnesia the striking feature is the failure to recall a period of time when to the observer, the patient, was in full possession of his senses.

Examples:

A business-man had been at a party with his wife. During the evening there was a considerable amount of drinking but nothing untoward was observed about the patient's behaviour and he drove his wife home after the party.

In the morning he awoke in a panic with no memory of where he had left the car. His wife told him he had driven home without difficulty but he had to go to the garage and see for himself that the car was parked as usual, before he could be sure that he had not left it in the street. He had no recollection of the evening.

A young alcoholic was interested in model boats. When drunk he would break these and in the morning have no recollection of the damage he had done. He was astonished and very disappointed that he had destroyed the product of weeks of meticulous work.

Blackouts had occurred in 73% of patients. There was no relationship between a history of such amnesias and response to treatment and they occurred with similar frequency in the

hospitalised and out-patient groups. (See Table 4).

Each patient was asked about the time which had elapsed since he first experienced alcoholic amnesias at all frequently. Table 5 shows that 30% had been familiar with such amnesias for 2 to 5 years before referral: eight had known them for more than 15 years.

The Abstinence Syndrome

Withdrawal symptoms on reducing alcohol intake are a feature of alcohol addiction: patients were asked if they had experienced these. The definition was - "the occurrence of coarse tremor of the hands and general shakiness, which may be controlled by having another drink. In addition, this abstinence syndrome may be characterised by anxiety and depression, also relieved by taking a drink. These latter symptoms should be regarded as constituting the abstinence syndromes only if they occur in the morning and invariably follow drinking the previous day".

83 of the patients had this experience. When the time lapse since the first occurrence of the abstinence syndrome was estimated by the patient, it was found that like amnesias, they were commonly of recent duration (see Table 5). It is interesting that amongst out-patients, those with the longer history of withdrawal symptoms had a better prognosis. (Table 6).

TABLE 4

Relation between the occurrence of alcoholic amnesias and treatment response

Alcoholic Amnesias:

DRINKING STATUS AT 6 MONTHS

	<u>In-Patients</u>							<u>Out-Patients</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Experience of amnesias	9	7	2	-	6	11	-	35	6	4	4	-	10	14	-	38
No amnesias	5	2	1	-	5	2	-	15	5	-	1	1	1	3	1	12
TOTAL:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = -0.0957

Kendall's Tau = -0.117

Unit normal deviate = -0.74077

Unit normal deviate = -0.86769

N.S.

N.S.

TABLE 5

Time since first occurrence of Blackouts and Abstinence Syndrome:

	<u>Blackouts</u>	<u>Abstinence Syndromes</u>
None	26	18
0 - 1 year	18	23
2 - 5 years	30	39
6 - 10 years	13	8
11 - 15	5	6
16 - 20	5	1
21 †	<u>3</u>	<u>5</u>
	100	100

TABLE 6

The relation between time interval elapsed since first experience of withdrawal symptoms and treatment response

DRINKING STATUS AT 6 MONTHS

<u>Withdrawal symptoms:</u>	<u>In-Patients</u>							<u>Total</u>
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	
None	2	-	-	-	1	2	-	5
0 - 1 year	5	2	-	-	4	2	-	13
2 - 5 years	7	3	2	-	6	5	-	23
6 - 10	-	1	-	-	-	2	-	3
11 - 15	-	3	1	-	-	1	-	5
16 -20	-	-	-	-	-	-	-	0
21 †	-	-	-	-	-	1	-	1
TOTAL	14	9	3	0	11	13	0	50

Kendall's Tau = 0.1092 Unit normal deviate = 0.91945

N.S.

<u>Withdrawal symptoms:</u>	<u>Out-Patients</u>							
None	2	-	2	-	4	5	-	13
0 - 1 year	1	-	1	-	1	6	1	10
2 - 5 years	3	2	1	1	4	5	-	16
6 - 10	1	2	-	-	2	-	-	5
11 - 15	-	-	1	-	-	-	-	1
16 - 20	1	-	-	-	-	-	-	1
21 †	3	-	-	-	-	1	-	4
TOTAL	11	4	5	1	11	17	1	50

Kendall's Tau = -0.2945 Unit normal deviate = -2.53772

p < .05

Social Consequences of Pathological Drinking

Patients were asked if they had ever lost their job as a result of their drinking either because they had been drunk at work or morning hangovers had caused repeated absences. 29% of the sample had lost their jobs on some occasion, some more than once. The duration since first loss of job amongst those who had done so is shown in the Table 7.

TABLE 7

First loss of job	1 year ago	2-5 years	6-10	11-15	16-20	21+
Number of patients	7	12	5	3	1	1
	Total: <u>29</u>					

30 of the patients had been charged with drunkenness. This did not include those 9 of the 79 licence holders who had been arrested for drunken driving. 18 of the patients had been guilty of stealing or embezzlement to obtain money for drinking or to make good, losses incurred by drinking.

Although stealing, loss of job and arrest for drunkenness have a tendency to impair a patient's prognosis: only in those who had been arrested for drunkenness and were admitted does this trend reach significance (Table 8). Significantly fewer patients who gave history of arrest for drunkenness gave evidence of favourable progress after six months.

TABLE 8

The relation between various social disturbances and treatment response

DRINKING STATUS AT 6 MONTHS

	<u>In-Patients</u>								<u>Out-Patients</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>TOTAL</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>TOTAL</u>
Stealing or embezzlement	3	1	-	-	2	4	-	10	1	-	1	-	2	4	-	8
No " "	11	8	3	-	9	9	-	40	10	4	4	1	9	13	1	42
TOTAL	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
Kendall's Tau =	-0.0854								Kendall's Tau = -0.1336							
Unit normal deviate =	-0.66145								Unit normal deviate = -1.03815							
	N.S.								N.S.							

Loss of job due to drinking	4	1	1	-	3	5	-	14	1	2	-	-	6	6	-	15
No " "	10	8	2	-	8	8	-	36	10	2	5	1	5	11	1	35
TOTAL	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
Kendall's Tau =	-0.0948								Kendall's Tau = -0.1645							
Unit normal deviate =	-0.73381								Unit normal deviate = -1.27887							

Drunk arrest	2	2	-	-	-	8	-	12	2	3	2	-	4	6	1	18
No " "	12	7	3	-	11	5	-	38	9	1	3	1	7	11	-	32
TOTAL	14	11	3	0	11	13	0	50	11	4	5	1	11	17	1	50
Kendall's Tau =	-0.2989								Kendall's Tau = -0.0900							
Unit normal deviate =	-2.31439								Unit normal deviate = -0.69901							
	p < .05								N.S.							

Chronic Alcoholism

In this context chronic alcoholism was said to be present when physical sequelae of prolonged addiction had occurred. Patients placed in this category had suffered - delirium tremens, cirrhosis of the liver, peripheral neuropathy, alcoholic epilepsy, or organic brain disease due to alcohol. 34 patients suffered from chronic alcoholism within the definition. The presence of chronic alcoholism did not appear to affect prognosis. (Tables 9 and 10).

Previous Treatment

Approximately one third of the patients had received previous treatment for alcoholism. In most cases previous treatment had involved 'drying-out' and restoration of vitamin deficiencies in a mental hospital. Previous treatment did not appear to influence treatment response on this occasion.(Table 11).

Alcoholics Anonymous

All patients were asked about any previous experience they had of this agency. Only 18 had attended A.A. 28 of the patients were critical of A.A. methods. For instance one man felt that he could not accept their 'evangelical fervour'. Others were critical of the interminable breast beating, still others doubted the veracity of many of the stories they heard recounted.

Although Alcoholics Anonymous was not an integral part of the treatment regime, some patients were encouraged to attend after discharge or as was most often the case, amongst out-patients when it was felt that the patient lacked the experience to be gained from listening to other alcoholics.

These out-patients who had attended Alcoholics Anonymous at any time had a significantly better treatment response than those who had not. (Table 12).

TABLE 9

The relation between the presence of chronic alcoholism and treatment response

DRINKING STATUS AT 6 MONTHS

Signs of Chronic Alcoholism									<u>DRINKING STATUS AT 6 MONTHS</u>							
	1	2	3	4	5	6	7	TOTAL	1	2	3	4	5	6	7	TOTAL
Absent	9	6	1	-	5	10	-	31	9	1	3	-	9	12	1	35
Present	5	3	2	-	6	3	-	19	2	3	2	1	2	5	-	15
TOTAL	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = -0.0425

Kendall's Tau = -0.0394

Unit normal deviate = 0.32911

Unit normal deviate = -0.30598

N.S.

N.S.

TABLE 10

Physical consequences of alcohol addiction in this sample

Delirium Tremens	17
Peripheral Neuritis	6
Cirrhosis (Hepatic)	7
Withdrawal fits	4
TOTAL	<u>34</u>

(One case of peripheral neuritis and all patients who experienced withdrawal fits had delirium tremens in addition. These are not shown in the table. All cases of hepatic cirrhosis were diagnosed by physicians, and in 6 a confirmatory liver biopsy had been performed).

Discussion:

The observation that patients who had started drinking only in later life appeared to have a relatively good prognosis requires some clarification. The number who started drinking after they were 31 years old is very small (3) and all were admitted. The outstanding features of these three histories are set out below.

Patient 1:

A 58 year old married man who owned a prosperous wastepaper business was referred on account of excessive drinking. He was found to be suffering from 'inability-to-abstain' alcoholism and was admitted.

Both his parents had been heavy drinkers and his mother died when the patient was six of "alcoholic poisoning". A younger sister was an alcoholic and a young brother had died of meningitis at 26.

The patient's early days had been very unhappy and he experienced much poverty. He married at 27, his wife being 4 years older than himself - they confined the family to one son.

The patient shocked at the impact drink had made on his early experiences, abstained totally until the age of 40. His wife, who was extremely maternal towards the patient, had been teetotal all her life. In his 40s as his business proved more successful and onerous he started to drink as a means of relaxing after work. Throughout he had endeavoured to conceal his drinking from his wife and said at interview he wanted to stop drinking for her sake.

The formulation at initial interview was, a very dependent personality who had sought a maternal relationship with his wife, in addition he possessed a rigid conscience structure which was extremely critical of any self-indulgence, This combination of self-criticism and dependency rendered him unduly reliant on external supports and very susceptible to depression when he feared such support might be withheld.

Patient 2:

A 60 year old Engineer, widower, was referred by his general practitioner suffering from inability-to-abstain addiction and evidence of peripheral neuritis. He had only started drinking 15 years previously, shortly after his father's death. His father had been a strict teetotaler which the patient felt represented his reaction against a family tradition of heavy drinking. His father had dominated the patient who had been required to remain abstinent during his life time. The patient's mother had died within a few days of his birth.

It is interesting in view of the paternal attitude towards alcohol that the patient married a woman who was herself a heavy drinker. She had been an invalid much of their married life and had died young when the patient was 53.

He had experienced anxiety symptoms since his father's death, presumably on account of this intense and unresolved relationship which had existed between them. The death of his wife aggravated symptoms of anxiety and he experienced a prolonged and complex grief reaction. His wife had been a difficult woman to live with, and he had frequently wished that her illness, which was causing her great suffering, would bring a timely end to her life. The patient endeavoured to cope with these stresses by using alcohol as a tranquilliser, at first taking whisky in small doses three times daily. In the year before admission he had been drinking at least one bottle of whisky in the day. He would take a bottle of whisky to bed with him and drink during the night if he was unable to sleep.

The psychiatric formulation was alcoholism and anxiety neurosis: he was admitted to the unit.

Patient 3:

A 61 year old spinster had been referred from another psychiatric unit where she had been admitted suffering from delirium tremens. She was found to be suffering from loss-of-control pattern of alcohol addiction and admitted.

Until her early 30s this woman had been teetotal and had occupied her time by caring for her father and sister, as her mother who was an alcoholic, was not in a position to look after the house. When she was 30 her father was killed in dramatic circumstances. The patient had been content with her intense devotion to her father and his death effected a dramatic change in her mode of adaptation. She drifted from one job to another and started drinking socially. She was subject to profound depressions and in these she would drink excessively, a pattern which had been present for 25 years before her admission.

1½ years prior to admission her mother had died and this had precipitated the patient into a depressive reaction which had required hospital admission at that time. She had been attending a psychiatrist irregularly up to the time when she was referred to this clinic.

It was felt that this patient suffered from a personality disorder which was predominantly hysterical in type - in addition she had suffered recurrent depressive episodes.

It is clear that these patients were very much older than the majority of the sample. It has already been noted that older patients in this study have a better prognosis than the others. In addition it is apparent that in all three cases described, abstinence had been adopted as a way of life in response to stressful childhood experiences which were associated with alcohol. The numbers represented are so small that it would be unwise to arrive at any general conclusion but it does seem that it is easier to recapture a former pattern of abstinence than to develop one as a new tradition.

The observation that most first drinks are taken out-with parental aegis is in accord with the findings of Maddox and McColl (2). That no habitual users of meths' or cheap wine were seen at the clinic is surprising because many are known in

the city. Those who had started taking such drinks had a poor prognosis. It appears that the clinic was not catering for this group of drinkers. Patients such as those recently described by Edwards ⁽⁴⁾ were not referred to the clinic probably because general practitioners were aware that facilities for coping with this problem were not yet available. An extension of the alcoholism treatment programme is necessary to deal with patients who are grossly deteriorated socially.

The patient's estimate of the duration of his excessive drinking did not appear to be of prognostic significance. Examination of Table 2 does show that those 3 who claimed to have been drinking excessively for less than a year had a poor prognosis in terms of abstinence - all were drinking at six months' review. It is likely that this conservative estimate of his drinking pattern reflects a distorted perception which would make it difficult for the patient to utilise treatment. Patients with - brief drinking history would demur from the diagnosis of alcoholism when their concept of the alcoholic was the down and out social derelict. It may be that the educational function of the unit assisted in-patients to arrive at a new image of the alcoholic while out-patients benefited less as the majority had little contact with the alcoholics at similar stages in their illness.

It was the impression of the unit staff that out-patients with a brief duration of excessive drinking were commonly able to rationalise a return to drinking on the grounds that other

men of similar age appeared to drink as much and were not labelled 'alcoholic'. More experienced alcoholics had been so labelled by their peers and this may have facilitated their acceptance of the diagnosis. Amongst out-patients there was a distinct trend favouring the prognosis of those with a long history of excessive drinking. This element of self-labelling as alcoholic was regarded as an important requisite of successful treatment. It is likely that this factor operated in the relative success of patients who had at any time attended Alcoholics Anonymous even when such attendance did not coincide with treatment from the clinic. (Table 12).

It is interesting that amongst out-patients those with the longest histories of withdrawal symptoms have a significantly more favourable treatment response. In part the factors discussed above may contribute to this finding - that is, patients who have been clearly alcoholic for many years find that the diagnosis has been made, not only medically, but by their peers and within their environment. It may also be argued that patients who report many years of "the shakes" are better motivated and more concerned about their addiction than those in whom the affliction is regarded as being of recent origin. Age might be regarded as an important factor in that those with the longest histories would be relatively older than those with shorter histories. All but one of the six out-patients who had been drinking for more than 10 years were between 50 and 59 years of age, the exception was in 40-49 group.

Alcoholism is a disease which commonly produces social disturbances as these findings indicate. Lipscomb⁽⁵⁾ has commented on the use which could be made of these social upheavals in detecting alcoholism at an early stage. Consideration of the results shows that the disease had often shown itself by such consequences many years before the patient sought help. Had industry and the courts been on the look-out for the diagnosis then these patients might have received help at a much earlier stage and thereby much suffering and social inefficiency avoided. The relationship between employee and alcoholic requires more detailed study. The success of Pfeffer's⁽⁶⁾ techniques in the Ediswan company is a model which might well be studied in this country.

The association between previous arrests for drunkenness and poor prognosis amongst the hospitalised sample requires closer examination.

Of these 12, nine were men and three women. Four of the nine men had also lost jobs on account of drinking. Seven of the patients had been classified as suffering from severe personality disorders, the remainder had been regarded as moderately disordered. Two thirds were loss-of-control addicts as opposed to those of inability-to-abstain pattern which was the reverse of the pattern for the hospitalised sample in general. As shown the difference is significant. (Table 13).

TABLE 13

Pattern of drinking against history of arrests

Pattern of Drinking	<u>Drunk Arrest</u>	<u>No Arrest</u>	<u>Total</u>
Inability to Abstain	28	4	32
Loss of Control	10	8	18
TOTAL	38	12	50

$$X^2 = 5.70 \quad p < .02$$

The social class distribution of those who were arrested for this reason, is also of interest. Seven were in social classes IV and V, four in III and only one in II. This does not reflect the trend for the hospitalised sample. (See table 14). It seems that those arrested for public drunkenness tend to suffer from loss-of-control alcoholism and come from a social milieu in which it may be more difficult to conceal the consequences of drunkenness. It might have been anticipated that those who were arrested would not only have had loss-of-control addiction but would have been catagorised as being hedonistic. This was not borne out only two were so catagorised, 8 were regarded as intropunitive or predominantly so.

TABLE 14

Social Class V, Arrest for drunkenness (In-Patients only)

	<u>No Drunk Arrest</u>	<u>Drunk Arrest</u>	<u>Total</u>
Social Class I & II	27	1	28
III	5	4	9
IV & V	6	7	13
TOTAL:	38	12	50

$$X^2 = 14.9 \quad p < .01$$

CHAPTER VIII

ATTEMPTED SUICIDE IN ALCOHOLICS

All patients were asked about previous episodes of self-poisoning or self-inflicted injury. 20 of this sample had attempted suicide, 8 of them more than once. It is quite likely that these represent an underestimate as patients are often reluctant to talk of episodes about which they feel ashamed or distressed. In certain circumstances patients may have attempted suicide during a period for which they experienced amnesia.

Findings:

The majority (12) of patients who had attempted suicide had done so within one year of admission. Table 1 shows the prognostic implications of a history of attempted suicide. Amongst in-patients such a history was significantly related to unfavourable treatment response - no such relationship was shown for the out-patient group.

TABLE 1

The relation between previous suicide attempt and treatment response

<u>Suicide Attempts</u>	<u>In-Patients Outcome</u>								<u>Out-Patients Outcome</u>							
	1	2	3	4	5	6	7	TOTAL	1	2	3	4	5	6	7	TOTAL
No history of attempt	12	8	3	-	10	5	-	38	10	1	5	1	10	14	1	42
One attempt	2	-	-	-	1	5	-	8	1	1	-	-	-	2	-	4
More than one attempt	-	1	-	-	-	3	-	4	-	2	-	-	1	1	-	4
TOTAL	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = 0.3342

Kendall's Tau = 0.0258

Unit normal deviate = 2.65384

Unit normal deviate = 0.20408

$p < .01$

N.S.

Discussion

Patients who gave a history of suicide attempt had a poor prognosis. It appeared that more patients with such a history were admitted although the difference between the two groups was not significant. ($\chi^2 = 1.1$ d.f. N.S.). When the diagnostic categories of those who had attempted suicide were examined more than half had severe personality disorders. Patients in this clinical category have been shown to have an unpromising prognosis. (Table 2).

TABLE 2

Diagnostic Categories of Patients Attempting Suicide

	<u>History of Suicide Attempt</u>	<u>No History</u>
Neurosis or mild personality disorder	2	28
Moderate personality disorder	5	36
Severe " "	12	15
Psychosis	<u>1 (Depression)</u>	<u>1</u>
	20	80

The Social Class distribution of this group is also at variance with the sample as a whole. (Table 3). Relatively few of those attempting suicide came from social classes I and II.

TABLE 3

Social Class of Patients Attempting Suicide

	<u>I</u>	<u>II</u>	<u>III</u>	<u>IV</u>	<u>V</u>
Suicide Attempt	-	3	5	6	6
Other Patients	8	34	18	8	12
TOTAL	8	37	23	14	18

The patients who attempted suicide were 4 females and 16 males. The age range is of interest and is shown on Table 4.

TABLE 4

Distribution by age of patients who had attempted suicide

	<u>All Patients</u>	<u>Those who attempted suicide</u>
20-29	15	8
30-39	21	5
40-49	27	5
50-59	30	2
60-69	5	0
70 +	2	0
	<hr/>	<hr/>
TOTAL	100	20

From the examination of the sub-group of alcoholics who had attempted suicide it is apparent that compared with the clinic population they were younger and more disordered psychologically and tended to come from social classes IV and V. All of these factors have been shown to be of ominous prognostic implication. It appears that the treatment offered to these patients did not help them to attain sobriety.

It is likely that a number of patients who had at some time attempted suicide were reluctant to admit this. This may have influenced reporting from Classes I and II and amongst older patients.

In many cases self-poisoning had been a dramatic cry for help and it often formed a means of drawing attention to the patient's drink problem. 12 of the patients attempted suicide less than a year before coming to treatment.

The same impulsiveness which seeks a solution to a problem by attempting suicide may lead to relapse when the abstinent patient is faced with some stressful situation. This incapacity for tolerating anxiety and indeed for utilizing psychotherapy is illustrated by the following tragic history:

A 39 year old unmarried inability-to-abstain addict was admitted to the unit from the regional poisons centre where he had been treated following a suicide attempt by gassing. This had not caused him any lasting physical damage and was reputed to be his first attempt.

He claimed to have tried to gas himself because he was so concerned about having stolen money from his father's firm a few days previously. He could not bring himself to admit to his father that he had taken this money. He regarded his father as unapproachable, and had done so all his life.

His father had been a caretaker for 40 years and was described as a deeply religious man. The patient was afraid of him and had confined his rebellion to avoiding Church and drinking heavily. The patient had always felt himself much closer to his mother, and had been disproportionately upset about her admission to hospital with a fractured femur three months previously. He had a brother six years older; they had never enjoyed a particularly close relationship.

Throughout his life the patient had conspicuously failed to establish lasting friendships with anyone. His army career ended ignominiously with his being charged with assault and robbery and serving a two year prison sentence. It was during this time in the army that he started drinking heavily. Since being discharged from the army at 22 he had held numerous jobs in the hotel trade, frequently losing them on account of drunkenness. It was his impression that he had been drinking pathologically for 7 years - drinking daily and experiencing frequent amnesias and withdrawal symptoms. He had been unemployed for 18 months prior to admission and was living with his parents.

At the time of admission he was regarded as suffering from a severe personality disorder and appeared very depressed. He was extremely uncommunicative and for the first week his only spontaneous comment was "Is it really necessary to have problems to start drinking?" For the most part he avoided involvement with the other patients except at the most superficial social level. When he had been in the unit for nearly 3 weeks he confided in a female patient that he was homosexual adding "how could he tell others about that" and that he thought he should leave. He impulsively left the unit that evening and got very drunk. He telephoned the unit later that evening and returned. He talked to the doctor about his homosexuality. His homosexual relationships had been transient since the age of 18; none had become lasting friendships and he was commonly the passive partner. He then told the group about his life crying and saying he should be in another ward "they couldn't help homosexuals and jail-birds". The patients reassured him that they would continue to accept him and felt he had made an advance by telling them about his troubles. When sober the following morning he again became anxious and left the unit insisting that no one could help him.

He committed suicide two days later taking alcohol and barbituates.

The relationship between suicide and alcoholism is well established. (1,2,3) It appears that those alcoholics who have once attempted suicide are very likely to attempt the same solution with a fatal outcome on a later occasion. (4) The present treatment for the suicide prone alcoholic is unsatisfactory and more detailed study of this group is required so that more effective therapy can be offered.

CHAPTER IX

CLINICAL EVALUATION

Pattern of addiction:

All patients in this sample were categorised in terms of their predominant drinking pattern. Jellinek⁽¹⁾ has pointed out that the loss of control addict is the form of addiction most commonly described in both scientific and fictional literature and it is this form which is catered for by Alcoholics Anonymous. Jellinek has distinguished between patterns of alcohol addiction and the classification employed here is based on his original categories of alcohol addiction.⁽¹⁾

Inability-to-abstain addiction: This corresponds to Jellinek's "Delta" type. Here the drinker can not go without a drink for even a few days on pain of developing a craving for alcohol and unpleasant withdrawal symptoms. These inveterate drinkers rarely become drunk and tend to maintain their alcohol intake at the minimum required to offset withdrawal symptoms.

Loss-of-control addiction: This corresponds to "Gamma" alcoholism of Jellinek. The outstanding feature of this group is that once they start taking alcohol they are unable to control their intake and a bout ensues which ends only with unconsciousness, physical illness, arrest, admission to hospital or some similar catastrophe.

Although in their extreme form these types are clinically

distinct and can be readily differentiated, a number of patients will be found who can not be placed in either group. For this reason two intermediate categories were available, one for predominantly inability to abstain drinkers, and the other for those who seemed predominantly loss of control.

Examples of Inability-to-abstain addiction:

A patient who started drinking late in life said that alcohol helped him to forget about his business worries and his wife's unpleasantness. For one year before admission he had never been without a bottle of whisky. He would drink it every few hours throughout the day and should he wake during the night he would have a glass of whisky. He had not lost any time off work and had an active social life without difficulty. When he tried to abstain he developed marked withdrawal symptoms. On admission he was found to be suffering from peripheral neuritis.

A 57 year old married chemist was referred from the regional poisons centre having attempted suicide. He had been addicted to alcohol for three years; his pattern was as follows. He would buy whisky on his way to work, and sip it throughout the day all day and every day. He did not drink after 8 p.m. or on Sundays. During the previous year he had experienced amnesias three or four times each week. This was particularly distressing as he was unable to recall whether he had made any mistakes in making up prescriptions during this time.

Examples of Loss-of-control addiction:

A 51 year old married chemist started drinking at 27. At this time he regarded drinking as a 'naughty and daring' thing to do as both his parents were total abstainers. In the four years before admission he became aware that he was drinking excessively. He would abstain totally for several weeks and then have a few drinks when he felt he could cope once more. He was never able to control his intake on these occasions and would drink for two or three days almost continuously, staying up much of the night drinking and on occasion being unable to go to work. He had lost his driving licence for driving, under the influence of alcohol.

A 29 year old married docker was referred to the Clinic by his own General Practitioner as he had been 'getting into trouble because of his drinking'. At the first interview he said - "When I start I can't stop, all my money goes, I get into fights, I have been arrested three times, I am violent at home and break up the house. When I am over one of the bouts and see the damage I have done, I could cry". His usual habit was to abstain at the start of a working week and start drinking on Wednesday. Most weekends would be spent in one of the terrible bouts described above.

Findings:

42 of the patients were classified as Inability-to-abstain addicts and an identical number were regarded as Loss-of-control addicts. 16 were placed in the intermediate categories. There was a significant tendency for the Inability-to-abstain addicts to be admitted to the unit (Table 1)

TABLE 1

The patterns of addiction of in-patient and out-patient sample compared

	<u>Admitted</u>	<u>Not Admitted</u>	<u>Total</u>
Predominantly Inability-to-abstain.	32	17	49
Predominantly Loss-of-Control.	18	33	51
TOTAL:	50	50	100

$$\chi^2 = 8.74 \quad 1 \text{ d.f.}$$

$$p < .01$$

Table 2 shows that pattern of addiction is not an important prognostic factor for in-patients, but that the Inability-to-abstain addicts who were not admitted have a very poor prognosis.

TABLE 2

The relation between pattern of addiction and treatment response

Drinking status at six months

<u>Pattern of addiction</u>	<u>In-Patients</u>							<u>Out-Patients</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Inability-to-abstain (1)	10	4	1	-	8	7	-	30	1	-	-	1	3	6	1	12
More (1) than (2)	-	1	-	-	-	1	-	2	1	-	-	-	2	2	-	5
More (2) than (1)	-	1	-	-	-	-	-	1	1	-	1	-	2	4	-	8
Loss of control (2)	4	3	2	-	3	5	-	17	8	4	4	-	4	5	-	25
TOTAL	14	9	3	-	11	13	-	50	11	4	5	1	11	17	1	50

Kendall's Tau = 0.0618 Kendall's Tau = -0.3666

Unit normal deviate = 0.49087 Unit normal deviate = -3.05388

N.S.

p < .01

Discussion:

The prevalence of inability-to-abstain addicts amongst patients referred to this Clinic was noted in an earlier study ⁽²⁾. At that time it was suggested that the surprisingly large number observed with this pattern of addiction might contribute to the excessive incidence of alcoholism in Scotland as reports ⁽³⁾ from England do not emphasise this form of alcoholism. Further study in other centres is required.

The importance of this large number of inability-to-abstain addicts is further emphasised by their relatively poor prognosis. In this study referred to above ⁽²⁾ the loss-of-control addicts were observed to have a more favourable prognosis and similar findings were reported by Davies et al (1956) ⁽⁴⁾. The present study shows that the inability-to-abstain addict fares much better when he is admitted to hospital.

It may be argued that the loss-of-control drinker will have gaps between his drinking bouts and the follow-up studies will favour those who may be abstinent for lengthy periods. Very few of the loss-of-control addicts in this series had in the past experienced periods of abstinence approaching the six months which elapsed before their first revue. The change in drinking habit amongst the loss-of-control addicts was just as dramatic as that observed in the inveterate drinkers. It seems likely that the loss-of-control addicts capacity for abstaining makes it easier for him to take part in out-patient treatment

and continuing psychotherapy can assist him in avoiding a further bout. The inveterate drinker may find the first step of achieving abstinence too difficult if he is not hospitalised.

Conscience structure:

(2)
In a preliminary study the staff at this Clinic observed that those patients who were excessively self-critical appeared to have an unfavourable prognosis. Similar criteria were again employed in assessing the conscience structure of this sample and the hypothesis that very self-critical patients would show a poor treatment response was again tested.

It is difficult to assess such a global concept as conscience structure and yet it is something which we all recognise in patients and is clearly of importance in determining their reactions. The following categories were devised.

'Self-critical' - Here the patient has an hypertrophied conscience that belittles the patients achievements and magnifies his shortcomings. Instinctive behaviour is viewed as alien to the person. The patient may require to drink to enjoy himself and then drink once more to placate his conscience.

'Hedonistic' - Here the patient is conspicuously lacking in 'super-ego' controls. The patient does not perceive shortcomings in himself nor does he feel responsible for the damage he causes others.

Most patients could be placed in one or other of these categories. When this was not possible they were assigned to

intermediate categories - more hedonistic than self-critical or more self-critical than hedonistic.

The following examples may help to clarify the concept.

Self-critical personality - example 1

A 37 year old unmarried foreman on a building site. He lived with his aged father, a retired miner who was strictly teetotal and believed in a high standard of behaviour for his children. The patient's mother had died 10 years previously. He was fifth in a family of six. His relationship with his mother was crucial in the development of his personality. She was an alcoholic who was openly promiscuous when drunk. The patient recalled his first drink as being at his mother's suggestion. She wanted him to stay at home with her rather than go out with his friends. He went and obtained drink for them both and they got drunk. When drunk his mother insisted that they have intercourse. This pattern was repeated many times when the patient was sixteen.

Since then he had failed to establish any satisfactory relationships with women. He had occasional transitory sexual affairs but had to be drunk to engage in them. Afterwards he would feel very guilty and drink even more heavily to forget about it. The patient believed that his father was unaware of the incestuous relationship. He felt that he had to make reparation to his father for what he had done and gave this as his reason for staying at home after the other children had left. The patient regarded himself as intrinsically sinful and could not enjoy himself without alcohol. When he relapsed shortly after discharge from the unit, he described himself as feeling miserable and lonely. He saw the other men going into a pub and wished that he could be like them.

Self-critical personality - example 2

A 54 year old alcoholic was referred to the clinic. His mother had died shortly after his birth and he was brought up by a housekeeper, and from the age of eleven, by a stepmother. His upbringing had been strict, his father set high standards for his son. He left school at seventeen and joined a Bank and eventually became a bank manager. His meticulousness and obsessionality was much respected by his work associates. He was religious and indeed a "kirk elder". Throughout the time that his social status improved he was drinking increasingly steadily. He found it difficult to afford such excessive

drinking and 'borrowed' money from the Bank. He was subsequently discharged from their service, and eventually obtained a job as a clerk. The drinking persisted and eventually his wife left him although the couple characteristically pretended that she had not left on account of his drinking but simply as a matter of convenience in view of her job as a hostel warden.

At initial interview it was clear that there was a conflict between his ideal self - the strict puritan with a good sense of public duty and the double dealing drunkard who would be dishonest with money. He found it impossible to live up to his idealised self and overcome by this failure he would drink to take himself off the hook of his own conscience

Throughout his treatment, first as an in-patient and then in a closed out-patient group, he endeavoured to maintain a facade of moral righteousness upbraiding the other patients for their shortcomings.

Hedonistic personality - example 1

A business man aged 53 was admitted to the unit having been treated in a general hospital for delirium tremens. Although he had been extremely ill he made a rapid recovery and began to retract earlier agreement that he was alcoholic.

On discharge he attended his out-patient group regularly at first but only occasionally when he relapsed. He appeared quite unwilling to view alcoholism as an illness and was apparently unconcerned that his home life and business were both suffering. He stated "How do you expect me not to drink at the merchants dinners, I wouldn't enjoy them at all. I have always had a drink with my friends after a game of golf and I have no intention of giving up that". This concern with immediate gratification pervaded his activities and he was unwilling to examine aspects of his life which were unflattering. The news that his business was failing was greeted by "That's the Government - doesn't give us a chance."

Hedonistic personality - example 2

A middle aged bookseller was admitted to the unit. He had been a patient attending the hospital intermittently for ten years with anxiety symptoms. His wife suffered from Disseminated Sclerosis and was also an alcoholic. He also had a mistress, stating that he had to have someone who could look after him as his wife was "no use". His approach to treatment was that doctors would endlessly provide him with support and sympathy. He did not feel that the group members should criticise him stating,

"surely you don't want to deprive me of everything" when it was suggested that changes in his way of life might be necessary.

Findings:

Table 3 shows that 37 patients were regarded as markedly self-critical: this group does not differ in outcome from the other categories. When the categorisation of conscience structure and outcome variables are modified to make them identical to those employed by Walton et al (1966)⁽²⁾ it is clear that the relationship between degree of punitiveness and outcome observed on that occasion is not supported by the present findings. (Table 4).

Psychiatric diagnosis:

The following view expressed by Thomas French⁽⁵⁾ suggests that behind the presenting psychiatric symptoms is concealed more extensive and deeply rooted disturbance. "An individual's current behaviour can be understood as the expression of individual solutions to currently experienced focal conflicts. These 'focal conflicts' are rooted in long standing nuclear conflicts developed early in life."

While much of the disorganisation apparent in alcoholics may be attributed to the effects of their addiction it is always possible during the psychiatric interview to gain a picture of the kind of person who drank so heavily that he became addicted. Evidence for this derives from the pattern of his life, the quality and endurance of his relationships and

TABLE 3

Relation between conscience structure and treatment response

Drinking status at six months

	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Hedonistic 1	4	-	1	-	3	3	-	11	3	2	3	-	2	5	1	16
More 1 than 2	1	-	-	-	5	2	-	8	2	1	-	1	2	5	-	11
More 2 than 1	4	3	1	-	-	3	-	11	2	-	-	-	1	3	-	6
Self critical 2	5	6	1	-	3	5	-	20	4	1	2	-	6	4	-	17
Total	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = -0.0700

Kendall's Tau = -0.0548

Unit normal deviate = -0.58847

Unit normal deviate = -0.46171

N.S.

N.S.

TABLE 4

Relation between conscience structure and outcome after six months.

	Impunitive		Moderately self-punitive		Grossly self-punitive	
	A	B	A	B	A	B
Abstinent	12	7	12	9	0	9
Relapsing but asbstantent.	5	6	12	6	4	10
Drinking	8	14	15	21	11	18

(2)

A. Findings of Walton et al (1966)

B. Present study.

and from his own subjective experiences as recounted at interview.

The following categories were employed:

Psychoneurosis: for inclusion within this category the patient required to give evidence of anxiety neurosis, obsessional state, hysteria or depression.

Personality disorder: patients with neurosis as described above were excluded from this category. Here were included patients in whom the psychic distress evident in the neurosis was slight and yet the patient's response to situations was clearly maladaptive. It may be argued that all alcoholics are in a sense behaving in a maladaptive way by attempting to solve conflicts by drinking. Patients with personality disorder show a failure in relationships which can not be ascribed solely to alcohol. The degree of disturbance was rated as:

Mild when in most respects the patient had made a successful adaptation to life. For instance had a constant work record and a satisfactory marriage. There should be some evidence of an ability to form lasting relationships with other people. Patients in this category would experience difficulties in certain areas of their life experience. For instance an inability to cope with certain situations such as dependency or hostility. The patient himself in most cases would not be aware of this incapacity but evidence for it would emerge from the anamnesis.

Moderate - Here the disorder would be seen to have had a more marked effect on the patient's effectiveness. To be placed in this category the patient should show evidence of an inability to manage at least one area of his life experience, e.g., his work, sexual life or his capacity to form lasting relationships.

Severe - This category encompasses the markedly inadequate or sociopathic personalities. Such patients from adolescence have not shown any evidence of being able to form lasting relationships or of coping with marital life or an occupation. This does not imply that such patients had not experienced periods of successful adaptation. What characterised this group was that such periods were short lived and early promise gave rise to inexplicable failure.

Psychotic illness - This included cases of schizophrenia and psychotic depression.

Chronic Brain Syndrome - This comprised those patients in whom there was clear evidence of impaired mental function.

Note: The last two categories were combined under the heading 'psychosis'. In fact no cases of chronic brain syndrome were found in this sample, but see Appendix 1 where one patient who was suffering from organic brain damage is described.

Findings:

The distribution of the sample by psychiatric diagnosis is shown in Table 5. More than half 28 (56%) of the in-patients

had been categorised as suffering from moderate personality disorder. This diagnosis was applied to 13 (26%) of those treated as out-patients and a larger number of this group were severe personality disorders 17 (34%). It is this latter number that appeared to show a particularly unpromising treatment response.

In the in-patient group psychiatric diagnosis does not appear as a useful prognostic indicator except for the ten patients who had severe personality disorders - only two of these were abstinent at the time of follow-up. It is interesting that both psychotic patients had an excellent prognosis. One had a primary diagnosis of schizophrenia and the other was suffering from a psychotic depression.

Amongst those who were treated as out-patients the distinction between those diagnosed as psychoneurotic or as having mild personality disorder and those who were more severely ill is more clearly of prognostic value. Ten of the eleven out-patients who abstained throughout the first six months of treatment had been placed in one or other of the first two categories. These patients with mild disorders of personality or those who have been drinking in response to a neurosis appear to respond well to out-patient treatment.

In examining this sub-group more closely it is apparent that many of these patients not only had more internal psychological advantages with which to cope with their illness, but also

TABLE 5

The relation between psychiatric diagnosis and treatment response

Psychiatric Diagnosis:	<u>Drinking status at six months</u>															
	<u>In-Patients</u>							<u>Out-Patients</u>								
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Psychoneurosis	2	1	-	-	4	-	-	7	3	-	1	-	3	3	-	10
Mild personality disorder.	1	1	-	-	1	-	-	3	7	0	1	-	1	1	-	10
Moderate personality disorder	8	6	3	-	5	6	-	28	1	1	3	1	2	5	-	13
Severe personality disorder	1	1	-	-	1	7	-	10	-	3	-	-	5	8	1	17
Psychosis	2	-	-	-	-	-	-	2	-	-	-	-	-	-	-	0
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50
Kendall's Tau = 0.1689		Kendall's Tau = 0.3101														
Unit normal deviate = 1.39882		Unit normal deviate = 2.62796														
N.S.		p < .01														

TABLE 6

Pattern of addiction compared with psychiatric diagnosis

	<u>Psychoneurosis and mild personality disorder.</u>	<u>All other diagnosis</u>	<u>Total</u>
Predominantly inability to abstain addicts:	4	13	17
Predominantly loss of control addicts:	16	17	33
Total	20	30	50

$\chi^2 = 2.61.$

d.f. = 1.

N.S.

the majority came from Social Class 2 which we have seen is itself of favourable prognostic significance. Of the twenty patients in this category, thirteen were in Social Class 2, four in Class 3 and two in Class 4 and one in Class 5.

They did not differ significantly from other out-patients in terms of their pattern of addiction, which has already been shown to be of prognostic significance for the out-patients (Table 6).

The following example may help to define this group of patients who were able to make good use of out-patient treatment.

A middle aged director of a large Engineering Company was referred to the clinic after a bout of drinking. At the time of his attendance he had not had a drink for four days. For the previous ten years he had experienced frequent bouts of uncontrollable drinking commonly precipitated by an argument with his wife.

His childhood he described as a strange mixture of happiness and worry. He said, "I was very small, white faced and timid, always afraid of the other boys". His father was a strict disciplinarian and a great believer in the importance of physical achievements. For this reason the patient was a disappointment to him while his two older brothers were much more athletic.

He married when he was 28 and there had been a great deal of disharmony. His wife was seen as being excessively mother attached and was frigid. They had three sons.

His personality was very obsessional and it appeared that he habitually used obsessional defences as a means of controlling anger which he did not feel able to express. When the tension became unbearable a bout of drinking would ensue. He had an active social life, several friends, a successful career and clearly possessed considerable personality assets.

The patient attended the clinic regularly throughout the year and his wife was seen regularly by the Psychiatric Social Worker. He did not drink again - took his Antabuse with obsessional regularity and was able to use his relationship with the therapist to express his anxiety about his hostility first towards his wife and ultimately towards his father and the therapist.

CHAPTER X

EVALUATION OF TREATMENT RESPONSE

In this Chapter aspects of each patients treatment experience are examined and correlated with the subsequent response to treatment.

On admission all patients were told that they would be in hospital for at least three weeks and that for a number of patients the stay might be considerably longer.

Table 1 shows that the duration of stay in hospital is not related to subsequent treatment response.

Ten patients discharged themselves against the advice of the staff. Table 2 shows that leaving the Unit in this way did not exclude the possibility of a good outcome and half of these patients were abstinent when seen six months later.

Drinking in the Unit occurred with only three patients; all were unimproved six months later.

Antabuse:

All patients in this study were offered Antabuse. Those who agreed to make use of Antabuse were encouraged to attend for an Antabuse/Alcohol reaction (Described in Chapter 2, 2.) The majority (60%) of patients underwent this reaction.

The use made of Antabuse was assessed at the end of the first six months of treatment. This was based on the patient's own evaluation of the regularity with which he had taken Antabuse and on the basis of these estimates their replies were placed in one of the following four categories.

TABLE 1

Relation between duration of in-patient stay and treatment response

Drinking status at six months(In-Patients only)

Length of stay	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Less than 2 weeks	-	-	1	-	-	1	-	2
2 - 4 weeks	5	4	1	-	6	1	-	17
5 - 6 weeks	4	5	1	-	2	6	-	18
7 - 10 weeks	4	-	-	-	2	5	-	11
11 - weeks	1	-	-	-	1	-	-	2
	14	9	3	0	11	13	0	50

Kendall's Tau = 0.0631
Unit normal deviate = 0.52726

N.S.

TABLE 2

Relation between discharge category and treatment response

Drinking status at six months(In-Patients only)

	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Discharged self against advice	3	1	1	-	1	4	-	10
Discharged with staff agreement	11	8	2	-	10	9	-	40
	14	9	3	0	11	13	0	50

Kendall's Tau = 0.0629
Unit normal deviate = 0.48673

N.S.

TABLE 3

Relation between usage of Antabuse and treatment response

Drinking status at six months

	<u>In-Patient's</u>							<u>Out-Patient's</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Relies on Antabuse	6	1	-	-	-	-	-	7	4	1	1	-	1	-	-	7
Takes Antabuse intermittently	1	6	1	-	1	-	-	9	1	1	-	1	1	-	-	4
Took Antabuse initially	5	2	-	-	10	8	-	25	-	1	-	-	1	6	-	8
Did not take Antabuse	2	-	2	-	-	5	-	9	6	1	4	-	8	11	1	31
Total:	14	9	3	0	11	13	-	50	11	4	5	1	11	17	1	50

Kendall's Tau = 0.4505

Kendall's Tau = 0.2209

Unit normal deviate

= 3.75343 Unit normal deviate = 1.81654

p < .01

N.S.

1. Those who relied on Antabuse and had used it consistently throughout the six months.
2. Those who used Antabuse intermittently at times of stress.
3. Those who had found Antabuse of moderate value and had taken it regularly at first and then given it up completely.
4. Those who never took Antabuse.

While the reliability of a rating scale based solely on the patient's own reporting is questionable, it does seem that the reliance placed on Antabuse is a significant index of treatment response. Table 3 shows a significant relationship between Antabuse usage and treatment response amongst in-patients. This supports the clinical impression that patients who confidently abandon Antabuse early in treatment often do so as a prelude to relapse.

Physical Health:

In assessing each patients progress consideration was first given to the degree of improvement in his physical health. On admission the patient was allotted a position in the scale shown below and rated once more on this scale at the time of discharge. The difference between these two scores gives an estimate of degree of physical improvement. Thus patients with a high score were both iller than others and had received more prolonged physical attention.

Physical Health Rating:

Very poor: - sufficiently debilitated to warrant spending more than four days in bed or so ill as to require transfer to general hospital. (e.g., 1. a man suffering from chronic alcoholism was discovered to have lobar pneumonia. 2. a man who developed hepatic coma and had to be transferred to a general hospital).

Poor: - a patient whose physical state requires treatment beyond that routinely given for more than his first week in hospital (e.g., cardiac failure, peripheral neuropathy).

Fair: - any evidence of physical ill health on clinical examination or stated by routine laboratory investigations. (Excluded from this category are those patients in whom there is long-standing physical debility which is not susceptible to treatment, e.g., old poliomyelitis).

The majority of patients (N = 38) needed no more than routine detoxification. Six were rated as in fair health on admission. Two were in the category poor and four were regarded as being in very poor health. (2 Hepatic failure, 1 Jaundice, 1 Pneumonia). Two of these four required admission to general hospital.

It might have been expected that those who required physical attention and who had experienced personally the danger alcohol presented to their health would have a better prognosis but Table 4 shows that this expectation was not fulfilled.

TABLE 4

The relation between physical health on admission and treatment response

<u>Physical Health:</u>	<u>Drinking status at six months</u>							<u>Total</u>
	<u>In-Patients</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	
Good (no more than routine care)	9	8	2	-	8	11	-	38
Fair (extra investigations and treatment)	2	-	-	-	3	1	-	6
Poor	1	-	1	-	-	-	-	2
Very Poor	2	1	-	-	-	1	-	4
Total:	14	9	3	0	11	13	0	50

Kendall's Tau = -0.1327

Unit normal deviate = -1.06386

N.S.

At the close of each patients treatment in hospital a 'discharge conference' amongst the staff assessed the patients understanding of four problem areas:

A. "Understanding of the disease concept of Alcoholism"

1. Knowledge that he must not drink again.
2. Knowledge that one drink will cause his illness to start again.
3. Acceptance that personal conflicts underly pathological drinking.
4. Views alcoholism as an illness not as moral weakness.

The patient would score one for a positive response to each of these questions.

Findings: Table 5 shows that the majority (N = 23) had a good understanding of alcoholism but rating on this scale was not related to treatment response at follow-up.

B. "Understanding of techniques to avoid drinking"

An attempt was made to establish the extent to which the patient had anticipated future stresses that might cause him to drink and the means he had developed to cope with them.

Each patient scored one point for an appreciation of the following problems and of a plan for coping with them.

1. 'Understand that he must avoid all drink'- The patients capacity to deal with situations in which he would normally be expected to drink. For example,

an hotelier noted for his hospitality to customers planned to have a non-alcoholic drink at hand when customers encouraged him to 'have one with him'. If the difficulties became too great he would leave the bar to an assistant. This detailed plan of action contrasts with those who say it will be no problem and are not able to visualise their actions in a threatening situation.

2. 'Understands about Antabuse' - The patient was questioned on the way he planned to use Antabuse. If he was clear that his intention was to make a daily habit of taking it then one point was scored. As these opinions were expressed at a discharge conference we expected the patient to indicate that he was going to take Antabuse regularly, e.g., I shall take it every night when I go to bed, the bottle will be beside my bed. Vague replies such as "I will use them when I feel the need" were not accepted.
3. 'Recognises problems that he has resolved in the past by drinking' - In almost all cases it was possible to elicit areas of conflict in the patient's interpersonal relationships which aggravated his drinking and had on occasion precipitated a bout. Patients who had become aware of this tendency and were alive to further hazards in this relationship scored one point.

For example, a patient recognised that rather than argue with his wife he would go out and drink in his local pub. While in the unit both

partners had come to realise that a marriage in which there was no overt disagreement was not realistic and the patient now hoped to be able to be more frank about difference in the future.

4. 'Has decided on measures he could take instead to correct such stressful situations - This category encompassed those who detected in the manner outlined focal conflicts in their lives which had precipitated drinking and had decided on less maladaptive solutions which they would try out in the future. For example:

A woman drank excessively during the time that her aged and domineering mother was in the house. She would criticise her mother to her daughter in secret and then attack her daughter later for being so unpleasant to her grandmother. While in the unit she gained an understanding of the way in which her anger with her mother was being displaced to her daughter and of the unrealistic extent to which she allowed her own mother to dominate the house. She was also able to involve her husband in helping her reassert her position in the household which she had willingly relinquished when drinking. It was now her plan not to acquiesce to all her mother's demands and to discuss her difficulties more openly with the family. Putting this solution into practice proved more difficult than anticipated and continued support from her out-patient group was required before she could re-establish her position in the home.

Findings: Table 6 shows that a patient's rating on this scale was of no prognostic value.

C. "Resolution of conflicts"

This concept concerned a more detailed evaluation of each patient's acceptance and awareness of his psychological difficulties and motives.

1. 'Accepted it as important to resolve conflicts' - This category includes those who are able to acknowledge the existence of psychological problems in their lives.

Thus some patients insist throughout treatment that they just drank heavily and will have to employ more self-control in the future and that no anxieties have played any part in their drinking. Patients who agreed that some of their problems had aggravated their drinking and that it would be easier if they could deal with them some other way scored 1.

2. 'Identified current problems' - This implies a more specific awareness of the general concept outlined in (1). Here the patient not only agrees in general with the notion that anxieties have been relevant to his drinking but is able to specify these, e.g. some patients are very clear that without alcohol they are unable to enjoy sexual relations.
3. 'Discussed difficulties with other people concerned in his (her) conflict' - This very important step of not only being aware of difficulties but of testing out their reality by discussing them.

A patient whose brother was a heavy drinker was bitterly annoyed that he should upbraid him when he tried to abstain. He had felt himself in competition with his more successful sib all along and he felt that drinking was an area in which he had previously excelled. He had never spoken of these intense feelings to the brother and was much relieved when he was able to do this.

4. 'Taking some steps to resolve conflict' - To make observable changes in one's habitual behaviour patterns.

For example:

A woman insisted that her husband took no interest in her and that he encouraged her to drink. The in-patient group pointed out that he visited very regularly and was very attentive. It became clear that her hostility towards her husband was largely a remnant of her attachment to and intense emotional involvement with her father. The couple were able to talk more freely about their feelings for each other. In their case it was difficult to display feelings of affection and it was necessary for them to discard their fighting relationship.

Findings: Table 7 shows that 17 patients received a maximum score for development of techniques. There was a significant trend for those with higher ratings to have a favourable prognosis.

D. "Environmental factors"

At first most alcoholics are reluctant to discuss their illness with those around them. In this part of the questionnaire the extent to which he had made known his alcoholism is rated.

1. 'Discussed drinking problem with spouse (or equivalent)'

Thus a husband who felt guilty about his drinking bouts and yet had never discussed the compulsion prompting him to drink would be expected to talk to his wife about his addiction.

2. 'Discussed this with a circle of friends who know he

is alcoholic' - Many alcoholics have a circle of drinking companions. A patient who discussed his addiction with a number of friends scored one.

TABLE 7

Relation between the understanding of techniques to avoid drinking and treatment response

Understanding of techniques to avoid drinking.	<u>Drinking status at six months(In-Patients only)</u>							Total
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	
<u>Score</u>								
0	-	-	-	-	-	-	-	0
1	-	-	-	-	1	1	-	2
2	1	2	2	-	4	4	-	13
3	6	3	-	-	2	7	-	18
4	7	4	1	-	4	1	-	17
Total:	14	9	3	0	11	13	-	50

Kendall's Tau = -0.3007

Unit normal deviate = -2.49149

p < .05

TABLE 8

Relation between effecting environmental change and treatment response

Environmental Changes.	<u>Drinking status at six months(In-Patients only)</u>							Total
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	
<u>Score</u>								
0	-	-	-	-	2	2	-	4
1	1	1	-	-	1	5	-	8
2	4	3	1	-	4	1	-	13
3	6	2	1	-	2	3	-	14
4	3	3	1	-	2	2	-	11
Total:	14	9	3	0	11	13	0	50

Kendall's Tau = -0.2437

Unit normal deviate = -2.08780

p < 0.5

3. 'Employers aware of illness' - In most cases patients were encouraged to let their employers know of their alcoholism.
4. 'Employers aware of illness and accepting him to secure job' - In some cases it was possible for the patient to enlist his employers support in helping him with the addiction. Thus a journalist who discussed his alcoholism with his Editor was able to turn to him for further assistance during a transient lapse.

Findings: Table 8 shows a significant trend favouring the prognosis of patients who score highly on the environmental change scale.

At the end of the discharge conference the staff rated the patients prognosis in terms of his capacity to remain abstinent. The relationship between predicted and actual outcome is shown in Table 9. Table 9 shows that staff predictions of prognosis were significantly related to outcome.

TABLE 9

The relation between prognosis and treatment response

Drinking status at six months(In-Patients only)

Prognosis	1	2	3	4	5	6	7	Total
Poor	1	2	0	-	6	7	-	16
Doubtful	6	3	2	-	3	2	-	16
Promising	4	2	-	-	2	3	-	11
Excellent	3	2	1	-	-	1	-	7
TOTAL:	14	9	3	-	11	13	-	50

Kendall's Tau = -0.3048

Unit normal deviate = -2.56549

p < .01

Out-Patient Attendance Record:

The majority (N = 41) of in-patients were assigned to out-patient groups, and in most cases the patient would be assigned before he left hospital. Amongst out-patients only 4 were assigned to such groups. The relationship between number of attendances at a group and treatment response is very highly significant. (Table 10)

Those patients who were treated entirely as out-patients were encouraged to attend regularly for individual interviews. 9 of the patients attended once only, whereas 16 attended more than five times. Table 11 indicates that those who became involved in treatment as reflected in continued attendance made significantly better progress during six months.

TABLE 10

The relation between attendance at out-patient group and treatment response

Drinking status at six months

Out-Patient Group attendance	<u>In-Patients</u>								<u>Out-Patients</u>							
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Did not attend	1	-	-	-	1	1	-	3	-	-	-	-	-	-	-	0
Attended once	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-	0
Attended 2 - 5	-	-	-	-	1	1	-	2	-	-	-	-	-	1	-	1
Attended 6 - 10	-	-	-	-	1	3	-	4	-	-	-	-	-	-	-	0
Attended 11 - 15	1	2	-	-	3	3	-	9	1	-	-	-	-	-	-	1
Attended 16 - 20	2	1	3	-	3	2	-	11	1	-	-	-	-	-	-	1
Attended 21 - 25	6	3	-	-	-	-	-	9	-	-	-	-	-	-	-	0
Attended 26 +	2	-	-	-	1	-	-	3	-	-	-	-	-	-	-	0
Total:	12	6	3	0	10	10	-	41	2	0	0	0	1	0	0	3

Kendall's Tau = -0.4964

Unit normal deviate = -3.90289

p < .001

TABLE 11

The relation between out-patient attendance and treatment response

Drinking status at six months (Out-Patients only)

Out-Patient attendance.	1	2	3	4	5	6	7	Total
One only	1	-	2	-	2	3	1	9
2 - 4	1	1	3	-	5	11	-	21
5 and more	6	3	-	1	4	2	-	16
Total:	9	4	4	1	11	16	1	46

Kendall's Tau = -0.3121

Unit normal deviate = -2.44418

p < .05

Discussion:

Detecting and defining the elements of therapy which are therapeutic constitutes a significant and unresolved problem in psychiatry and this problem is perhaps most marked within the complexities of a therapeutic community^(1,2,3,). The number of variables involved is immense and only a few can be singled out while the remainder must pass uncontrolled and often unnoticed. More detailed analysis of the relationship between what takes place in the therapeutic community and subsequent therapeutic change is necessary.

In this Chapter a selected number of variables have been examined, some are much more reliable than others and have been chosen because they are susceptible to objective measurement while the others are phenomenological, based on the observed and repeated experience of the patient. In the former category are measures of duration of stay in hospital, and number of attendances as out-patients.

Duration of stay in hospital did not emerge as a useful guide to treatment response. This is not surprising as duration of stay is no measure of intensity of involvement during the time in the ward. All of the staff were familiar with patients who used the unit as a retreat from their problems and anxieties and were content as long as they could turn their face away from the outside world. It is interesting that many patients who left the unit prematurely coped well with their alcoholism. This reminds the clinician that the patient often knows what is best

for himself and it may also indicate that an act of rebellion of this kind may be an important prelude to new patterns of behaviour, particularly amongst patients who have hitherto proved extremely passive and afraid of overt expression of hostility.

Frequency of out-patient attendance as expected, is closely associated with abstinence. Once patients lapse they tend to remain away from treatment and services could possibly benefit patients by being more active in encouraging the newly lapsed alcoholic to return to the unit where he was being treated. The observation that those out-patients with more than five attendances represent those who are involved in treatment and have a good prognosis fully supports the observation of Chafetz (4) in a similar study.

Turning to the more subjective elements in the assessment of each patient's treatment experience the use made of Antabuse has proved a valuable indication of prognosis amongst the in-patient sample. This probably reflects the patients enthusiasm for treatment and his desire to co-operate with the doctor. Clearly those patients who do relapse will of necessity have stopped taking their Antabuse. Although all patients were told that they should contact the unit if they had stopped taking their Antabuse and were about to drink very few availed themselves of this gap, and contact, if re-established, usually occurred during or after the relapse. It appears that Antabuse usage was less significant in prognosis amongst out-patients.

This suggested that out-patients who attended less often and had little opportunity of discussing the use of Antabuse with other patients were reporting their use of the drug less accurately and were not so co-operative in taking it.

Of the reported attitudes and changes made by the patient during his in-patient stay, it appeared that an understanding of techniques to avoid drinking, and involvement of others in his drinking problem, were important prognostic factors. It is likely that resolution of conflicts and understanding of alcoholism were insufficiently specific and perhaps too generally applicable to all patients to be of much selective value. It appears that evidence of a capacity for anticipating future situations and seeking realistic solutions is a good prognostic sign. This realistic anxiety about future difficulties with alcohol is more mature than a sweeping statement that "I will never touch it again" or "I shall just say no thank you - it will be no problem". A patient who is reluctant to discuss his alcoholism with friends and relatives and who refuses to disclose the diagnosis to his boss has a poor prognosis. It may be that his desire to conceal his addiction from others represents an extension of his own denial of the illness. Contrary to patients' initial expectations friends, relatives and even employers are sympathetic and understanding towards the alcoholic when his illness is revealed, and patients who have done so gain added support from these sources. The ability to discuss his drinking problem with others also reflects the patients' domestic and social

security, both factors which it has been shown are associated with favourable prognosis.

No attempt has been made to evaluate the criteria on which the staff based their prognosis given to each patient at the discharge conference. The findings show that the staff prognosis and actual out-come are significantly related. It is probable that the prognosis was based on observations made by all staff during the patient's stay and also on reports and opinions passed by staff members whose judgement ^were highly regarded. It may also be that the prognosis itself which reflected on staff attitude would contribute to treatment response. The relationship observed here simply reinforces the importance of examining the way in which staff arrive at decisions and the influence of such decisions on subsequent events. This itself should form the basis of further study.

CHAPTER XI

THE INFLUENCE OF THE SPOUSE ON TREATMENT RESPONSE

Being married and more particularly having a good marital relationship has frequently been cited as a valuable prognostic indicator amongst alcoholics ^(1,2,3,4,). The civil state of patients in this sample has already been discussed in an earlier chapter. In this section the quality of the marital relationship and its relations to treatment is discussed.

Amongst in-patients those who had at any time been married had a more favourable treatment response than those who were single. No such trend was observed amongst out-patients (Table 1).

The method of assessing the quality of marital relationships used a technique devised by McCullech ⁽⁵⁾. The following definitions were employed:

Excellent - a relationship where both partners describe the marriage as good and there is no history of hostility, violence or separation.

Good - where there is a satisfying marriage despite friction and there is no violence or periods of separation.

Fair - a marriage in which there are frequent differences of opinion interspersed with periods of tranquility with no apparent desire for the marriage to come to an end.

Poor - is a marriage with much disharmony between the partners and with regret at the union. However, the couple are not prepared to do anything about this. Frequent hostility is an essential component of this category.

TABLE 1

Relation between marital status and treatment response

Drinking status at six months

	<u>In-Patients</u>							<u>Out-Patients</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Married	12	9	2	-	8	6	-	37	10	1	4	1	8	13	1	38
Married more than once	1	-	1	-	1	2	-	5	1	-	-	-	3	-	-	4
Single	1	-	-	-	2	5	-	8	-	3	1	-	-	4	-	8
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = 0.3363

Kendall's Tau = 0.0219

Unit normal deviate = 2.68919 Unit normal deviate = 0.17438

p < .01

N.S.

TABLE 2

Relation between state of marriage and treatment response

Drinking status at six months

State of marriage	<u>In-Patients</u>							<u>Out-Patients</u>								
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>Total</u>
Excellent	2	1	1	-	-	2	-	6	1	-	-	-	1	2	-	4
Good	2	1	-	-	2	-	-	5	5	-	3	-	2	-	-	10
Fair	3	1	1	-	1	-	-	6	2	-	1	-	-	5	-	8
Poor	3	2	-	-	3	1	-	9	1	-	-	-	4	-	-	5
Bad	2	3	1	-	2	3	-	11	-	-	-	-	2	3	1	6
Total:	12	8	3	0	8	6	0	37	9	0	4	0	9	10	1	33

Kendall's Tau = 0.1197

Kendall's Tau = 0.34364

Unit normal deviate = 0.87621 Unit normal deviate = 2.10960

N.S.

p < .05

Bad - is a marriage where there is constant hostility and violence with frequent separations or a marriage where one or both partners wishes it to end.

Clearly alcoholism is a disease which would test the resources of the most stable home. The quality of each patient's marital relationship was assessed if possible on the consensus of views expressed by both partners. When, as was often the case, they differed widely in their concepts of marital harmony the more pessimistic opinion was accepted. Isolated episodes of disruption due to drinking were not taken into consideration. Only those patients with extant marriages were included in this assessment.

Findings: Table 2 shows that 25 (36%) of the marriages were regarded as excellent or good. A clear relationship between good marital relations and favourable treatment response is demonstrated for out-patients but not for in-patients.

Seven patients had spouses who were alcoholics although three of these were no longer living together at the time of referral. In none of these cases was it possible to involve both partners in treatment. The following illustration demonstrates the effect an alcoholic spouse can have on her partner's treatment.

A middle aged alcoholic who had experienced a grossly deprived childhood married at the age of forty, a woman who was recovering from the death of her father, himself an alcoholic whom she had nursed for many years. She was known to be a heavy drinker at that time. He said, "I thought we had both had an unhappy life, and that we might be able to make up for it if we married."

The patient made excellent progress after a stay in hospital and attended his out-patient group regularly for nine months. At this point he started drinking although it was a very brief lapse, lasting only one week. He explained that his wife had been objecting to his attendance at the hospital. She felt that her husband did not have a mind of his own if he needed to run off to his group each week. She was drinking very heavily and experiencing severe withdrawal symptoms while refusing to have any medical treatment. She would not see the Psychiatric Social Worker whom she had reluctantly talked to once in the past. When her husband came to his group she would drink excessively so that on his return home she would be lying on the floor very drunk and saying "you don't care what happens to me you are more concerned about that group". On another occasion she telephoned the unit and shouted "don't take him away from me!"

The Psychiatric Social Worker (P.S.W.) interviewed the patient's spouse or nearest relative whenever this was possible. Such an interview took place in 80% of cases amongst in-patients and in 20% of out-patients. There was a tendency when the spouse was assigned to casework for the patient to have a good prognosis but the figure is not significant (Table 3).

At the first interview the P.S.W. clarified the attitude towards alcoholism of the person who was in closest contact with the patient. She rated this understanding of alcoholism on the following three point scale which was empirically devised: good, fair and poor understanding of alcoholism.

Responses that caused the Psychiatric Social Worker to place a client in the category of possessing a "good understanding" of alcoholism" would be for example:

"I realise that he can't stop drinking and that it has become a disease with him".

"I can see that one drink leads to another, it is like a drug for him."

"We realise that it is a disease and want to help".

Those which indicated a "fair understanding" were:

"He can't handle his drink like he used to, I don't know what has got into him".

"I realise he doesn't want to drink but something seems to drive him on".

Those rated as "Poor understanding" were

"I keep telling him that he should be like other men and drink in moderation. He doesn't seem to know when to stop".

"He has no consideration for others, we have all told him to cut down his drinking but he just doesn't care about his family".

The distinction seems to be between those spouses who regard their husbands as being ill, those who realise that something out of the ordinary has happened to his drinking habits and those who view his behaviour as a conscious decision to disregard his obligation to his wife and family.

The table (4) indicates that the majority of spouses were sympathetic towards their partner's illness and realised that his drinking habits were not the result of lack of concern or weak-will. Very few had a grasp of the disease concept of alcoholism at the first interview. There is no relationship between this variable and treatment response. The figures given are for inpatients only as those for out-patients were too small (N = 9) for analysis.

TABLE 3

Relation between assignment to casework of spouse and treatment response

	<u>Drinking status at six months</u>															
	<u>In-Patients</u>							<u>Out-Patients</u>								
	1	2	3	4	5	6	7	Total	1	2	3	4	5	6	7	Total
Spouse or equivalent interviewed and assigned to casework	10	2	2	-	4	5	-	23	2	-	-	-	2	1	-	5
Interviewed only	2	2	1	-	6	6	-	17	1	-	2	-	1	-	-	4
Not seen	2	5	-	-	1	2	-	10	8	4	3	1	8	16	1	41
Total:	14	9	3	0	11	13	0	50	11	4	5	1	11	17	1	50

Kendall's Tau = 0.0997

Kendall's Tau = 0.1839

Unit normal deviate = 0.81296

Unit normal deviate = 1.44589

N.S.

N.S.

At the end of six months of casework the P.S.W. assessed the extent to which the goals which she had defined for those assigned to casework, had been achieved. There is a tendency for those with whom great progress had been made to show a favourable treatment response but the advantage is not statistically significant (Table 5).

TABLE 4

Relation between spouse's understanding of alcoholism and treatment

Spouse possessed:	<u>Drinking status at six months</u>							Total
	<u>In-Patients</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	
Good understanding of alcoholism.	1	2	1	-	-	2	-	6
Fair understanding of alcoholism	8	1	1	-	5	6	-	21
Poor understanding of alcoholism.	3	1	1	-	5	3	-	13
Total:	12	4	3	0	10	11	0	40

Kendall's Tau = 0.0354

Unit normal deviate = 0.25430

N.S.

TABLE 5

Relation between attainment of casework goals and treatment response

Casework goals.	<u>Drinking status at six months</u>							Total
	<u>In-Patients</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	
Totally achieved	1	-	-	-	-	-	-	1
Partially achieved	5	-	1	-	-	1	-	7
Minimally achieved	3	1	1	-	3	4	-	12
Not Achieved	1	1	-	-	1	-	-	3
Total:	10	2	2	0	4	5	0	23

Kendall's Tau = 0.2614

Unit normal deviate = 1.41556

N.S.

the trend is not statistically significant. A closer examination of the techniques used and of the therapeutic gains obtained in casework should form part of a later study. Since the time of this report a spouses' group has been formed in the unit with the aim of exploring difficulties in common experienced by the spouses of alcoholics.

When this study was designed it was anticipated that those wives who had a good understanding of alcoholism would be able to be of greatest help to their alcoholic spouses. The evidence of Table 4 does not support this. An interesting insight into the spouses concept of alcoholism and its effect on the marital relationship has been offered by Pattison et al ⁽⁸⁾. It was suggested that it is easier for the spouse to tolerate anxieties about alcoholism when it is not seen as a disease. When alcoholism is labelled as an illness the spouse experiences guilt at her hostility towards the patient. The aim of skillful casework in this situation would be to recognise and facilitate the expression of such a conflict.

CHAPTER XII

PSYCHOLOGICAL EVALUATION

All patients in this sample were asked to complete a number of psychological tests at the initial interview and again at the time of six month assessment. The relationship between these scores and treatment response is discussed in this chapter.

(1)
Foulds has pointed out that "personality traits, attitudes and types emphasise the continuities in behaviour whereas symptom and sign clusters signal a disruption of continuity arising from the failure of defence dynamisms". Thus a test designed to evaluate evidence of such disruption such as the personal illness scale (see appendix) used in this study, would be a measure of the distress experienced by the patient both at the time of referral and following treatment. It was anticipated that those patients who were improved in terms of their drinking status would also show a reduction in the incidence of personal illness in this sense.

As a measure of the more enduring elements of each patient's personality the General Punitiveness scale was used, this scale was derived by Foulds et al (1960) (2) from the Extra-punitive and Intropunitive scales of the Minnesota Multiphasic Personality Inventory. This scale has been shown to differentiate between personality disorders (comprising psychopaths, neurotics and psychotics) and normal personalities. (1)

Results - Personal Illness

All these patients who were admitted completed the Personal Illness questionnaire (P.I) on the first occasion and 48 completed it on the second occasion. Amongst those receiving out-patient treatment alone 48 completed the P.I. on the first occasion but only 45 would agree to do so on the second occasion.

The mean score for hospitalised alcoholics on the first occasion was 7.74 (SD 3.26). on the second occasion the mean score was 4.83 (SD 3.25). Thus the expected shift involving a reduction in symptoms has occurred during the six months. A similar shift was observed amongst those alcoholics who were not admitted, the mean score for this group on the first occasion was 6.75 (SD 3.83) and after six months the mean score was 4.53 (SD 3.11).

The relationship between score on each occasion and drinking status at six months was computed and the results are shown in Table 1.

TABLE 1

Relation between 'personal illness' score and treatment response

	<u>In-Patients</u>	<u>Out-Patients</u>
P.I occasion 1	Kendall's Tau = 0.0856	Kendall's Tau = 0.1004
Drinking status at 6 months	Unit normal deviate = 0.77305 N.S.	Unit normal deviate = 0.89588 N.S.
P.I occasion 2	Kendall's Tau = 0.1176	Kendall's Tau = 0.2468
Drinking status at 6 months	Unit normal deviate = 1.03524 N.S.	Unit normal deviate = 2.08170 p < .05

The Personal Illness questionnaire does not appear to help in predicting outcome of treatment although there is a trend suggesting that those patients with a relatively low score have a better outcome. After six months those patients who have made good progress appear to have lower scores and it has already been shown that there is a shift in the mean scores of the patients over this time interval.

Results - General Punitiveness

The scores for General Hostility for patients at initial interview in both groups are shown in the histogram (Fig. I). These scores were correlated with each patient's drinking status six months later. There is a tendency for patients with lower scores and particularly scores in the range 10 to 20 to have a better prognosis - 19 of the 26 patients in the hospitalised group who were abstinent six months later had scores in this range.

The strength of the association between the variables was computed and the scores resulting were:

In-Patient Sample Drinking Status at 6 months against General Hostility -

Kendall's Tau = 0.0895

Unit normal deviate = 0.82931

N.S.

Out-Patient Sample Drinking Status at 6 Months against General Hostility -

Kendall's Tau = 0.2981

Unit normal deviate = 2.69846

$p < .01$

Thus for out-patients the relationship shows that those who have high hostility levels have a poor prognosis. The relationship between hostility and prognosis is less clear amongst in-patients although the favourable outcome of those who scored between 10 and 20 has already been observed.

FIGURE 1

Histogram shows general punitiveness scores of patients at initial interview

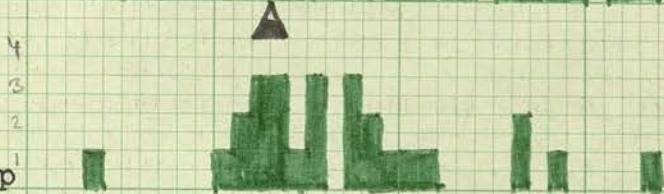
In-patients

Mean = 18.98
(SD = 8.2)

All Patients



Patients Abstinent at Follow-up



Patients Unimproved at Follow-up



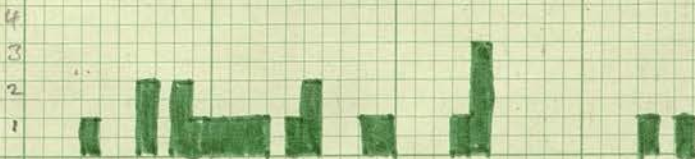
Out-patients

Mean = 20.5
(SD = 9.57)

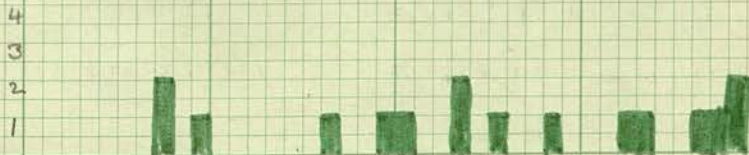
All Patients



Patients Abstinent at Follow-up



Patients Unimproved at Follow-up



▲ Indicates mean of a sample of normal subjects.

It seems that there is a small group of patients with low scores (under 10) who fare badly - only one of 6 patients in the in-patient sample who scored 10 or less was abstinent at follow-up. This may represent patients in whom defence mechanisms are exceptionally active in masking the personality.

The relationship between each patient's score on the sub-divisions of general hostility and treatment response was also examined. The associations are shown in Table 2.

It is clear from this Table that these patients who direct hostility outside themselves have a poor prognosis. This is only true at a significant level for the out-patient group. The inwardly directed components of hostility are less valuable in predicting treatment response.

TABLE 2

Relation between scores on 'general hostility' sub-divisions and treatment response

<u>Sub-Test</u>	<u>In-Patient</u>		<u>Out-Patient</u>	
	<u>Relationship to Drinking status at 6 months.</u>	<u>Relationship to Drinking status at 6 months.</u>	<u>Relationship to Drinking status at 6 months.</u>	<u>Relationship to Drinking status at 6 months.</u>
Acting out Hostility	Kendall's Tau = 0.1649 Unit normal deviate = 1.46745 N.S.	Kendall's Tau = 0.3253 Unit normal deviate = 2.86294 p < .01		
Criticism of Others	Kendall's Tau = 0.1239 Unit normal deviate = 1.10674 N.S.	Kendall's Tau = 0.2744 Unit normal deviate = 2.41432 p < .05		
Delusional Hostility	Kendall's Tau = 0.0857 Unit normal deviate = 0.71177 N.S.	Kendall's Tau = 0.2756 Unit normal deviate = 2.26126 p < .05		
Delusional Guilt	Kendall's Tau = 0.0789 Unit normal deviate = 0.68178 N.S.	Kendall's Tau = 0.1881 Unit normal deviate = 1.60199 N.S.		
Self-Criticism	Kendall's Tau = 0.1159 Unit normal deviate = 1.02999 N.S.	Kendall's Tau = 0.1997 Unit normal deviate = 1.72118 N.S.		

When the patients were asked to complete the hostility battery again six months later 48 of those in the in-patient group co-operated as did 44 of those who were out-patients. As anticipated there had been less change in overall hostility than was observed in personal illness. The mean for the in-patient group was 17.29 (SD 7.38) and for the out-patient group 16.9 (SD 8.47). The relationship to the patient's drinking status at that time was very similar to the relation observed between hostility and prognosis when the test was first administered. Table 3 shows the results of the computation - Hostility score after six months against treatment response after six months.

TABLE 3

Relation between scores on general hostility subdivisions after 6 months and treatment response

	<u>In-Patient</u>	<u>Out-Patient</u>
Sub-Test (second occasion)	<u>Relationship to Drinking status at 6 months.</u>	<u>Relationship to Drinking status at 6 months.</u>
Acting out Hostility	Kendall's Tau = 0.2516 Unit normal deviate = 2.19555 p < .05	Kendall's Tau = 0.2713 Unit normal deviate = 2.25160 p < .05
Criticism of Others	Kendall's Tau = 0.1135 Unit normal deviate = 0.99187 N.S.	Kendall's Tau = 0.3119 Unit normal deviate = 2.60916 p < .01
Delusional Hostility	Kendall's Tau = 0.1485 Unit normal deviate = 1.20561 N.S.	Kendall's Tau = 0.2536 Unit normal deviate = 1.97267 p < .05
Delusional Guilt	Kendall's Tau = 0.0565 Unit normal deviate = 0.49157 N.S.	Kendall's Tau = 0.1341 Unit normal deviate = 1.12034 N.S.
Self- Criticism	Kendall's Tau = 0.2287 Unit normal deviate = 1.93269 N.S.	Kendall's Tau = 0.3229 Unit normal deviate = 2.59008 p < .01

The spouse of each patient was asked to complete the General Punitiveness scale. 33 spouses co-operated. The average scores for general punitiveness and the association between score and prognosis for their alcoholic partner are shown in Table 4.

TABLE 4

Relation between spouses score on general hostility and treatment response

	<u>In-Patients</u>	<u>Out-Patients</u>
Number co-operating	20	13
Average score on General Punitiveness	13.75	13.12
S. D.	5.87	7.9
Relation between score and patient's treatment response	Kendall's Tau=0.0138 Unit normal deviate=0.10323 N.S.	Kendall's Tau = 0.5978 Unit normal deviate=2.57589 p < .01

This suggests that amongst out-patients very 'hostile' spouses are an omen of poor prognosis for their alcoholic partner. Examining this relationship more closely it is apparent that of the six wives who scored more than 17 on general punitiveness all had spouses who were drinking six months later.

Discussion:

The personal illness questionnaire afforded a useful measure of the decline in neurotic symptoms experienced by the alcoholic during treatment. Experiments⁽³⁾ have shown that alcohol taken by the alcoholic increases rather than lowers anxiety so that symptoms of psychological reaction to stress might be anticipated at the time of referral when the patient has been drinking. The presence of such symptoms was not of prognostic value.

The General Punitiveness scores proved of interest not only because of their prognostic significance but also because of the wide range of scores recorded. Although the mean values of both groups 18.98 and 20.5 are close to the values obtained from neurotic populations the standard deviations are large and the figure 1 shows that there is a wide scatter about this mean. This suggests that patients of widely differing psychiatric pathology suffer from alcoholism. This certainly accords with clinical experience.

The observation that patients who scored high in terms of General Punitiveness had a poor prognosis supports the clinical observation that patients who were diagnosed as psychopathic had a poor prognosis. Further confirmation of the usefulness of the test is that of 15 patients who scored 30 or more, 11 had been diagnosed as having severe personality disorders and four as having moderate personality disorders.

From the small number of spouses who co-operated in this study it appeared that those with high hostility scores had partners with relatively poor prognoses. This suggests that the more "psychopathic" spouses find it difficult to adapt to the domestic adjustments brought about by treatment. This would support the observation by Rae^{4,5} that alcoholics with psychopathic wives have a poor prognosis. It may be that like personalities marry and that the findings do no more than underline the prognostic implications of psychopathy. The data here is insufficient to clarify this question but Hope⁽⁶⁾ has investigated this relationship and did not find a close similarity in the hostility levels of married couples where one partner was alcoholic.

The importance of the spouse in the treatment of alcoholism needs no further emphasis. It is understandable that those spouses who are themselves psychologically disordered will be less able to assist their partner and will be more likely to provoke anxieties which contribute to relapse. Relatively few spouses co-operated in this study and this of itself reflects the difficulty in implicating the family in treatment when the alcoholic alone is seen as needing aid. It is likely that many of the most disordered wives did not co-operate with the unit and would not be included in this sample.

CHAPTER XIII

SUMMARY AND CONCLUSIONS

The main findings and their implications are summarised in this Chapter.

The patients seen at the clinic could not be taken as reflecting Edinburgh's alcoholic population. A 'field-study' of a sample population of this city would be required before the true prevalence of alcoholism could be determined. Nonetheless the characteristics of the patients referred are of interest because they demonstrate the demands likely to be made on an alcoholism unit in such a setting. The experiences of this clinic provide useful information for the increasing number of specialised units for the treatment of alcoholism⁽¹⁾ and offer data for comparison with centres elsewhere. This study's objectives may be seen as descriptive and evaluative.

Descriptive:

Background and characteristics of the patient sample:

The majority of patients referred were male and middle-aged. The report of Straus and Bacon (1951)⁽²⁾ showed that most patients attending an alcoholism clinic were well integrated socially. The experience of this clinic further emphasises this observation. Of this sample 57% were married and living with their spouses. The social class distribution showed a preponderance of class I and II and in this respect resembles the alcoholic

populations described by Glatt (1961)⁽³⁾ Vallance (1965)⁽⁴⁾
and Walton et al (1966)⁽⁵⁾. It seems that the socially
deteriorated alcoholic was not being referred to this clinic
and that such patients present a problem for more study.^(6,7,)

Parental loss in childhood was not prominent in this
sample. Many parents were described as heavy drinkers (48%).
While agreeing with Smith and Sclare⁽⁸⁾ that many patients
gave a family history of alcoholism it was not predominantly
in their mothers but in their fathers that excessive drinking
had been present. Nylander⁽⁹⁾ has stressed the impact of
paternal drinking in the sons of alcoholics.

Drinking History:

The majority of the patients had their first drinks
away from home and started drinking in their late teens. Most
preferred to drink in company and 71% drank predominantly
whisky. Alcoholic amnesias were reported by 71%, a figure
similar to Glatt's⁽³⁾ 76% incidence in male alcoholics.

Withdrawal symptoms had been experienced by 83% which
may be compared with the 75% incidence recorded by Glatt⁽³⁾.
Most often the patient felt he had been drinking abnormally
for two to five years (N = 38) but some had conspicuously longer
histories of alcohol addiction. Thirty-four of the sample suff-
ered from chronic alcoholism.

The social consequences of heavy drinking had caused
approximately one-third of the patients at some time to lose

their job and an equal number had been arrested for drunken behaviour. 18% of the sample had stolen or embezzled to obtain money for drink. Alcoholism commonly reveals itself by such evidence of social disharmony and should provide clues for more active involvement of the police, social agencies and employers in early detection and referral of the alcohol addict. Too often alcoholics are jailed ⁽¹⁰⁾ and a detailed study of prisoners in Scotland would probably reveal a high incidence of alcoholism which could more properly be treated in hospital.

The pattern of drinking found in the alcoholics described revealed a surprisingly large number (42%) of inability-to-abstain addicts. It seems that this kind of addiction which carries a poor prognosis ^(5,11,) has been insufficiently recognised in the past perhaps because a drinker of this kind so little resembles the traditional image of the loss-of-control addict fostered by Alcoholics Anonymous.

Any attempt to evaluate and compare psychiatric diagnoses is beset by inaccuracies; nonetheless it is of interest to note that approximately one quarter of this sample were regarded as suffering from severe personality disorders. Thus only a minority of patients were placed in that category which would include all those clinically regarded as psychopaths. This study produces no evidence to support the commonly held belief that the majority of alcoholics coming for treatment are psychopathic. Some objective evidence from this clinical impression

may be derived from the general punitiveness of this sample. This showed a wide distribution of scores, not as might otherwise have been expected, a cluster within the range normally found in populations of psychopaths ⁽¹²⁾.

Evaluation:

This study investigates outcome with an approach which used two main treatment procedures. It was not ethically possible to plan the research so that the two therapeutic techniques could be directly matched. The design used emphasised the relationship between the characteristics of the patient and his response to treatment.

The evaluation of treatment response in alcoholism is complex and the comparison of one therapy with another difficult because of differing diagnostic and out-come criteria. This problem has been explored in Chapter I. The reliability of data based mainly on the reports of patients and relatives at six month intervals is open to question. The relationship between patient and relative estimates of drinking behaviour has been discussed by Guze et al (1963) ⁽¹³⁾. It would have been better but in the circumstances impracticable to have a full time research worker engaged in regular follow-up visits to the homes of patients. Edwards (1965) ⁽¹⁴⁾ has found monthly visits, by a research assistant trained in interviewing, a useful technique.

This study has reinforced the view that drinking status at six months is a useful measure of treatment response. It has also shown that abstinence is closely related to an improvement in domestic relationships and work status. These observations were true whether or not the patient was admitted to the unit. It is too early after one year to comment on the question of return to normal drinking amongst certain alcoholics. It is to be hoped that the follow-up of this sample will be extended over a number of years.

Of the sample 25% were abstinent throughout the first six months and a further 22% had only transient lapses 22% were regarded as being "improved but drinking" and 30% were unchanged, only one patient could not be traced. These findings are similar to those of Glatt (15) and others (5,11,16,17,) in which approximately two-thirds of alcoholics treated show some improvement while one-third remain unchanged.

The out-patient and in-patient groups did not differ significantly in treatment response. This does not imply that in-patient treatment was no more or less effective than out-patient as it was apparent that those who responded to in-patient treatment differed in many respects from those who benefitted from out-patient treatment alone. The Lancet (18) in a recent criticism of specialised units for the treatment of alcoholism states - "the aim (of specialised units) is to discover whether the alcoholic is suitable for group therapy, and if the patient does not fulfill these fairly narrow criteria he

is rejected for treatment". The findings here clearly show that not all patients benefit from group psychotherapy but that many of those not selected can be greatly helped by other techniques. The problem facing the specialised unit is one of tailoring the treatment to fit the individual patient.

This study has emphasised the relationship between a number of variables and outcome six months after the start of the out-patient regime. The patient brings certain assets to the initial interview and from the findings the relative value of these assets can be assessed in terms of his treatment response.

Only two factors known at initial interview were significantly associated with outcome in both hospitalised and out-patient samples. These were social class and age (Table 1). A patient coming from social classes I or II has a relatively favourable prognosis. This has been demonstrated in many other studies (11,15,19,21,) . Glatt (1958) (15) Wolff (1964) (22) have observed that older patients are more likely to remain abstinent, (11,19) although some other reports have not shown this association .

TABLE 1
Factors known at initial interview which are significantly related to outcome for both groups.

	<u>In-Patients</u>		<u>Out-Patients</u>	
	Unit normal deviate	P	Unit normal deviate	P
Age	-2.64695	<.01	-2.13245	<.05
Social Class	2.33736	<.05	2.00495	<.05

Those factors apparent at initial interview which significantly distinguished between outcome categories for out-patients but did not do so for in-patients were: drinking status at first attendance, involvement at some time with Alcoholics Anonymous, pattern of drinking and duration since the first experience of withdrawal symptoms, psychiatric diagnosis, state of the marriage and General Punitiveness both of the patient and his spouse (Table II).

A profile of the patient who is likely to remain abstinent with out-patient treatment would be - loss-of-control addict with a long history of addiction as measured by his first experience of the abstinence syndrome, who has been abstinent for more than one week, has had some contact with Alcoholics Anonymous, and if married has a relatively good relationship with his wife. Both the patient and his wife have low General Punitiveness scores. Clinical evaluation does not reveal severe psychiatric disorder.

Turning to those variables which are connected with his progress as an out-patient and those derived at subsequent evaluation, the following were shown to be significantly related to drinking status at six months. Number of out-patient attendances; work situation; domestic relationships; personal illness score and General Punitiveness (Table III).

We may add to the above profile that the successful out-patient attends the clinic regularly, shows an improved adaptation at work and at home, and has a low score on general punitiveness and neuroticism when these are evaluated after six months.

TABLE II

Factors obtained at initial interview which are significantly related to outcome for out-patients

	Unit normal deviate	P
Drinking status when first seen	-2.94616	<.01
Pattern of addiction	-3.05388	<.01
Psychiatric diagnosis	2.62796	<.01
Acting out hostility	2.86294	<.01
General Punitiveness	2.69846	<.01
Spouse General Punitiveness	2.57589	<.01
Time lapse since first experience of abstinence syndrome	-2.53772	<.05
Experience of Alcoholics Anonymous	-1.98129	<.05
State of marriage	2.10910	<.05
Criticism of others	2.41432	<.05
Delusional hostility	2.26126	<.05

TABLE III

Treatment variables significantly related to outcome for out-patients

	Unit normal deviate	P
Domestic situation	3.98564	<.001
Criticism of others at follow-up	2.60916	<.01
Guilt at follow-up	2.59008	<.01
Out-patient attendance	-2.44418	<.05
Work status	2.53035	<.05
Personal illness score at follow-up	2.08170	<.05
Acting out hostility at follow-up	2.25160	<.05
Delusional hostility at follow-up	1.97267	<.05
General punitiveness at follow-up	2.53749	<.05

In the hospitalised sample the following variables were significantly related to outcome: civil status, age at first drink, a history of arrest for drunkenness, traffic offences, attempted suicide, and state of marriage (Table IV).

A profile of an in-patient with a good prognosis would have an extant marriage and no history of arrest for drunkenness or driving under the influence of alcohol, or of attempting suicide. The out-look would be particularly promising if he had started drinking late in life.

These variables which are associated with quality of the treatment experience and response and are significantly related to drinking status at six months are: drinking in the unit, rating in capacity to develop techniques for avoiding further drinking and the extent of environmental changes effected, staff assessment of prognosis and regularity of attendance at the out-patient group, level of acting out hostility, domestic and work status evaluated at follow-up (Table V).

To the above profile may be added that the in-patient showing a favourable treatment response does not drink in the unit, develops and considers techniques to combat further drinking and has involved the environment in facilitating his new way of life, he is given a good prognosis by the staff, attends the out-patient group regularly and has an improved work status and domestic situation. He has a low score on acting out hostility.

TABLE IV

Factors obtained at initial interview which are significantly related to outcome for in-patients.

	Unit normal deviate	P
Civil status	2.68919	<.01
Age at first drink	-3.21683	<.01
Suicide attempt	2.65384	<.01
Arrest for drunkenness	2.31439	<.05
Drunk driving charge	2.09895	<.05

TABLE V

Treatment variables significantly related to out-come for
in-patients

	Unit normal deviate	P
Domestic situation at follow-up	3.91458	<.001
Attendance at out-patient group	-3.90287	<.001
Taking Antabuse	3.75343	<.01
Work status at follow-up	2.82785	<.01
Prognosis given by staff	-2.56549	<.01
Drinking in the unit	2.33328	<.05
Developed techniques to combat drink- ing	-2.49149	<.05
Environmental involvement	-2.08780	<.05
Acting out hostility - score at six month follow-up	2.19555	<.05

The findings indicated that out-patient treatment alone could be helpful to an appreciable number of alcoholics, particularly those patients who had attained abstinence at the time of initial interview. Amongst out-patients who remained abstinent the majority were regular attenders for individual interviews with their therapist. This suggested that the continuing relationship with the clinic was an important factor in their recovery.

Clinical and psychological measures were particularly significant in predicting outcome for out-patients. Thus patients with severely disordered personalities and a high level of hostility rarely benefitted from out-patient treatment whereas those variables were not significantly related to outcome for in-patients. It was tempting to suggest that the period in hospital assisted a wider range of psychiatric disorders.

The impulsive young alcoholic with a severe personality disorder was not helped significantly by either treatment regime. This group will demand more detailed study and the development of different treatment techniques ⁽²⁰⁾ .

An early index of treatment response was obtained by the regularity of a patient's attendance as an out-patient. Antabuse proved useful not only as a deterrent from drinking but as a measure of commitment to the treatment. It may be that greater mobility of the clinic staff within the community

would have enabled lapsed patients to return to treatment. Whether domiciliary visits to lapsed patients would have improved the prognosis for some alcoholics remains to be shown. Alcoholics Anonymous have used this technique with success for many years.

The personality of the patient's spouse and the quality of the marital relationship have been shown to be important factors in prognosis. Increasing recognition has been given to the necessity of involving the entire family in the patient's treatment. This study showed that it is often difficult to gain the co-operation of the patient's spouse, particularly when treatment is entirely on an out-patient basis. Techniques for engaging the spouse in treatment should be explored and further studies of family dynamics in the homes of alcoholics are required.

From the experience of this study it appears that treatment services for alcoholism should provide:

1. Adequately staffed out-patient facilities for evaluation and treatment. Well integrated loss-of-control addicts can be treated by out-patient individual therapy alone.
2. Facilities for detoxifying the majority of those patients attending the clinic under the influence of alcohol.

3. An in-patient ward such as that described in this study which would prepare the patient for continued attendance at a psychotherapeutic group after discharge. For such a ward to function optimally only a small number of in-patients can be treated at one time. Approximately twelve alcoholics seems appropriate as this permits the staff to possess and share detailed knowledge of each patient and allows the patients to gain an understanding of each other's personality.
4. It is suggested that patients with severe personality disorders and those who are markedly deteriorated socially would require a different treatment approach. Provision for longer term in-patient treatment progressing to working from a half-way house should be available within a comprehensive service for alcoholism.

In addition to a treatment service the alcoholism unit can provide a centre for education and research in alcohol addiction.

APPENDIX

APPENDIX I.

PATIENTS EXCLUDED FROM THIS STUDY

HISTORY 1

An 18 year old girl was referred by a child psychiatrist who had been consulted by the matron of an approved school where the girl was detained.

She had started drinking at 13 at first taking cheap wine and later vodka. She was also taking "purple hearts" at that time. Although she was an unusually heavy drinker for a girl of her age, there were no characteristics of alcohol addiction in her history.

She was the second oldest of four siblings. Her mother had died when she was 13 and the family had been looked after first by her elder sister and then when she married, by the patient herself. Her father was drinking heavily following her mother's death and made a precipitous and unsuccessful re-marriage. Aged 16 she ran away from home and drifted about with a group of friends who were stealing, drinking and taking drugs. She was charged with theft and had been in Dr. Guthrie's Girls School for one and a half years at the time of referral. On one occasion when she was on leave from school she absconded and went on a drinking spree. It was this episode which attracted matron's attention to her alcohol problem.

It was felt that this girl did not suffer from alcoholism but that her main problem was a severe personality disorder arising in an emotionally deprived girl who drank excessively in an endeavour to escape from her anomic emotional state. Her treatment was continued by the psychiatrist who had referred her.

HISTORY 2

A 33 year old woman, married but separated was referred by a psychiatrist. At interview it was clear that her drinking was secondary to serious psychiatric disturbances. She was vague, apathetic and in answer to questions would talk past the point. She appeared to be disoriented in time. The initial diagnosis was that she was suffering from organic impairment following cerebral malaria in her youth. She was admitted to the General Psychiatric Hospital.

She remained in hospital for one month and at discharge it was felt that she had a severe personality disorder along with the probability of some organic impairment. She lapsed shortly after discharge and an attempt was made to treat her as a day patient. This proved ineffective as she did not attend regularly. One year after the initial interview there had been no improvement in either her mental state or her drinking pattern.

HISTORY 3

A male alcoholic aged 50 was referred by his General Practitioner from a distant town. He was unmarried and he had held the same job in an iron foundry for many years. He had been hospitalised on two occasions on account of alcoholism and on the more recent of these occasions he had been in hospital for two years. He had made no serious attempt to remain sober since discharge. Seemingly a row with the man he lived with had caused him to seek help from his doctor.

It seemed more appropriate that he should be treated at the mental hospital near his home as he would not be able to attend regularly as an out-patient. One year later this patient was an irregular attender at his local psychiatric out-patient clinic. He appeared to have made some advance in that home conditions had improved but there had been no change in his drinking habits.

HISTORY 4

A 47 year old alcoholic was referred from the casualty department of a general hospital where he had sought help. The patient had been married twice, both wives leaving him. He had not had a regular job since 1958 nor had he maintained any lasting relationships during that time. He had no knowledge of his wife's whereabouts and had not seen her for 3 years.

Since 1957 he had been in mental hospitals on nine occasions for treatment of alcoholism. On no occasion had he abstained for more than a few days after discharge. He was in fact on his way from a hospital in Glasgow to a clinic in Newcastle when he decided to seek treatment in Edinburgh.

As he was on the verge of delirium tremours he was admitted to the general mental hospital for "drying-out". Subsequent assessment showed that he suffered from gross personality disorder and was markedly sociopathic. Although he remained in this hospital for 3 months, little progress was made and he drank soon after discharge. No improvement was reported one year later.

HISTORY 5

A 55 year old alcoholic who had been in hospital on five previous occasions was referred to the clinic by his general practitioner. During the initial interview, he spoke in a distracted manner. He said that while waiting for the interview he pulled a waste paper basket close to him because he hated to drop ash on the floor and "there was string in the bin so I thought I will string along with you." He explained this by saying "you throw a life line to someone, you do not leave him to drown."

The clinical impression was that he was suffering from schizophrenia and that his alcoholism was a symptom of this disorder. He was admitted to the general mental hospital and they undertook his further treatment. He made excellent progress at first although he relapsed once after discharge. One year later he was working as a seaman and thought to be abstinent.

HISTORY 6

A 70 year old male alcoholic was referred by another psychiatrist. He had suffered from inability to abstain alcoholism for many years. His drinking had increased since his wife's death three months previously. He was living with his son, daughter-in-law and two children in a four roomed flat. All his old age pension was being spent on alcohol and debts were mounting at licensed grocers. Impairment of memory and intellectual capacity was apparent at interview and his son had observed a deterioration in the old man during recent years.

It was felt that he was in need of long term care and presented a social problem which was outwith the scope of the clinic. The local authority was asked to undertake his future support.

HISTORY 7

A 40 year old unmarried male alcoholic was referred by a psychiatrist. The patient was at that time in a general psychiatric hospital. He was a policeman who had served overseas for much of his life. Both parents had been alcoholic and he was the youngest of 3 siblings. Two years previously he had experienced auditory hallucinations and passivity feelings. This was at a time when he had not been taking any alcohol. In recent years he had made two suicide attempts. He was homosexual and had never formed any lasting relationships with other people.

It was found that he was suffering from a psychotic illness and had a gross disturbance of personality. It was decided that he should continue treatment in the referring hospital. Since that time he has been hospitalised almost continuously and there has been no improvement in his mental state or in his drinking habits when not in hospital.

HISTORY 8

A 28 year old medical student who had been married for only a few days was referred by his general practitioner. He was seeking help because a court appearance was pending. His father, grandfather and great-grandfather had all been alcoholics and all had been violent when drunk. The patient had shown a similar pattern being quiet and competent when sober and giving way in his drinking bouts to outrageous anti-social behaviour which had ended in arrest on several occasions. He had been extremely violent to his fiance and feared that he might injure her during such a bout.

At the initial interview he impressed as a quiet spoken and charming young man who seemed horrified at his behaviour when drunk. He suffered from loss of control alcoholism and a severe personality disorder. As he was going to live in London he was referred to a clinic there for further treatment. Six months later follow-up by letter revealed that he had not attended his appointment in London and that he had once more relapsed. He, and his wife, had separated.

A P P E N D I X I I

DATA SHEETS AND PSYCHOLOGICAL TESTS

Unit for the Treatment of Alcoholism
 Professorial Unit, Royal Edinburgh Hospital
INITIAL INTERVIEW DATA AND FOLLOW-UP

January, 1965

SURNAME: Unit No.
 Christian Name:

1. Sex
 1. Male
 2. Female

2. Age

3. Marital Status
 1. Single
 2. Married
 3. Separated, not legally
 4. Separated legally
 5. Divorced
 6. Widowed

4. Nationality
 1. Scot
 2. English
 3. Irish
 4. Other

5. Social Class

1 2 3 4 5
 State Occupation.....

6. Religion
 1. Protestant
 2. Roman Catholic
 3. No affiliation

State Church.....
 Church Attendance

 1. Attends regularly
 2. Attends infrequently
 3. Does not attend

7. Source of Referral

- 1. Self
- 2. Family Doctor
- 3. Hospital Consultant (other than psychiatrist)
- 4. Psychiatrist in General Hospital (e.g. Psychiatric O.P.Department)
- 5. Psychiatrist in Ward 3
- 6. Psychiatrist in Psychiatric Hospital.....
- 7. Other (specify).....

8. Date of first Contact with Unit.....

9. Drinking Status on first attendance

- 1. Drinking
- 2. Sober under 1 week
- 3. Sober over a week

10. Suitable for admission to Unit

- 1. Yes
- 2. No

State reason if not suitable.....

11. Attitude about Father

- 1. Positive
- 2. Negative
- 3. Ambivalent
- 4. Non-committal

12. Attitude about Mother

- 1. Positive
- 2. Negative
- 3. Ambivalent
- 4. Non-committal

13. Number of siblings

14. Patient's position in sibship

15. Permanent separation from a Parent in Early Life

Father

- 1. Not applicable
 - 2. 4 and under
 - 3. 5 - 9
 - 4. 10 - 15
- State age

Reason for separation.....

15. Permanent separation from a Parent in Early Life (contd.)

Mother

- 5. Not applicable
- 6. 4 and under
- 7. 5 - 9
- 8. 10 - 15
- State age

Reason for separation.....

Both parents

- 9. 4 and under
- 10. 5 - 9
- 11. 10 - 15

16. Death of parent before 16

- 1. Not applicable
- 2. Mother State Age.....
- 3. Father State Age.....

17. Family History of Excessive Drinking

- 1. Father
- 2. Mother
- 3. Other close relative
(specify relationship).....

18. Parents opposed to drink

	<u>Mother</u>	<u>Father</u>
1. Yes
2. Neutral
3. No

19. Strict Abstinence in Parents

- 1. Mother
- 2. Father
- 3. Both

20. Spouse Alcoholic

- 1. Yes
- 2. No
- 3. Patient single

21. Number of Marriages

- 1. One
- 2. Two
- 3. More
- 4. Patient single

22. Number of Children

DRINKING HISTORY

23. Age at First Drink

- 1. In family
- 2. Outside family circle

24. Duration of Excessive Drinking

25. Main Type of Drink.....

26. Drinks Mainly

- 1. In company
- 2. When alone (solitary)

27. Alcoholic Blackouts

- 1. No
- 2. Yes
- 3. Onset years age

28. Withdrawal Symptoms (tremors, shakiness)

- 1. No
- 2. Yes
- 3. Onset..... years age

29. Stealing or Embezzlement

- 1. No
- 2. Yes

30. Lost job because of drinking

- 1. No
- 2. Yes
- 3. First occurrence.....years age

31. Arrested for being drunk

- 1. No
- 2. Yes
- 3. First occurrence.....years age

32. Traffic Offence while under the influence

- 1. No
- 2. Yes

33. Suicide Attempt

- 1. No
- 2. Yes, once (state method and date).....
- 3. Multiple attempts(specify number).....

34. Drinking of cheap wine or spirit

- 1. No
- 2. Yes

35. Previous Treatment for Alcoholism

- 1. No
- 2. In another alcohol unit
- 3. In psychiatric hospital
- 4. Other.....

36. Attended A.A.

- 1. No
- 2. Yes

- 37. Positive Attitude to A.A.
- Negative Attitude to A.A.

38. Hostility scale

- a
- b
- c
- d
- e
- Extrapunitive (a+b+c)=
- Intrapunitive (2d+c) =

39. Assessment of Marriage Relationship

- 1. Excellent
- 2. Good
- 3. Fair
- 4. Poor
- 5. Bad

40. Chronic Alcoholism (physical complications from addiction: cirrhosis, peripheral neuritis, delirium tremens, organic brain syndrome)

- 1. No
- 2. Yes (specify)
-

41. Assessment of pattern of drinking

- 1. Inability to abstain
- 2. More 1 than 4
- 3. More 4 than 1
- 4. Loss of control

42. Assessment of Conscience-structure

- 1. Hedonistic
- 2. More 1 than 4
- 3. More 4 than 1
- 4. Intrapunitive

43. Psychiatric Diagnosis

- 1. Psychoneurosis.....
(Specify: anxiety neurosis, hysteria, obsessional neurosis or reactive depression)
- 2. Personality Disorder.....
(Mild, moderate or severe)
- 3. Borderline State (compensated psychosis)...
- 4. Psychosis.....
- 5. Chronic brain syndrome.....

TREATMENT

- 44. a) Admitted as inpatient
 - 1. No
 - 2. YesSpecify duration
- Number of re-admissions
- b) Admitted elsewhere for "drying out".....
- c) Patient admitted to another psychiatric hospital
 - 1. Name.....
 - 2. Date(s).....

45. Unco-operative Behaviour in Unit

- 1. No
 - 2. Yes
- Specify.....

46. Drinking in Unit

- 1. No
- 2. Yes

47. Discharged Self

- 1. No
- 2. Yes

OUTCOME AFTER SIX MONTHS

48. Drinking Status

- 1. Abstinent (i.e. dry for 6 months)
- 2. Lapsed but abstinent (not drinking at follow-up)
- One lapse
- Two lapses
- Three lapses
- More
- 3. Improved but drinking
- 4. Not improved
- 5. Unknown
- 6. In hospital
- 7. Dead

49. Antabuse test reaction

- 1. Given
- 2. Not Given

50. Antabuse Usage

- 1. Using Antabuse, relies on it
- 2. Uses it intermittently up to present
- 3. Used Antabuse initially
- 4. Not using Antabuse

51. Estimation of Length of Time Patient Used Antabuse

52. Patient's Estimation of Value of Antabuse

- 1. Much value
- 2. Moderate value
- 3. No value

53. Work Status

- 1. Working in better job
- 2. Working in same job, improved
- 3. Working in same job unchanged
- 4. Working in worse job
- 5. Not working at screening interview but is now
- 6. Not working but had job since screening interview
- 7. Not working

54. Address

- 1. No change
- 2. Change (specify).....

55. Home Situation

- 1. The same
- 2. Change (specify).....

56. Change in Marital Status.....

57. OUTPATIENT GROUP

- 1. Not assigned
- 2. Assigned but did not attend
- 3. Assigned and attended
- 4. Date of first attendance

Unit for the Treatment of Alcoholism
Professorial Unit, Royal Edinburgh Hospital

SOCIAL WORK DATA

January, 1965

CLIENT

1. Name
2. Sex
 1. Male
 2. Female
3. Relationship to Patient
 1. Spouse
 2. Parent
 3. Child
4. Whether assigned to Casework
 1. Yes
 2. No
5. No. of Possible Attendances
- No. of Actual Attendances
- Percentage attendance
6. Understanding of Alcoholism at First Interview
 1. Good
 2. Fair
 3. Poor
7. Assessment of State of Marriage when first seen
 1. Mutually stable marriage
 2. Wife supportive (husband)
 3. Wife Ambivalent (husband)
 4. Wife hostile (husband)
 5. Separated from spouse
 6. Divorced from spouse
 7. Not applicable
8. Additional Clients also Contacted
 1. Yes
 2. No

OUTCOME AFTER SIX MONTHS

9. Understanding of Alcoholism

- 1. Good
- 2. Fair
- 3. Poor

10. Whether personal conflicts have been faced

- 1. Actively explorative from the beginning.....
- 2. Reluctant at first later explorative.....
- 3. Intermittently explorative
- 4. Non-explorative throughout

11. Initial Casework Goal

- 1. Totally achieved
- 2. Moderately achieved
- 3. Somewhat achieved
- 4. Not achieved

Unit for the Treatment of Alcoholism
Professorial Unit, Royal Edinburgh Hospital

ASSESSMENT OF PROGRESS AT DISCHARGE

SURNAME:
Christian Name:

DATE:
Unit No.:

1. Degree of Improvement

a) Physical Health

	very poor	poor	fair	good
on admission				
on discharge				

Score discrepancy

2. Prognosis

- 1) Poor
- 2) Doubtful
- 3) Promising
- 4) Excellent

3. Understanding of Problems

a) Understanding of alcoholism

- 1) Knows that drink must be stopped completely
- 2) Knows that one drink will cause the illness to start again
- 3) Accepts that personal conflicts underly pathological drinking
- 4) Appreciates that alcoholism is an illness rather than a moral weakness

Score

b) Understanding of techniques to avoid drinking

- 1) Understands that he must avoid all drink
- 2) Understands about Antabuse
- 3) Recognises problems that he has resolved in the past by drinking
- 4) Has decided on measures he could take instead to correct such stressful situations

Score

c) Resolved Personal Conflicts

- 1) Accepted it as important to resolve conflicts
- 2) Identified current problems
- 3) Discussed difficulties with other people concerned in his (her) conflict
- 4) Taking some steps to resolve conflict

Score

d) Environmental factors

- 1) Discussed drinking problem with spouse(or equivalent)
- 2) Discussed this with circle of friends who know he is alcoholic
- 3) Returning to secure work
- 4) Employers aware of his illness

Score

.....

General Punitiveness Scale

Instructions: Please fill in this form by putting a circle round the "True" or the "False" following each statement. If you find it difficult to decide ask yourself whether you think the statement is on the whole true or false and put a circle round the appropriate word,

Remember to answer each statement

- | | | |
|--|------|-------|
| 1. Most people make friends because friends are likely to be useful to them. | True | False |
| 2. I do not blame a person for taking advantage of someone who lays himself open to it. | True | False |
| 3. I usually expect to succeed in things I do. | True | False |
| 4. I have no enemies who really wish to harm me. | True | False |
| 5. I wish I could get over worrying about things I have said that may have injured other people's feelings. | True | False |
| 6. I think nearly anyone would tell a lie to keep out of trouble | True | False |
| 7. I don't blame anyone for trying to grab everything he can get in this world. | True | False |
| 8. My hardest battles are with myself. | True | False |
| 9. I know who is responsible for most of my troubles. | True | False |
| 10. Some people are so bossy that I feel like doing the opposite of what they request even though I know they are right. | True | False |
| 11. Some of my family have habits that bother and annoy me very much. | True | False |

- | | | | |
|-----|---|------|-------|
| 12. | I believe my sins are unpardonable. | True | False |
| 13. | I have very few quarrels with members of my family. | True | False |
| 14. | I have often lost out on things because I couldn't make up my mind soon enough. | True | False |
| 15. | I can easily make other people afraid of me, and sometimes do for the fun of it. | True | False |
| 16. | I believe I am a condemned person. | True | False |
| 17. | In school I was sometimes sent to the principal for cutting up. | True | False |
| 18. | I have at times stood in the way of people who are trying to do something, not because it amounted to much but because of the principle of the thing. | True | False |
| 19. | Most people are honest chiefly through fear of being caught. | True | False |
| 20. | Sometimes I enjoy hurting persons I love. | True | False |
| 21. | I have not lived the right kind of life. | True | False |
| 22. | Sometimes I feel as if I must injure either myself or someone else. | True | False |
| 23. | I seem to be about as capable and smart as most others around me. | True | False |
| 24. | I sometimes tease animals. | True | False |
| 25. | I get angry sometimes. | True | False |
| 26. | I am entirely self-confident. | True | False |
| 27. | Often I can't understand why I have been so cross and grouchy. | True | False |
| 28. | I shrink from facing a crisis or difficulty. | True | False |
| 29. | I think most people would lie to get ahead. | True | False |
| 30. | I have sometimes felt that difficulties were piling up so high that I could not overcome them. | True | False |

- | | | | |
|-----|--|------|-------|
| 31. | If people had not had it in for me I would have been much more successful. | True | False |
| 32. | I have often found people jealous of my good ideas, just because they had not thought of them first. | True | False |
| 33. | Much of the time I feel as if I have done something wrong or evil. | True | False |
| 34. | I have several times given up doing a thing because I thought too little of my ability. | True | False |
| 35. | Someone has it in for me. | True | False |
| 36. | When someone does me a wrong I feel I should pay him back if I can, just for the principle of the thing. | True | False |
| 37. | I am sure I get a raw deal from life. | True | False |
| 38. | I believe I am being followed. | True | False |
| 39. | At times I have a strong urge to do something harmful or shocking. | True | False |
| 40. | I am easily downed in an argument. | True | False |
| 41. | It is safer to trust nobody. | True | False |
| 42. | I easily become impatient with people. | True | False |
| 43. | I deserve severe punishment for my sins. | True | False |
| 44. | At times I think I am no good at all. | True | False |
| 45. | I commonly wonder what hidden reason another person may have for doing something nice for me. | True | False |
| 46. | I get mad easily and then get over it soon. | True | False |
| 47. | At times I feel like smashing things. | True | False |
| 48. | I believe I am being plotted against. | True | False |
| 49. | I certainly feel useless at times. | True | False |
| 50. | At times I feel like picking a fist fight with someone. | True | False |
| 51. | Someone has been trying to rob me. | True | False |
| 52. | I am certainly lacking in self-confidence. | True | False |

Symptom-Sign Inventory

PI Scales

Surname

Christian Name

Sex

Reference Number

Age

Occupation

Marital Status S M W D Sep.

Date of Testing

Does your hand often shake when you try to do something?

1. Do you sweat very easily, even on cool days?
2. Do you suffer from palpitations or breathlessness?
3. Are you afraid that you might be going insane?
4. Are you afraid of being in a wide-open space or in an enclosed space?
5. Have you difficulty in getting off to sleep (without sleeping pills)?
6. Are you afraid of going out alone?
7. Have you any particular fear not mentioned so far?
8. Do you cry rather easily?
9. Have you lost interest in almost everything?
10. Is the simplest task too much of an effort?
11. Have you found it difficult to concentrate recently?
12. Does the future seem pointless?
13. Are you more absent-minded recently than you used to be?
14. Are you slower recently in everything you do?
15. Do you often feel puzzled, as if something has gone wrong either with you or with the world, without knowing just what it is?
16. Do you ever have "blackouts", dizzy spells or faints?
17. Are you troubled by waking in the early hours and being unable to get off to sleep again (if you don't have sleeping pills)?

PI Score

A P P E N D I X I I I

EXAMPLES OF FOLLOW-UP LETTERS

The following typewritten letter was sent to patients who had lost contact with the unit.

Unit for the Treatment of Alcoholism,
Royal Edinburgh Hospital.

Dear Mr. _____

It is some time since we last saw you at this clinic.

The staff of the unit like to keep in touch with former patients and I have been wondering how you are getting on. I should like to see you at on Please let me know if this is inconvenient and another time can be arranged.

Yours sincerely,

E. B. RITSON.

If the patient did not respond to this letter, more individual letters, often handwritten, were sent.

Dear Mr. _____

I am sorry that you have not been able to come to the unit for your recent appointment. As I am interested in the progress of all our former patients so that I can learn how they have coped with their problems, I should very much like to see you again. I shall call on

Please let me know if this is inconvenient and another time can be arranged.

Yours sincerely,

E. B. RITSON.

Dear Mr. _____

As we are in the process of working out the best service we can give to patients attending this Unit, I like to keep in touch with our former patients. I understand that it is difficult for you to come to the Unit, and wondered if it would be convenient for me to call on

Please let me know if this time is unsuitable and another time can be arranged.

Yours sincerely,

E. B. RITSON.

At the time of 1 year follow-up, it was not possible to interview personally a small number of patients. They were asked to complete the following questionnaire.

THE ROYAL EDINBURGH HOSPITAL

Unit for the Treatment of Alcoholism,
Morningside Terrace
EDINBURGH, 10.

12th April, 1966.

Dear

We would like your assistance in helping us to provide the most effective treatment for sufferers from alcoholism. As you have been a patient at this Clinic, your answers to the following questions would be of great help in our future plans.

- (1) What is your present employment?
- (2) How long have you been in your present employment?
- (3) Have you had any recent illness?
- (4) If yes, what was the trouble?
- (5) How is your appetite?
- (6) How are you sleeping?
- (7) How are you feeling in yourself?
- (8) Have there been any changes in your home life?
- (9) Have you found Antabuse helpful?
Do you still take it?
- (10) When did you last have an alcoholic drink?

- (11) Since attending this Clinic, what have been your drinking habits? (Please underline the statement which most nearly applies to yourself).
- Never touch it: occasional drink: moderate drinker:
unchanged: worse than before
- (12) Would you like any further help from the Clinic?
- (13) Would you favour regular reunions of patients to discuss their progress and common problems?
- (14) Any further comments?

Thank you very much for your help in answering these questions. A stamped, addressed envelope is enclosed for your reply.

Yours sincerely,

E. B. RITSON.

If your address has changed, please state your new address.

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