1961

Study of the stability of alcoholic patients seen in a private hospital

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A STUDY OF THE STABILITY OF ALCOHOLIC PATIENTS SEEN IN A PRIVATE HOSPITAL

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Submitted in Partial Fulfillment for the Degree of
Doctor of Medicine

College of Medicine, University of Nebraska

1961

Omaha, Nebraska

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I. INTRODUCTION

Purpose of the Study. It is an interesting observation that, prior to the middle of this century, scientists had little basis for characterizing alcoholics other than as unstable individuals. Both Bacon's survey in 1942 of inebriates in Connecticut (1) and Malzberg's study in New York in 1944 (2) supported such a view. This widely held impression that the "typical" alcoholic is characterized by a low degree of social and economic status has been undergoing an important change. The basis for the modification of this stereotype is of rather recent origin, emanating primarily from a study in 1950 of patients seen in nine clinics (3). A subsequent comparable study (4) made at the Shadel Hospital in Seattle, Washington (devoted exclusively to the treatment of alcoholics) provided additional and substantial support for the view that many and perhaps most alcoholics are characterized by a relatively high degree of stability. A completely reliable description of the alcoholic population in the United States, such as might be obtained from a truly representative sample, would be of enormous value, however nothing of this nature is within reach at the present time. For this

reason, it is important to obtain basic descriptive information regarding every sizable and available alcoholic population in the hope that the accumulation of such studies will render a fairly realistic conception of the total. These considerations pointed to the desirability of a survey of the alcoholic patients treated at a private facility in a Midwestern city, i.e. - Richard Young Memorial Hospital, Omaha, Nebraska. That these patients, as well as the Shadel Hospital patients in Washington, represent a somewhat distinct subgroup of the alcoholic population is suggested by the fact that a substantial fee for the therapeutic services is involved. Thus, it would seem that studies of such a group could render a valuable contribution to the development of a representative picture of the typical alcoholic in the United States.

By 1950, sufficient records had accumulated in nine eastern clinics treating alcoholism for Straus and Bacon to undertake an analysis of this source of information (3). Many of the findings were in sharp contrast with Bacon's and other's earlier studies (1, 2, 5, 6). Most previous studies reflected the severe limitations under which such data could be obtained. Until the clinics came into being, there had been no way of obtaining basic descriptive information on the vast majority of uncontrolled

drinkers in U.S. communities who had not been seen in jails and welfare agencies and who had not had the means and motivation to resort to private facilities. The implications of their findings regarding this previously unstudied segment of the alcoholic population were important. No longer could it be said that a low degree of social and occupational stability is nearly always characteristic of alcoholics. It appeared to Straus and Bacon that the type of patient showing up at the clinics "consisted of men who have maintained a high degree of family, community, and occupational integration and that such a person is perhaps the most significant element in the entire alcoholic population."

Just as the studies of the clinical patients (3) indicated a need to modify the picture of the "typical" alcoholic (as previously seen in jails and welfare agencies), so the Shadel studies (4) of alcoholics (who submitted voluntarily and paid a substantial fee for therapeutic services) augmented the implications derived from the clinical survey.

As identical factors were considered in the Shadel Hospital survey (4) as had been used in the clinical survey (3), it was decided to use the same considerations in the evaluation of the Richard Young Hospital patients as a basis for comparison. This survey included a review of all patients

admitted to Richard Young Hospital since its beginning in 1955 with an admission and dismissal diagnosis of alcoholism.

II. PRESENT STUDY

The present study was made by reviewing the charts of 320 patients admitted to Richard Young Hospital over a six-year period with a diagnosis of alcoholism. By eliminating records for successive admissions of the same patient, insufficient information in the charts, etc., 164 records were examined extensively and the following information derived.

Marital Status. Data on the marital status of the Richard Young sample is presented in Table I (column 3). The significance becomes apparent when compared with the clinical patients (column 1) who were found by Straus and Bacon to have a relatively high degree of marital stability. Data on the Shadel patients substantiates this significance (column 2).

It can be seen first that a greater per cent of the Richard Young patients, 89.5, and the Shadel patients, 92.2, had married compared to the clinical patients, 83, and the general population, 88, (2).

The greatest difference is found in the greater proportion of private patients who were married and living with their spouse as compared to the clinical patients--73 per cent of Richard Young patients, 75 per

cent of Shadel patients, and 64 per cent of clinical patients. When only those who had married are considered, it can be seen that only 19 per cent of the Richard Young patients and 23 per cent of the Shadel patients were divorced or separated as compared to 33 per cent of the clinical patients.

TABLE I

MARITAL STATUS

(in per cent)

	Clinical Patients	Shadel Patients	Richard Young Patients
Single	17	7.8	10.5
Married	53	68.9	67.8
Separated	15	4.6	4.6
Divorced	12	16.5	11.9
Widowed	3	2.2	5.1
TOTALS	100	100	100

Occupational Classification. The occupational comparison of the three samples is shown in Table II. The greatest difference is found in the first category of officials, managers, and owners. The proportion of clinical patients in this category was substantial, 14 per cent. More striking yet was the fact that over 31 per cent of the Richard Young patients were in this category (three-fourths were owners) and nearly 41 per cent of the Shadel patients were so classified (seven-eighths were owners). When the "professional" group is added to that of officials, managers, and owners, 20 per cent of the clinical, 40 per cent of the Richard young, and 47 per cent of the Shadel patients fall into these higher social status categories. But it should not be overlooked that well over half of the private patients are in the remainder of the categories; hence the cost of treatment in a private institution is admittedly a selective factor but evidently not a prohibitive barrier. When labor as a group is considered, 56 per cent of the clinical patients were so classified, 41 per cent of the Richard Young patients, and 32 per cent of the Shadel patients.

TABLE II

OCCUPATIONAL CLASSIFICATION

(in per cent)

	Clinical Patients	Shadel Patients	Richard Young Patients
Official, Manager, Owner	14	40.9	31.3
Professional	6	6.5	8.7
Public Servant	7	1.3	1.5
Clerical	6	2.6	4.6
Sales	10	9.7	11.7
Skilled Labor	23	9.5	10.2
Semi-skilled Labor	16	17.6	20.0
Unskilled Labor	17	5.0	9.9
Other	1	6.9	2.1
TOTALS	100	100	100

Employment Status. Table III rounds out the employment picture. Private patients were well over three times as often self-employed and unemployed only one-sixth as often as the clinical patients. When one remembers that Bacon considered these clinical patients well adjusted and stabalized as compared to patients included in his previous surveys (1), it becomes even more significant. These factors are, of course, inter-related. It is obviously much more difficult for a self-employed person--even an alcoholic--to become unemployed than it is for a person who works for someone else. The self-employed alcoholic may neglect his business and be going downhill financially, but unless he losses his business, he has not joined the ranks of the unemployed.

As can be seen, there is no significant difference in those classed merely as employed and one must refer back to Table II to derive an implication, i.e. - how they are employed.

TABLE III

EMPLOYMENT STATUS

(in per cent)

	Clinical Patients	Shadel Patients	Richard Young Patients
Self-employed	11	42.2	34.5
Employed	54	53.1	56.6
Unemployed	35	3.4	8.9
Not Ascertained	0	1.3	0
TOTALS	100	100	100

Age. Another factor that can be considered in comparing private and clinical patients is age (Table IV). Straus and Bacon had found the clinical patients to have a lower mean age (41.2 years) and a smaller per cent of patients over 50 years of age (19%) (3) than was true of other groups of alcoholics studied prior to 1950. Comparable data shows the private patients to have a higher mean age (42.6 years for Shadel patients and 47.5 years for Richard Young patients) than the clinical patients. These comparisons are of value only in so far as they remove all basis for attributing any of the previous results (marital stability, employment, etc.) on a younger age basis.

TABLE IV

AGE

(in per cent)

	Clinical Patients	Shadel Patients	Richard Young Patients
Under 30	10	8.4	2.7
30 - 34	14	12.0	8.6
35 - 39	22	20.1	12.0
40 - 44	20	21.6	23.7
45 - 49	15	16.1	15.8
50 - 54	11	11.7	14.5
55 - 59	5	6.6	12.5
60 and over	3	3.5	10.2
TOTALS	100	100	100

Screening for Organic Illness. The Richard Young patients included in this survey were those who were admitted with a diagnosis of alcoholism by the admitting M.D., treated for such, and discharged with the same diagnosis. In reviewing these patients, it was found that slightly over 20 per cent showed a markedly elevated erythrocyte sedimentation rate. By careful examination of the charts of this group, it was found that 60 per cent had definite organic illness either diagnosed or confirmed by physical examination and/or subsequent laboratory studies.

It has been estimated that approximately one third of the violent deaths in this country occur subsequent to drinking. Just how many of the total number of deaths are hastened by drinking is, of course, only subject to speculation, but the implication is apparent. The relationship of the alcoholism to the organic involvement (or of the organic malady to the alcoholism) is undoubtedly abstract, but the value of a routine erythrocyte sedimentation rate on such a group as a screening test is evident.

TABLE V

ORGANIC ILLNESS ENCOUNTERED

(in incidence)

Pathological Symptom or Process		Cases
Anemia		3
Epilepsy (Idiopathic)		1
Gallbladder Disease		1
Glycosuria and Hyperglycemia		3
Hypertension with Cardiomegaly		1
Hepatic Disease		19
with Hepatomegaly	6	
with jaundice	1	
Peptic Ulcer		1
Pneumonitis		2

III. DISCUSSION

An estimate of the alcoholics in the United States places the number as near five million (7). Those seen in the welfare agencies of the Skid Rows of America, members of Alcoholics Anonymous meetings, etc., account for only a small fraction of this number, hence one wonders where the rest are.

The answer seems to be that most of them are hidden from general recognition--hidden, for the most part, from recognition because they do not conform to the old and accepted stereotype of what an alcoholic is like. They are not believed to be alcoholics because they do not exhibit the personal and social disorganization held to be typical of chronic inebriates. They are hidden by their ability to present a fairly normal appearance of personal and social integration.

The present study of Richard Young patients, added to Straus and Bacon's clinical study and the survey of Shadel patients does not, of course, prove that the majority of alcoholics are persons who are maintaining such a high degree of social stability. None of these studies is based on definitive representative samples; yet each of these studies has examined a

definite alcoholic population and each has given evidence that a generally high degree of stability can be compatible with clear cut alcoholism--at least for a time. All the findings on the private patients cannot be dismissed from consideration on the grounds that the group is atypical--that is, a group selected on the basis of their ability to pay a substantial fee for the treatment program. The profile showing a larger proportion of private patients than clinical patients in the self-employed and higher occupational categories is admittedly a product of the fee-paying situation in a private hospital, nevertheless it is apparent that there are many alcoholics in these groups.

When it comes to the marital status however, there is no basis for believing that this favorable profile is also a function of fee-paying ability. If there is any relationship between these two factors, it is more plausible to assume that the seeking of treatment is, in part, a function of a high degree of stability, for the fee has not proved to be an obstacle to patients of very moderate means when sufficiently motivated. The payments involved seldom exceed the pretreatment expenditures for alcohol.

Such a perspective on the nature of the alcoholic

population was difficult to conceive prior to the survey of clinical patients in 1950 (3). By utilizing the same pattern of examination, this survey of Richard Young patients has not only supported the Straus and Bacon findings but has projected an even higher base for developing the picture of the typical inebriate in this country.

IV. SUMMARY

Support given to the misconception that alcoholics in this country are characterized by a low degree of stability and integration was a product of the type of inebriate available for study prior to the middle of this century. The typical clinical patient examined by Straus and Bacon was found to be living an apparently normal life at home, keeping marital ties intact, and maintaining steady employment. Shadel studies supported these findings. The Richard Young patients utilized in the present study were found to be characterized by an even greater degree of stability. This study, therefore, gives strong support to and broadens the base for the implication of the clinical study--that most alcoholics do not present a picture of considerable disorganization.

V. CONCLUSION

The implications of this conclusion are far-reaching, suggesting a refocusing of attention and effort on the part of those concerned with the detection and treatment of the "typical" alcoholic in this country.

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