WITHOUT PSYCHOSIS--CHRONIC ALCOHOLISM*

A Followup Study

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The purpose of most studies is to clarify a specific aspect or detail of one field. In this report, an effort has been made to investigate the progress of alcoholic patients who received routine hospital care and treatment. In addition, the report attempts to utilize a "trend" approach in the investigation of the individual patient.

Much has been written dealing with alcoholics "cured" by one or another type of treatment. Papers have been written on patients who gradually deteriorated or suffered from one of the alcoholic psychoses. There are also many cross-section and retrospective personality studies. These accounts are taken from the records of the treatment period, from the family, the patient, and occasionally from the family doctors.

Very little material is available on developments subsequent to such hospitalization as the majority receive, either in the mental hospital, state or private, or in a psychopathic ward. How many stop drinking and for how long? What happens to those who do not stop? In what ways do the former differ from the latter? Why do some abstain and what happens to them thereafter? What can the hospitalization accomplish? Wherein does it fail?

The Postulates

1. A followup study will reveal much which did not appear while the patient was incarcerated.
2. Such a work must be critical and analytic yet deal with individual case studies.

Field of Study

This study concerns 158 patients, cases of alcoholism, admitted to the Syracuse Psychopathic Hospital between January 1, 1935, and June 30, 1936.

This hospital is a diagnostic unit established in the New York State Department of Mental Hygiene to classify mental patients re-

*Condensation of thesis submitted in partial fulfillment of requirements for degree of master of arts in psychology at Syracuse University.

ferred to it from within the central area of New York State, transferring to State or private institutions those requiring prolonged treatment and caring for those who can be adequately treated in a shorter period of time.

Each case was peculiarly selective in that either the police judge or a near relative or the family physician was able to convince the admitting physician that the patient was probably psychotic. In this way, all mild cases of alcoholism, and, with one exception, all cases of acute alcoholism were eliminated. This single exception has not been included in the series.

The patients studied were kept in the hospital only sufficiently long to make an adequate diagnosis. They were presented at staff meeting in about two weeks and usually discharged within a month. At the time of the followup study, four years after hospitalization, the patients in this series were all regarded as "without psychosis." Some had had acute psychotic episodes; but such interludes in the course of chronic conditions were regarded as, in all probability, not being factors affecting the subjects' situations at the time of study. As for diagnosis at the time of hospitalization, the fact that as a diagnostic unit the Syracuse Psychopathic Hospital provided three full-time physicians for about 60 patients tended to standardize diagnosis and insure an adequate treatment program with modern technique.

Verification by Elimination

So that the conclusions might have greater reliability, the records were carefully reviewed, and all cases that would fall within the following groups were discarded:

1. Patients admitted to the hospital less than four years prior to the beginning of this study. 2. Individuals over 50 years of age at the time of admission. 3. Individuals with major physical disease or defect, or one which conceivably might affect the outcome, including disabled war veterans, early cases of arteriosclerosis, systemic or neurologic syphilis and severe head trauma. 4. Individuals who were diagnosed psychopathic personality associated with chronic alcoholism. 5. Alcoholics with a criminal record showing marked anti-social trend. 6. Individuals with definite intellectual retardation, specifically those with a Binet-Simon test record score

below 70. 7. Individuals diagnosed as having a functional psychosis, e. g., manic-depression or schizophrenia, associated with chronic alcoholism. 8. Patients with alcoholic psychoses of the more chronic type, specifically Korsakow's psychosis; alcoholic hallucinosis; alcoholic deterioration; alcoholic paranoid psychosis. 9. All individuals readmitted with chronic alcoholic psychoses before the beginning of this study. 10. All females, because of their relative scarcity—they were in proportion of one to seven. 11. Inadvertently a considerable number of patients were not located, as they had moved out of town or could not be contacted because of other change of address.

It is interesting that only one former patient had to be eliminated because of failure to cooperate.

It may reasonably be assumed that those individuals who could not be located would not have bettered the statistical results, inasmuch as the mere fact of their being transients is usually indicative of a poor social adjustment and would justify, in general, poor prognoses.

It is possible that the mechanisms underlying patients' admissions to the hospital play an important rôle in affecting the selection of cases. It is logical that admission under coercion would militate against recovery. The size of this series prohibits effective control of this factor.

Method of Study

The sources of material for this study were the charts kept on the patients during their stay in the hospital. Although several of them had more than one admission, this factor did not affect the conclusions, but only supplied more complete records of those patients. The hospital record included a history taken by a psychiatric social service worker from the closest available member of the family; the mental status and physical examination done by a staff physician; laboratory reports; nurses' notes on behavior in the hospital and a transcription of the staff meeting held on each case.

In addition to this longitudinal and cross-section study, there is included a followup interview held approximately four years after discharge from the hospital. Wherever possible, this followup in-

terview was conducted with the patient himself, otherwise with the nearest relative available. In many cases, outside sources such as a probation officer, family lawyer, or physician, or employees of the hospital who were acquainted with the patient, enriched the routine study.

A questionnaire as developed from a number of sources, was used as the basis for a rather extended test, self-administered by each patient. The questions were graded from a nonemotional to an emotional content, and several questions were framed in an effort to detect deterioration and intellectual dishonesty. This method did not seem to give the information desired in a trial of six patients—not included in the series reported here—and the questionnaire was, therefore, discarded.

The shorter "topic type" of questionnaire was then utilized as the basic outline for an interview which was planned to require about an hour. An effort was made to guide the interview as a friendly conversation and to couch questions so that the critical and indifferent questions were difficult to differentiate. The subject was assured that anonymity would be guarded, and the introductory remarks were planned to relieve any guilt feelings and even to make existing alcoholism unimportant in respect to the interview. Thus: "We of the Psychopathic Hospital are trying to better our service and to get an evaluation of it by a few of you who were in the hospital for a period, but were not mentally ill." The problem of drinking was avoided at first and made to appear bit by bit as the conversation developed. The individual case record was first correlated with the material of the interview and subsequently organized into a coherent whole, with every effort made to keep the interviewer, his opinion, and feeling of condemnation or praise isolated. The matters about which questions were asked were not presented in the form which follows or in any stereotyped form. It must be emphasized that they were merely the basis for the interview. They are outlined for the interviewers'—and the present reader's—convenience.

OUTLINE FOR INTERVIEW WITH PATIENT

1. Marital status.
2. Type of work four years ago and now.

3. Did your hospital stay help you? Temporarily? Permanently?

4. Which helped most—rest, being separated from your old acquaintances, talks with the doctor, work in the hospital, baths etc.?

5. How long did you leave drink alone after you left the hospital?

6. How many times have you "sworn off?"

7. How many sprees a year, four years ago and this year? Length of the sprees?

8. How many jobs since you left the hospital? The average time lost per month four years ago and today?

9. Polyneuritis—numbness, tingling, cramps in arms or legs?

10. Were you ever knocked out by a blow on the head?

11. Family history—relative with mental illness, in State hospital, queerness, habitual drinker?

12. For how many years have you been drinking? When did you first begin to take a pick-me-up? What do you find the best morning-after drink?

13. When was your first real drunk?

14. Why did you first start drinking?

15. What do you think causes the urge now?

16. Do you think you have an adequate reason for drinking?

17. Where do you drink?

18. Describe an ideal drunk.

19. Do you usually start out planning to get drunk?

20. Do you like to be alone? Have a few close friends?

21. When drinking, are you apt to become friendly with strange women?

22. When drinking, do you like to talk about sexual matters?

23. Do you have severe "guilty" feelings after a bout?

24. Do you consider your drinking an evil or a weakness?

25. Have you had the "D. T.'s," snakes, fits?

26. What has helped you to decrease your drinking?

27. What has prevented you from stopping your drinking?

28. Has religion helped or hindered?

29. Have you found any substitute for drinking? Other drinks, foods, sweets?

30. Does your family back you or are its members opposed to you?
31. How do your friends treat you when you are drinking?
32. Do you think you can take it or leave it after the first drink?
33. Do you think yourself a failure in life?
34. In what club, association, or social group are you interested or active?
35. Do you think that people are often unfair to you?
36. Name one big worry, fear, problem that you face now.
37. What are your plans for the future?
38. Do you envy the moderate drinker?
39. Do you have periods of depression—elation?

THE APPROACH

In testing the material obtained, the technique of factor analysis was considered inadvisable and probably misleading, inasmuch as the past records were sometimes incomplete and were taken from interviews and reports by various persons. Furthermore, many factor analyses have been made on far larger series; and the conclusions reached were not of much importance in leading to more rational treatment.

A specific effort was made to evolve what has been called the "trend approach." This effort at correlating the available information into a panoramic view of the patient undoubtedly has many faults, but it was used here in an attempt to visualize the individual and his problem in the light of his background and his present situation. By this method, each individual record was the basis for certain generalizations and predictions. These generalizations and predictions are valid only in each specific instance, but, as valid in such instances, they represent experimental data.

There is an avowed use of personal feeling in the evaluation of what the patient and relatives have to say and the interviewer's formulation of this. Obviously, it must be admitted that the personal equation is present. Yes, it must be insisted that it is paramount. A mere mechanical recording of even an ordinary conversation carries little of the meanings with which looks, gestures, surroundings, tones of voice, and subtle inferences enrich the mere words—and these interviews were no ordinary conversations. On

the other hand, much effort was directed toward keeping the interviewer neutral and his feelings out of the field of force. He was interested, and only that.

Findings

Of the original 158 cases studied, all were eliminated except 81; and, of these 81, accurate followup information was available on 26. Of this number, 15 (or 58 per cent), were interviewed personally; in eight cases (or 31 per cent), it was possible to talk with relatives of the first degree; and in three cases (or 11 per cent), information was obtained from other sources only.

The present adjustment of the 26 was: eight (31 per cent) improved for the four-year period; two (8 per cent) improved for a shorter period; 12 (46 per cent) relatively static or worse; two (8 per cent) addiction relieved but adjustment poorer; and two (8 per cent) deceased.

Case Studies

Case 1, *D. G., Aged* 38

The Record Says: D. G. was an excellent business administrator, although he had only two years of college before his marriage necessitated his leaving. His older brother felt that the mother had "spoiled" D. G. He was first seen in 1932, and the history states that he had been drinking hard for eight years, or since two years after his marriage. His expressed reason for drinking was his wife's infidelity; but it is probable that she had contracted her gonorrhea and syphilis from him. She had obtained a divorce on the basis of adultery in 1931.

In the past four years, D. G. had lost several good positions and was involved in automobile liability suits resulting from three accidents while driving. Most of his drinking was done with a crowd at a third-rate hotel. D. G. paid the bills. After release from the hospital, D. G. adjusted rather nicely for seven months, only to "take up" first with a "loose woman," and later with a male ex-convict, to each of whom he gave large sums of money while in a state of chronic intoxication. His second admission, in 1935, during an attack of delirium tremens, was an effort on the part of the brother to stop payment of some of the checks signed to the ex-convict. Three months after this hospital period, it was discovered that the patient was drinking heavily again.

Four-Year Followup: During the interview, it was revealed that the patient was not remarried: "We men stick with men." He said that he had

never had any desire to stop drinking, and "when I'm drinking I go with men I wouldn't speak to if I was sober." This is in direct contrast to his earnest protestations on both admissions and his three signed pledges "never to touch another drop." Asked concerning his plans for the future, he definitely promised to "keep drinking" but swore that he really had no desire to drink. He feels that men drink to: (1) lower their moral standards; (2) escape unpleasant reality; (3) celebrate happiness or drown trouble; (4) relax; and (5) stop a blue spell.

Conclusions: Intellectually superior, D. G. is emotionally hopelessly juvenile. The maturity demanded by marriage had only aggravated his addiction; and, in protest against inhibitions, he became more promiscuous. That this bit of heterosexual activity was in protest against his inherent homosexuality, is supported by his drinking habits and by his statements at the interview. His spontaneous discussion of why people drink undoubtedly reveals much of his own motivation and he appropriately puts "first things first." It is felt that he is showing early moral and ethical deterioration.

Case 2, *C. J., Aged* 42

The Record Says: The oldest of six boys and four girls, C. J. is said to have never been allowed by his mother to stand on his own feet. The father was a brilliant but unstable inventor of quite some note. He died in 1920 when the patient was abroad. The family did not tell him because "he might be upset." The mother is kind, generous and affectionate. The patient went to a military preparatory school and had one year in college. Then he spent a year as United States attaché at the capital of one of the Balkan states. He was very popular at school and as an attaché, as he was a brilliant conversationalist and an accomplished pianist.

C. J. began drinking heavily when in the diplomatic service. He returned from Europe after one year "because the family needed him," but soon rejoined the service as attaché in a South American country. One year later, when the embassy was bombed, his mother insisted that he give this up. He has worked steadily since then, selling school specialties in the New England states. In 1928, he married an attractive, stable, childhood friend, who was like the patient in being very fond of night life. She describes him as likable, egotistical, but apt to "strut and pose," and dates his heavy drinking as of 1933. Both C. J. and his wife relate his later drinking to financial stress. On the first admission, the patient had a typical case of delirium tremens and, of course, swore never to touch "firewater" again. He returned two months later, blaming this bout on a fight with his wife and her desertion of him.

Four-Year Followup: An extended interview with his mother, a kindly but dominant person, revealed that C. J. stayed away from alcohol for one year after his discharge, but had been drinking as hard as ever since then. The mother feels that his marriage was a failure from the start as C. J. had never gone out with the same girl twice. According to the mother, the wife was sickly and a nagger; and both of them were unfaithful. She further stated that C. J. probably started this. "He keeps going back to her but there's always trouble. I find it best never to have anything to say." Whenever C. J. lives at home, he stays sober; and after each spree he comes to mother crying, depressed and full of promises. His philosophy of life is, "Mother's the only friend I have in the world."

Evaluation: The oldest child is often firmly bound to his family and controlled by it. C. J. was taught to expect babying; and, in adulthood, he used alcohol in revolt against the realization that the world didn't exist for his pleasure. Never able to form new bonds of loyalty, he kept asserting that he was masculine and dominant in the Don Juan manner. It is noted that his pathological drinking grew out of a social situation where drinking was important. Yet, C. J. could adjust to life when at mother's side.

Case 3, *J. O., Aged* 45

The Record Says: The patient is one of a family of nine, with two paternal uncles in mental hospitals. His history is one of heavy drinking for 10 years. Although he has been married for 20 years, there are no children. J. O. was said to be a good mixer with a host of friends, "high-strung," selfish, stubborn, and generous with all but his family. Although an alcoholic for years, it was only since his partnership venture in running a saloon, one year before admission, that he had been intoxicated almost constantly and had become increasingly abusive of his wife. Before admission he had threatened her and had denuded himself in public. His wife had been supporting their home for several years.

Four-Year Followup: In the interview, it was revealed that J. O. had sold out to his partner shortly after his discharge from the hospital. He had done little or no work since and had been supported by his wife, who said she did not mind this. He had been restricting his drinking although he had never "sworn off." He showed no evidence of deterioration or recent alcoholism. The wife estimates his drinking at "three beers a week."

An interview with an acquaintance confirmed the fact that J. O. has not at any time drunk to excess since the sale of the saloon.

Evaluation: The existence of an inherent predisposition is seen to be a more logical possibility here than in most individuals. That the defect is severe was thrown into prominence in the followup visit. Well-dressed and

at his ease in their lovely apartment, J. O. was a "kept" man and resented it not at all. The change from alcoholic addiction to limited drinking is a rare one and is evidence that the situational factors were strong in the exacerbation and subsidence of the pathological phase.

Case 4, *M. H., Aged* 49

The Record Says: His father died three days before the patient's birth. The mother remarried when the patient was nine years old. The stepfather was a heavy drinker. M. H. was first a house painter, then an interior decorator. He is characterized as seclusive, selfish and cocksure. He has partial deafness on the left, as a result of being hit by a baseball in his youth. His marriage at the age of 25 was a success for 18 years, although in his traveling around the country he consorted with many women. In 1928, he found his wife guilty of infidelity; and he never forgave her, even though he lived with her for several years before she succumbed to cancer.

The patient had been drinking for years, but only since his mother died in 1932 (in a mental hospital diagnosed as psychosis with cerebral arteriosclerosis) had it been beyond his control. He had become manager and part owner of a saloon and restaurant. During the past two years, he had insisted that he was a victim of undiagnosed tuberculosis. He sold his interest in the saloon to pay for a gallbladder operation in 1934 and more recently had refused to work. Some time later, he returned, tried to fire all the employees, and then threatened suicide. His fellow bartender said he had used about a quart of whiskey a day for 20 years and had done no work for two years before hospital admission in 1936.

Four-Year Followup: At the present time, M. H.'s seclusiveness and deafness make him resistant to discussion of his method of self-cure, but it is agreed by several of his associates that he has never drunk during the years following his hospitalization. He lost all his investment in the saloon and considerable in savings. Now, since his release from the hospital, he has been a regular employee in the saloon which still bears his name, and he seems quite proud of his position. The writer talked with him on three occasions, but he insists there was no reason for his stopping drinking, nor did he want to speak of his hospitalization.

Evaluation: It is obvious that many factors tended toward the alcoholic addiction. Identification with an alcoholic stepfather probably was unusually strong, inasmuch as there was no father surrogate until the age of nine. Dependence on the mother's guidance was so complete by then that his own marriage was never a success, inasmuch as he was promiscuous. The discovery that his wife was not "pure as mother" made the relationship un-

tenable, yet it was mother's death that precipitated his deeper addiction, hypochondriasis and almost a paranoid psychosis. Deafness is often a background for suspiciousness. In this individual, this suspiciousness and alcohol's availability, were important factors.

It is a difficult matter to explain why, as an employee of a saloon and with little that usually means security and self-respect, M. H. is totally abstinent. Freedom from an obnoxious, duty-bound marriage and from the responsibility of a business probably contributed but the basic factor may have been fear of an illness such as his mother's.

Case 5, *C. S., Aged* 40

The Record Says: C. S. was admitted to the hospital for three weeks in 1931 with a history of periodic drinking for many years and continuous drinking for one and one-half years. The incident causing admission was a short period of fearfulness, apparent hallucinations and several half-hearted attempts at suicide. C. S. asserted that overwork was the cause of his drinking. He was readmitted for two weeks in 1935 with a history of five months of abstinence in 1931 after the previous admission and, then, increasing addiction, with a recent episode of fearfulness, apparent hallucinations and an effort to cut his throat with a razor. Many of his recent sprees had been associated with periods of amnesia. During the bouts, he was belligerent, destructive and threatened suicide. There was no family history of mental illness, but his father was a severe alcoholic.

Four-Year Followup: At the interview, the patient was friendly. He said he had been a periodic drinker since 1917, that he always drank with the crowd and that it was hard to take only a few drinks. He was highly susceptible to alcohol, felt liable to periods of depression and then wanted to be alone. This was associated with a self-pity reaction, and he drank to alleviate this feeling. There were no episodes of elation. Each bout left him with guilty feelings which were followed by a sense of increasing confidence in his ability to take one drink—or a very few, as others did. He had never wanted to surrender completely and be "subservient" to alcohol. He felt that the hospitalization had been helpful and, although there was no immediate effect, the statement made in the hospital that he was showing evidence of deterioration—and the evidence of deterioration that he saw in others—did make him hesitate. He was associated with a church and, during the months immediately following his release from the hospital, he had come to a gradual decision to make a public confession, which he did a year and a half ago. He asserts that there was no true emotional upheaval at any time, but that there has been present an increasing revulsion for all

things alcoholic during the three years of relative abstinence and the period of complete abstinence.

C. S. admits endless previous attempts to swear off, using religion and all other proferred helps, but makes much of the fact that his family has never really ceased believing in him or feeling that he was doing his best. They were never antagonistic. He is sure he cannot be responsible for his control after the first drink and feels that his interest in the church, as a social group, is important in his rehabilitation, and that religious interest may be a substitute for his drinking. He has had no depressed periods since his cessation of drinking.

Evaluation: The acceptance of the patient as he is becomes the groundwork for therapy here as it does in all true psychotherapy. This family was wise, and wise too, in cultivating social activity for this cyclothymic individual.

Case 6, *W. P., Aged* 29

The Record Says: The patient is the son of an industrious, quiet, stern father who drinks heavily. The mother died when the boy was eight years old and had a record of several arrests for alcoholism.

W. P. was characterized as easy-going, unobtrusive, and lackadaisical. He is submissive and does not hold a grudge, but since 1931 has become increasingly seclusive, shy, and even afraid of his family. He had always associated, when drinking, with an antisocial group; and, since 1929, he has been arrested eight times, including once for third degree burglary. All these arrests occurred while he was intoxicated. At these times, he is "mean," irritable and talkative. He was brought to the hospital during an episode of pathological intoxication following arrest for willful trespassing.

Four-Year Followup: Conferences with his attorney, and his father, reveal that he has been arrested repeatedly since release from the hospital for crimes committed while intoxicated. The attorney says, "after two drinks he is a kleptomaniac." The patient was released from jail again and disappeared two weeks before the interviews.

Evaluation: With such an environment during the formative years, alcoholism becomes as real a part of life as eating, and no effort to set a limit is taken seriously. A schizoid personality, W. P. expresses his hidden aggression while drinking and—possibly—thus prevents an actual schizophrenic psychosis. Alcohol, it seems to the writer, preserves the integration of a badly-balanced personality.

Case 7, M. M., Aged 24

The Record Says: He was the sixth of eight children. The parents were respected members of the community. M. M. is said to be "outgoing," a leader and a person who enjoys the company of members of his age group and of both sexes. He is quick to lose his temper and overly frank. At the oldest brother's death, he had an episode of convulsions. The patient had become irritable and resentful of criticism for about one year before admission. More recently, he had begun working for his father. Shortly after starting this work, he told his sister he was married and then left home. On the night of admission, he had taken three drinks and, according to companions, had talked to trees and had the delusion that he was being followed. He said that he wished his father were dead. M. M. had a convulsive seizure a few minutes before admission and was threatening and abusive in the hospital. At one time he said he would commit suicide if he was not released at once. He was released against advice after a three-day period.

Four-Year Followup: At the time of this interview, M. M. came with his father and brother. Their story seems to indicate that he suffered from a severe depression at the time of the brother's death, associated with much crying, refusal to eat, and repeated fainting attacks. He married two years after the hospital admission and now works as a machine operator. He says that before hospitalization he drank to be sociable with his girl, but all are agreed that he has not touched a drop since his release from the hospital.

Evaluation: This is one of two cases, seen in this study, of alcoholism cured by hospitalization alone. M. M. is literally scared to drink since his attack of delirium tremens. Although his alcoholism was not severe, it depicted a psychiatric entity—a reactive depression. The factor of age undoubtedly contributed to easy modifiability or negative conditioning, if it is permissible to use the term.

Case 8, T. B., Aged 35

The Record Says: T. B. had been employed as a chauffeur since he was 18. Always a moderate drinker, T. B. had been heavily alcoholic since 1932 and the onset of the depression era. Neither of his parents approved of drinking. On his first admission to the Syracuse Psychopathic Hospital, he was charged with having assaulted a priest; and he had been previously arrested for indecent exposure while drinking. His second admission was after another arrest for indecent exposure. At neither time, was he considered psychotic. After the first period in the hospital, he had taken a pledge to the priest whom he had assaulted and had kept it inviolate for the

promised year. Then he had tried drinking in moderation and had failed. During this last hospital stay, he promised to cease drinking forever.

Four-Year Followup: At the time of the interview, the patient was friendly, cooperative and talked easily. He said he had been drinking moderately for a time, as he did before his second hospital stay. Both he and his wife said that he had never lost a job because of alcoholism, although he had been on welfare off and on for several years. He now is employed in operating an excavator and enjoys his work although it is somewhat irregular. He and his wife agree that his pathological drinking began with loss of employment in 1932, that he drinks only with a crowd of pals, and that he is least depressed if in the midst of a group. He has made numerous attempts to stop drinking, but never successfully for longer than two weeks, during which time he drank quantities of nonalcoholic beverages. Each time, he comments that he convinced himself he was now able to take an occasional drink. When he tried this, he lost all control and drank on. He gives much credit to his wife who, although she at first nagged at him, later tried to disregard his drinking.

He stopped drinking, he said, because of the gradual increase of amnesia for the events of his bouts and the increased realization that he was in worse condition than any of his companions. This was a year before the interview. At that time, after a severe bout, he began to avoid alcohol and, coincidently, began to raise canaries. This hobby soon developed into a strong interest and at the time of the interview, M. M. had 27 birds in a room in his home. The old tumble-down house was being replastered and renovated. He said, "I am convinced I can have as good a time without drinking with my pals, and the longer I stay sober the better I feel. I never knew it was possible to feel so good and enjoy living so much." After staying away from the saloons for two months he visited them to see if . . . He was successful, and now rarely goes even to visit.

Evaluation: M. M. is a person of marginal adjustment who, with the added strain of the loss of employment in 1932, made alcohol a part of his compensation. He would be called a "reactive" alcoholic. The appearance of crime against authority and sexual eccentricities are frequent in these persons. It is noteworthy that he credits his present remission to a tolerant wife, quantities of nonalcoholic beverages, fear of slumping, and interest in an avocation.

Case 9, *A. T. B., Aged* 50

The Record Says: The patient is the son of a stern physician-father who died when he was 11. His mother was a gay, indulgent parent who took him on yearly trips to Europe after the death of her husband whom she

had bitterly resented. A. T. B. was rejected by both his brothers at an early age. Until his mother's death he wrote to her daily if he was away from home.

His early life was uneventful, except for an operation for scrofula just before his father's death. This led the father to state that no one with that condition ever lived past the age of 30. At 16, he began drinking; but it was not until 1932 that he felt the need of a "pick-me-up." When intoxicated, he is depressed, anxious, and agitated, and at the time of hospitalization, he was suicidal. Although he is naturally sociable, his drinking is done alone. In more recent years, he had been hospitalized several times and had been operated on once for bleeding peptic ulcer. Warnings about the effects of alcohol were to no avail. His mother had been most beneficent, but the depression had decreased both their incomes to a pittance. At the time of admission, the patient had lost his excellent position as a sales manager for a large store.

A. T. B. married at 30; and, although his marriage was said to be congenial, the patient had suspicions of infidelity—entirely unfounded. During the patient's second admission, which differed not at all from the first, his mother died. This, of course, had a profound effect upon him. The admission had been preceded by two unsuccessful positions. During the first six months after his previous release from the hospital, he did not drink; but his control gradually decreased, and, supported by large quantities of paraldehyde, he had "kited" several small checks. This precipitated a suicidal attempt, followed by admission to the hospital.

Four-Year Followup: At the interview, in his pleasant, comfortable home, the patient and his wife said that he had not taken a single drink since this second release from the hospital. His prehospitalization history of positions held included jobs in investments, insurance and business, all of which he hated, and which both he and his wife felt had tended to bring on more drinking. Two years before the interview he had started in the roofing trade and is very certain that the long hours of hard work helped his abstinence. He is sure that the prayers of his friends and the threats of his family had no effect. Although drinking started as a social function, he volunteered that his mother's indulgence was "the worst thing anyone could do, and that had most to do with my lack of self-control." A severe head trauma with a lengthy period of unconsciousness in 1928, had decreased his tolerance; but neither that nor a severe attack of polyneuritis caused more than a few extra efforts in the countless number he made "to swear off." It is notable that he had always been disgusted with anyone who drank, and that drinking had no noticeable influence on his home life. Basically, the hospitalization gave him time to think and he became a

"fanatic"—"in that I can't ever take a drink. I feel I could go out and drink with anybody; but I wouldn't be fool enough to."

Evaluation: Here again, an indulgent mother and rejecting father provided a poor *milieu*. The conflicts created by A. T. B.'s dependence on mother and the emasculation which this produced were dramatically solved during the hospital stay, and even the patient recognizes the causal relationship. The tolerance of his wife, the feeling of power in physical accomplishment, and the development of an emotional rejection of alcoholism all serve to perpetuate the results of the "shock treatment" of his mother's death.

Conclusions and Generalizations

Generalizations from such a study as this are likely to be "Jerry-built" and on an inadequate foundation. The factors are numerous. Predictions usually prove that they shouldn't have been made on the basis of a few cases, for individual alcoholics vary so widely. Therefore, the writer has held to the naïve view that each patient is an individual; and his record is not valid unless taken alone.

It appears from a study of the period spent in the hospital and its results that the generally supposed ineffectiveness of a short period of hospitalization for chronic alcoholics is confirmed. Subjectively, patients preferred different features of the hospital experience. A few felt that the hospital had been of permanent help to them; many that it had been of temporary value; and there were only two who felt it had helped not at all. There was no significant trend or factor which those who had improved felt had contributed to their improvement. However, it is obvious that subjective feelings about hospitalization were influenced by the conditions which took the patients to the hospital and were associated with their releases and with imponderables which could not be controlled four years after release from the hospital. It is possible that enforced hospitalization, which this was in many cases, not only does not—as a rule—solve such personality maladjustments as characterized these alcoholics, but actually makes them more conspicuous and throws conflicts into bolder relief.

A summary of what conclusions and generalizations it has seemed possible to draw from this study may be attempted here:

I

Uncontrolled alcoholism is a syndrome, representing a successful "blackout" of reality, or, in contrast, a "revolt" against conforming to reality.

II

A surprisingly large number of the individuals studied, although not diagnosed psychopathic personalities, showed psychopathic traits of wide variety and profound character.

III

It is noteworthy that not one patient was seen who felt he had a legitimate cause for drinking or one whose addiction developed from an effort to relieve pain.

IV

A specified period of pledged abstinence affords, at its termination, a basis for rationalizing a readdiction.

V

It is presumptuous to expect any dramatic change in a habit pattern of many years duration to be brought about by a few weeks of hospitalization, even with intensive therapy of any type which may be selected, and few, if any, hospitals give intensive treatment.

VI

Classification is the basis of all prejudice and, as such basis, produces a selective blindness in understanding and treating the individual who is addicted to alcohol.

VII

Treatment is fundamentally an interpersonal relationship between the therapist and the patient.

VIII

This small series illustrates many of the common fallacies in the effort to "cure" an addict. Emotional pleas, reform marriages, rewards, punishments and use of "will power" are all empty ges-

tures. Even the knowledge of physical or mental dilapidation is not enough. Most medical treatment techniques also seem to be nearly as ineffectual. Physical rehabilitation, rest and countless supportive and suggestive methods are all ineffective in most cases, when they alone are used.

IX

In the present series, these factors appeared to militate for improvement: (A) An *emotional shock* with a true perception of the relationship to alcoholism, e. g., death of a relative during a patient's "spree," or involvement in a serious misdemeanor. (B) A new *fusion to reality,* e. g., a hobby or social alignment through organized group activities. (C) A new sense of *security,* e. g., a better job, the development of more satisfactory interpersonal relationships or a new relationship to the infinite. (D) A deeply imbedded *fear* of impending somatic breakdown, e. g., gastritis or mental deterioration. (E) A growing *realization* of the suffering caused to someone who still has faith and confidence in the alcoholic. (F) A *reaction of guilt* after recovery from a debauche. (G) A better *integration* of personality by the acceptance of greater sense of responsibility over a period of time. This must be carefully regulated to insure success. (H) A *substitute* for the physiological need, e. g., carbohydrate intake; nonalcoholic drinks; other oral activity. (I) *Psychotherapy.* This word is used in the broadest implication of the term, whether the therapeutic endeavor is by a professional worker, religious worker, member of the family or an erstwhile problem drinker now turned therapist. Psychotherapy usually must continue over a long period.

Theories

Questions and Concepts for Future Evaluation and Possible Utilization in Treatment

1. Is it not true that so-called social drinking is chemotherapy for the drinker, because of maladjustment between the still almost primitive individual and an environment which is evolving at a fast pace? All chemotherapy endures some fatalities.

2. It is possible that an emotional shock arising from a life situation may act to change habit patterns of living—as it seems to do in the alcoholic habit—in a way similar to that of the shock therapies (metrazol, insulin, electric shock) in the major functional psychoses.

3. Is it possible that abstinence should not be the aim in treatment? The real defect is in emotional maturity and integration. Why not kill the ogre by attrition? Negativism grows with opposition.

4. It is felt that the study of alcoholism, by this panoramic or psychobiological approach, may furnish information which cannot be obtained by the use of biochemical, physiological, or statistical studies with their fixation on the objective experimental approach.

5. Clinical progress then should proceed through an attempt to concentrate for study, not on single factors as the sole basis for the pathology, but on the refinement of the "field survey," and by increasingly detailed study of the series of events leading to individual alcoholism and of the field situation at the time, including the personality in cross-section and the field of force acting thereon. The present study is an attempt to provide a group of field surveys but without that emasculated "composite individual" whose vacillating character does little to illuminate the problem.

Summary

In a study of 158 alcoholics, of whom 81 were considered at the time of the study to be cases "without psychosis—chronic alcoholism," and without complication, adequate followup information was procurable four years after hospitalization on 26 patients. An impressionistic evaluation of each case of this group of 26 is the basis for certain generalizations and predictions; and case studies of nine have been presented here. Beyond that, the writer has also ventured to hypothecate from limited experience.

Forty-seven per cent of the 26 patients showed a definite improvement in drinking habits. This is in marked disagreement with most prognostications. Inasmuch as these patients were considered extreme types of alcoholics, this makes further investigation even more desirable.

The writer unashamedly acknowledges the inadequacy of the material and the premature tenor of the conclusions and hopes only that they will interest others to the point of making more exhaustive efforts.

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