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ANALYSIS AND COMPARISON OF THREE TREATMENT MEASURES FOR ALCOHOLISM:

ANTABUSE, THE ALCOHOLICS ANONYMOUS APPROACH, AND PSYCHOTHERAPY*

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In 1935 I joined the staff of the Institute of the Pennsylvania Hospital, and with the generous support of the senior staff members endeavored to work out a treatment plan to be available for those seeking help for acute problems. This plan had the then unique characteristic of being a positive, rather than a negative approach. By and large, at this period, most treatment consisted of the facilities offered by rest homes and "cures", where the whole emphasis was placed on sobering a man up. Temporary sobriety having been achieved, he was then discharged with little or no understanding of himself or his problem.

Dr. Edward A. Strecker, who held the Chair of Psychiatry at the University of Pennsylvania, collaborated with me in writing ALCOHOL: One Man's Meat, published in 1938. This book, because it presented a positive treatment plan, had the effect of stimulating a more optimistic approach toward the problem, and we were deluged by requests for help. We did not have the necessary staff, facilities, nor the economic support that would have made help available for all. Fortunately, the Alcoholics Anonymous movement became active at about this time, and has contributed a great deal of help for many alcoholic addicts who could not have received it in any other way.

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In 1949, Antabuse was introduced in our country for controlled study, and in 1951 it was released to the medical profession. This release was introduced in part by the following paragraph:

"Antabuse, the drug that builds a 'chemical fence' around the alcoholic, is now available for general prescription use in the fight against the Nation's number one emotional disease."

In sequence, then, we see three positive approaches, each of which was met by great optimism on the part of the public. This optimism has been tempered by the sobering fact that each one of these approaches had, along with successes, many failures, and did not live up to the hope engendered by wishful thinking. This does not mean that Antabuse should be discarded as a treatment measure because there are failures, and sometimes fatal failures; nor does it mean that those who fail to respond to the Alcoholics Anonymous group movement indicate that the A.A. is not a helpful measure; nor again does it mean that psychotherapy should be discarded because it, too, has failures. There are in the United States a number of treatments other than those we are discussing. Dr. Abraham Myerson points out: "The treatment of the individual case has at this time some twenty varieties, ranging from Alcoholics Anonymous and frank religious exhortation to spinal fluid drainage, benzedrine sulfate and the conditioned reflex, not forgetting psychoanalysis, psychotherapeutics, and shock therapy." Add to this the many advertised cures in sanitariums and health farms, and one sees how bewildering the burden of choice can be to the patient or his family seeking help.

Let us first analyze Antabuse as a treatment measure. Bear in mind that it was introduced as "the drug that builds 'chemical fence' around the alcoholic." We must first ask ourselves: what about the individuals who do not wish a fence built around them, and is it always wise to do so? In reference to the first group, who do not wish to be protected, there is in the United States not a legal statute to enforce this means toward total abstinence.

In connection with this point whether or not it is always wise to build a chemical fence around the alcoholic, my associates, Dr. Edward A. Strecker and Dr. Vincent T. Lathbury, have discussed two patients in whom the experimental use of Antabuse was followed by a psychotic reaction. A like reaction was discussed by Dr. 0. Martensen-Larsen, and more serious effects by Dr. Erik Jacobsen of Denmark.

Dr. Jacobsen says, in part, that the "effective deprivation of alcohol without adequate psychotherapy can be just as dangerous as the untoward effects of disulfiram." In the same article, Dr. Jacobsen reports that there were 17 fatal cases following treatment with Antabuse among 10,000 patients. Of this total, he cites five cases of death were due to sudden, unexplained causes. Deaths following the administration of Antabuse are cited by R. 0. Jones, M. C. Becker and G. Sugarman, and D. M. Spain, V.A. Bradess and A.A. Eggston. I am quoting only in part from the available literature dealing with such unfavorable reactions.

Briefly, then, we have three contraindications to the use of Antabuse. First, there are those who refuse this treatment; second, those who may develop a psychotic reaction following the treatment; and third, those to whom the treatment may be fatal. Let me add a fourth risk, perhaps the most important; namely that the indiscriminate use of Antabuse on a group of patients most apt to respond to psychotherapy might interfere with or even block their potential accessibility to psychotherapy. Experience with patients who have had previous treatment with Antabuse shows that they have often resented this treatment and discontinued it. As one of them expressed his attitude to me, "I found that my reaction to

alcohol after the Antabuse treatment was terrifying. Therefore I was pretty sure to take no more Antabuse." Several patients have told me that while taking Antabuse they found that a very little alcohol plus the Antabuse reaction gave them a desirable result of intoxication.

On the other hand, medical literature is full of successful results obtained by the administration of Antabuse. One patient of mine, a woman of 65, asked for the Antabuse treatment two years ago. My associates, Dr. Kenneth Appel and Dr. Alexander Vujan, after careful tests, administered Antabuse, and this woman has since then made a much better adjustment. We recommended follow-up psychotherapy, which was not accepted. Without such follow-up therapy, we can only guess as to why the Antabuse worked. This woman was highly intelligent, with a strong indication of psychoneurotic nucleus. She came from a protected walk of life. Later on she encountered more than her share of tragedy. The death of two husbands during her young womanhood probably augmented an already established unconscious feeling of rejection. The insidious sway of her addiction held fast through middle life. Now her grown children were repeating the pattern of rejection because of her addiction problem. At this psychologically important moment we supplied, via the Antabuse treatment, a way to make alcohol actually reject her even more severely than did reality from her neurotic viewpoint.

In 1939, the Alcoholics Anonymous group movement published their book Alcoholics Anonymous. It received a tremendous amount of publicity because of the enthusiasm of its members, plus the fact that it had a very understandable popular appeal. In the forward of this book the writers remark that they wish to show other alcoholics "precisely how we have recovered," and they state. "We are not an organization in the conventional sense of the word. There are no fees or dues whatsoever. The only requirement for membership is an honest desire to stop drinking. We are not allied with any particular faith, sect, or denomination, nor do we oppose anyone. We simply wish to be helpful to those who are afflicted."

Since this book was written, groups of Alcoholics Anonymous have formed in all the large cities of the United States, and in many of the smaller towns. As a movement it has a strong similarity to religious conversion. They state in their book:

"The great fact is just this, and nothing less: that we have had deep and effective spiritual experiences, which have revolutionized our whole attitude toward life, toward our fellows, and toward God's universe. The central fact of our lives today is the absolute certainty that our Creator has entered into our hearts and lives in a way which is indeed miraculous. He has commenced to accomplish those things for us which we could never do by ourselves."

I have gathered from talks with many of the group that the spiritual experience does not always take place, but that even without this experience some are successful in refraining from drinking. With or without the religious experience, members have a very deep sense of Cause, and each becomes an Apostle for this Cause. They insist that members attend weekly or bi-weekly meetings, at which meeting novices hear ex-alcoholics recount the misery of their drinking history, and how they had hurt all their loved ones, but how, now, with the help of the Alcoholics Anonymous group they are no longer hurting those they love, and are happy and successful without alcohol. They recommend twelve steps in their program to recovery:

"1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual experience as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."

I understand that you have similar groups in Great Britain. I believe that they work with the same principles as Alcoholics Anonymous in the U.S.A. In the States some of its appeal is because of the go-getter attitude contained in its emotional approach. It savors of the credo of the American success story, and it is colored by the aggressive streamlined glamorization so woven into American custom. My experience with members of this group has been that the successful

men and women are those who have made A.A. the most important thing in their lives. They devote a tremendous amount of time to discussion of Alcoholics Anonymous work, they attend meetings regularly, and are willing, at great inconvenience to themselves, to be called out to administer to one of their group who has fallen, or to call on some drunkard in order to persuade him to seek their help. Let me briefly try to analyze some of the aspects of what they have to offer.

Most of those who become members have gone downhill quite far. In fact, many A.A. members say you have to "hit bottom" before you are accessible to their movement. These men and women, due to their abnormal drinking lives, have by and large lost their normal friends and their contact with society. They are lonely, isolated by their addiction problem. To be welcomed again in an uncritical group, where their past alcoholic history can be worn as a badge of honor, provided they recover, must give them a tremendous emotional lift in re-establishing contact with other human beings.

All of us who are interested in the vast problem of mental hygiene owe a debt of deep gratitude to the circumstances that presented this movement at this time. The group is keeping many men and women sober, who otherwise would be cluttering up our jails and our mental hospitals. They are relieving psychiatrists of an already intolerable load, and most important, this approach is keeping many men and women from destroying themselves and crippling their families irretrievably.

With all due credit for A.A.'s valuable work, some of the more fanatical members bring to mind a sketch written by the American humorist, James Thurber, entitled, The Bear Who Let It Alone.

"In the woods of the Far West there once lived a brown bear who could take it or leave it alone. He would go into a bar where they sold mead, a fermented drink made of honey, and he would have just two drinks. Then he would put some money on the bar and say, 'See what the bears in the back room will have,' and he would go home. But finally he took to drinking by himself most of the day. He would reel home at night, kick over the umbrella stand, knock down the bridge lamps, and ram his elbows through the windows. Then he would collapse on the floor and lie there until he went to sleep. His wife was greatly distressed and his children were very frightened.

"At length the bear saw the error of his ways and began to reform. In the end he became a famous teetotaler and a persistent temperance lecturer. He would tell everybody who came to his house about the awful effects of drink, and he would boast about how strong and well he had become since he gave up touching the stuff. To demonstrate this, he would stand on his head and on his hands and he would turn cartwheels in the house, kicking over the umbrella stand, knocking down the bridge lamps, and ramming his elbows through the windows. Then he would lie down on the floor, tired by his healthful exercise, and go to sleep. His wife was greatly distressed and his children were very frightened."

About ten years ago, I was asked to read a short paper, "Emotional Immaturity in Alcoholics," at the Philadelphia General Hospital. This was followed by a talk given by one of the key men in Alcoholics Anonymous. He began his talk by saying that he agreed with me that all alcoholics were emotionally immature; hence they needed Alcoholics Anonymous to compensate for the deficiency of emotional maturity. This pointed out to me the outstanding difference between their approach and a psychotherapeutic approach; namely, that they accept the emotional immaturity, and supplied a crutch for it, where psychotherapy attempts to supply insight into the emotional immaturity, and helps the patient toward emotional growth and maturity as a necessary adjunct to abstinence.

One of the earliest papers on the subject of alcoholism that I have come upon was by Dr. Benjamin Rush, written in the early eighteen hundreds. He cites religious conversion as the only effective means of bringing about abstinence among his alcoholic patients. This phenomenon, I think, is explained in part by the extraordinary egocentricity we find in alcoholics, and this in turn leads us to uncover the omnipotent infant hidden behind the iron curtain of the unconscious, who is still dictating the personality, policy, and behavior of the patient. We see that these patients are in a way playing God. This highly disguised phenomenon was beautifully revealed in the William Saroyan play, The Time of Your Life. In religious conversion, one admits to an all-powerful God. Therefore the convert is forced to abdicate the throne, but in turn becomes God's lieutenant. This is an emotional growth step not always possible, not always wise, but where it works effectively and suffices to give a fractional degree of stability to the addicted personality, we should thank God for its occurrence wherever we encounter it.

Psychotherapy may include a great many different approaches and various disciplines and techniques. Alcoholics Anonymous might be described as a simple form of psychotherapy. Freudian psychoanalysis is considered by some as the only thorough approach to a non-addicted readjustment. This could be described as a very complicated and time-consuming psychotherapy. Because of the variant concepts of psychotherapy, I would like to outline briefly the type that we have found practical and effective with a certain group of patients.

"The first and often neglected step in the treatment of pathological drinking is a personality diagnosis. This diagnosis should be avoided during the intoxication symptoms and withdrawal symptoms. Even after a state of sobriety has been reached, the physician should delay opinion as to the best method of treatment until he has had ample opportunity to study the personality of his patient.

"The following classification can be employed advantageously in the clinic devoted to abnormal drinking if it is used in the spirit that Thompson suggests when he says: 'We have revised this classification to some extent, but we have altered still more extensively our application of it. Many individuals who are examined in this clinic we now regard as normal or average individuals with an exaggeration of some particular personality characteristic, rather than as psychopathic

personalities or deviates.' Even a glance at this classification makes clear how wide is the range of alcoholism. The classification is as follows:

A. Psychosis.

B. Borderline psychosis.

C. Mental deficiency.

D. Psychopathic personalities.

E. Neurosis.

F. Normal individuals with predominant personality characteristics:

Aggressive type.

Unstable type.

Swindler (hysterical type)

Unethical, sly, wily type professional gambler or 'con

man'; professional criminal of the planning, careful type. I think you have a slang word "Spiv" that describes the type.

Shrewd type.

Adolescent type.

(a) Adolescent immature type,

(b) Adolescent adventurous type.

Adult immature type.

Egocentric and selfish type.

Shiftless, lazy, uninhibited, pleasure-loving type.

Suggestible type.

A dynamic, dull type.

Nomadic type.

Primitive type.

Adjusted to lower economic level.

Personality adjusted to ordinary, average life."

We have found that the germ of alcoholism reaches far back into childhood and that most patients are suffering from unconscious feeling of guilt and rejection coming, usually, from these childhood experiences. We are beginning to see more clearly that drinking alcohol in itself did not create their problem. Rather it was their neurotic insecurity, which created their addiction. We see in the paranoid patient a tendency to project his personality discomfort outward, in the psycho-neurotic a tendency to project personality discomfort inward, and in the alcoholic a tendency to reach for a drug to anesthetize his personality discomfort.

We have found in the study of the personalities of those who consulted us that emotional immaturity manifests itself prior to drinking, and certainly we have found that emotional immaturity is ever-present in the emotional life of the abnormal drinker. "Man is but a child-born," and I doubt that in our civilization emotional maturity is a completely obtainable goal. When we talk of maturity, we talk of degree. In the abnormal drinker, emotional immaturity plus the addiction problem precludes emotional growth. We see a like reaction in the psychoneurotic, and we see, perhaps, in the psychotic a terrifying regression to the infantile level. Maturity, if we must attempt to analyze it, could be described as an individual's ability to deal with, compromise with, and sublimate the primitive infantile tendencies that exist in all of us. The alcoholic, when intoxicated, is on an infantile level. When sober, he is a very uncomfortable child in an adult body in an adult world.

I think we often see in the abnormal drinker an actor living a role of pretence that is fooling him far more than the audience. This actor has a complete misconception of the reality of himself. All he knows is that this reality is painful. He does not see that reality is painful because of his maladjustment to it. Having found that alcohol will induce a brief pleasurable fantasy of self; the abnormal drinker seeks more and more the escape mechanism of alcohol. Because such a patient appears to be normal to his family and the public when he is not drinking, the degree of his emotional maladjustment is not recognized by society, nor is it recognized by the patient. In the mind of the public and the patient the problem seems simple, i.e., if alcohol is destroying this man or woman's potentiality to live a normal, constructive life, then the answer is to give up alcohol. I think we can say that the majority of non-deteriorated and non-psychotic alcoholics want to get well. Despite the contradiction of oft-repeated drunken behavior, there is little doubt that somewhere within the mental recesses of the abnormal drinker there lies the desire to rid himself of his addiction. He wants to be normal, but he does not know how to start. To bridge the gap of understanding between the patient and those who want to help him we must first recognize and understand his conception of what constitutes normality. What does he mean when he says; "I want to get well?"

Mental exploration uncovers an apparent contradiction of sane thinking; i.e., normality is synonymous in the mind of the alcoholic with only one thing - drinking normally. He really believes he wants to drink in a normal way. Most patients give a history of repeated determination to drink in moderation, which attempt eventually ends in acute alcoholic episodes. This self-deception on the patient's part, of wanting to be temperate in the use of alcohol, should be discarded with the insight gained in psychotherapy. It is not easy for the patient to see that the one or two cocktails he thinks would suffice actually would be as unsatisfactory to him as one or two aspirin tablets would be to the morphinist awaiting his customary dose of morphine.

Therefore, in dealing with patients, we must realize that a mental condition exists which renders a normal response impossible. We do not tell our patients that they are normal and that all that is wrong with them is that they drink too much. If this were only true, everything would be so beautifully simple. We would only have to say, "Please stop drinking, and everything will be all right." Obviously if they stop drinking they will be more acceptable to society, but otherwise nothing has been accomplished toward curing the state of mind that originally sought escape from their personality discomfort by blunting this discomfort with alcohol. When the stream of alcohol is dammed but nothing else is done then there is merely produced a condition of suppressed alcoholism that could be rightly described as an alcoholic complex, or a partially repressed but imperative urge, that becomes endowed with a super-emotional content. In all probability this is the condition of many successful non-drinking alcoholics, wherein hate and fear have supplanted the love of and depending on alcohol. The partially repressed but imperative urge becomes endowed with a super emotional redirection. The truth is that abstinence frequently means the discarding of an all-important crutch by a sick personality. This may be the right moment for psychotherapy to be substituted for the crutch, not as something to lean on, but as a means of gaining insight into the little boy or girl who never grew up emotionally.

It is obvious to anyone who ever studied the problem of addiction that the abnormal drinker is playing a very passive role no matter how well he may disguise it by over-compensating action. The very role of drinking is passive. Without being conscious of it, he is asking a drug to change his ways of thinking and being and feeling. The addict carries the passive role to its extreme in deep intoxication. He is helpless.

With this hidden passivity in mind I endeavor to lead a patient into an active role toward treatment. I ask him to read and analyze the book, Alcohol: One Man's Meat, underscoring any passages that he thinks might give us insight into his own problem. By the very act of doing this he is taking an active rather than a passive role toward his recovery.

I inform the patient at the first contact that he and he alone will affect his recovery, that I can only help him to gain understanding of himself and his problem. If a good rapport is established I find it is helpful to anticipate with the patient the emotional growing pains that he will encounter during the beginning of his non-alcoholic readjustment. The patient puts much emphasis on the immediate withdrawal symptoms from alcohol. He has experienced these and knows how dreadful they are. He has no understanding of or preparation for the secondary emotional withdrawal symptoms that he will encounter during the first year or two of abstinence. These secondary withdrawal symptoms seem to take place in insidiously disguised protests against reality and in bombardments of rationalization urging him to return to alcohol. The late Richard Peabody contributed great insight into this phase of readjustment. In his book, The Common Sense of Drinking, he supplies this insight to the patient, as well as forearming him against the extraordinary rationalizing technique that he will uncover from time to time during his struggle to make readjustment without alcohol.

We encounter in alcoholism an age-old phenomenon of politics; the political psychology of the dictator. Dictator ideology survives only by creating and then enlarging the enemy without, in order to take the focus off the real enemy within -i.e., the dictator. With this technique whole populations are seduced into relinquishing their freedom. They become willing slaves to their State, hypnotized through propaganda by the imagined enemy without. In the addicted personality, alcohol is the dictator and here; too, the enemy without is created and becomes part of the rationalizing process of alcoholism. The typical alcoholic drinks because his wife nags him, or because he does not get the promotion he thinks he deserves, or because his friends let him down or shun him. In effect each aspect of reality soon becomes the threatening enemy without and the patient relinquishes his freedom to the alcoholic dictator in order to save himself from his own misconception of a hostile reality. There is always a paranoid-like rationalizing system in alcoholism. Understanding the abnormal psychology of addiction, one sees that rationalization is a necessary support to the alcoholic disease that has taken over the personality. Outside of delirium tremens, alcoholic psychosis and the occasional psychotic reactions following the administration of Antabuse, it does not reveal itself overtly, but it is there nonetheless, and it is very important that the patient gain insight into its abnormal mechanisms.

During therapy the patient will under our guidance gain insight into his unconscious feelings of rejection and guilt. If he is successful he learns to deal with these feelings instead of running away from them, and if acquired his insight into their source may help to allay a great deal of his personality discomfort.

I hope it will be seen from my very brief description of a treatment approach that I attempt to deal with a patient's personality problem as well as his alcoholic problem. Personality problems presented by patients vary enormously, as do the underlying causes for their addiction. They have, however, an extraordinarily similar system of irrational thoughts about drinking which will apply to all of them. Just as the understanding of the warped thought process in the paranoid schizophrenic will help to make the diagnosis and indicate the type of treatment, so also will the understanding of the warped thought process in the alcoholic help us to treat him.

A criticism of this type of psychotherapy is that it is limited to a group who can afford the expense involved in such a treatment. Many of our patients are outpatients, and do well on an outpatient status. In this way, the expense can be kept down so that it is within the reach of nearly everyone. However many of our patients need psychotherapy and would not respond to it without an initial and sometimes prolonged hospital stay, and this is, of course, expensive.

In order to make a treatment plan available to a greater number of people it has been suggested that group therapy might be instigated. Unhappily group treatment precludes the rapport, which has been shown to be so necessary. It has been tried by some of my associates, but the results have not been favorable.

In my attempt to analyze and compare three treatment measures, I have clarified for myself, and I hope for you, the fallacy of finding the treatment for alcoholics. Far better, and much more rewarding in results, is to find the form of treatment best suited to each type of personality afflicted with alcoholism.

Note: Francis T. Chambers, Jr. was a lay-therapist and was trained by Richard R. Peabody.