ally formed from alcohol at later points in the chain would fall below their usual concentration. The subject might become conscious of this deficiency in the same kind of way as the lowering of blood sugar may give rise to a sensation of hunger. The deficiency could be corrected by the ingestion of more alcohol.

It is clear that a great deal of very difficult work would have to be done before such a suggestion could be considered seriously, and it is unlikely that it would explain all cases of alcoholism. It is put forward here to indicate the possibilities that have to be considered if alcohol should ever come into the category of a physiological metabolite.

The Treatment of Alcoholism*

By

J. N. P. MOORE

FROM ST. PATRICK'S HOSPITAL, DUBLIN

ALCOHOLISM IS AN illness. In that sense it is a medical problem and one which must be dealt with by a doctor. I stress this because the medical approach is only one aspect of a problem which must interest the legislator, the educationalist and the clergy, all of whom have an important part to play in dealing with it.

It is only in comparatively recent times that alcoholism has come to be regarded, in its early stages, as a medical problem. Through the ages medical men have dealt with the physical effects of continued intemperance such as neuritis, gout, hepatic degenerations and mental manifestations such as delirium tremens and Korsakoff's psychosis.

If a man or woman drank too much it was regarded as evidence of excessive affluence, high spirits or, in its more tedious aspects, weakness of will or moral turpitude. That alcoholism is nowadays regarded as a serious social as well as a medical problem is not due to the fact that there is more drinking or a higher incidence of addiction. I think it can be much more reasonably attributed to a heightened social conscience which has made us more aware of the community health and happiness and its converse.

Many people drink to excess—the tired business man, the over-wrought professional man, the convivial adolescent, the inadequate ne'er-do-well, frustrated men and women from every walk of life, and some in whom this is the only obvious symptom of an inner disharmony. All these people have in common a desire to escape unpleasant reality. Alcohol is the medium which enables them to view the world in a rosier light. These people may be called "symptomatic" drinkers. Quite often their over-indulgence may affect their health, their efficiency or their domestic happiness, but the problem is not out of control and it is within their power by their own unaided efforts "to put their house in order", should the necessity arise. A proportion of people, variously estimated at from 5 per cent to 10 per cent, who drink symptomatically will in time become addicts. The age of onset of addiction and the extent of over-indulgence necessary to produce it are subject to considerable individual variation. Some can drink heavily for a lifetime without becoming addicted ; the resistance of others fails in their early 20's.

When must a diagnosis of addiction be made? How does one distinguish between the heavy drinker and the addict? The pathological drinker shows some or all of the following characteristics: he drinks secretly, urgently and uneasily ; he repeatedly drinks more than he intends ; he drinks because he must, not because he wants to ; earlier boasts about his capacity tend to be replaced by subterfuges to minimise the amount he drinks. The addict is constantly thinking about alcohol—planning when he will have his next drink, wondering before a party whether there will be sufficient alcohol—usually having a few beforehand to make sure. This anxiety to have his drug makes him gulp his drinks, and have what the Americans call "sneak drinks," and make sure to have his supply available at whatever cost or inconvenience. As the disease progresses, alcohol increasingly dominates his thoughts and actions from when he gets up in the morning until he goes to bed at night. In the early stages he may be worried because his drinking interferes with his business—in the later stages he is irritable and anxious if business looks like interfering with his drinking! Almost invariably the familiar pattern follows—lies, excuses, morning cures, hidden caches and blackouts.

Most people regard the onset of blackouts or, as they are sometimes called, "palimsets" as of crucial significance in the development of addiction. Many normal drinkers who take too much alcohol on some convivial occasion may have loss of memory for the period of their deepest intoxi-

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cation. In the addict, however, there is frequent loss of memory when only a comparatively small amount of alcohol has been taken. The individual may behave quite normally and show no outward sign of intoxication but next day may have a period of amnesia covering many hours.

The most sinister feature of the illness is a progressive deterioration in personality; untruthfulness in regard to alcohol consumption tends to invade other spheres of life; the addict becomes unreliable, inefficient, boastful or secretive. The inevitable personal, social and economic sequelae of this personality change are familiar. By the time intellectual deterioration, psychotic reactions and physical disorder have been reached, the prognosis is often hopeless. Sometimes the story is not one of uninterrupted deterioration, and long periods of sobriety are interspersed between bouts of addictive drinking. These bouts tend to become longer and more frequent and the final stages are much the same as when the illness is steadily progressive from the beginning.

It is important to remember that it is not the amount a person drinks which is the diagnostic factor—it is the manner in which he drinks. Many alcoholics point to the fact that they can go for days or weeks or even months without a drink, as evidence that they are not addicted. This is not necessarily so, because it is possible for an alcoholic to be abstinent—it is impossible for him to drink in moderation. A much more valuable test when the diagnosis is in doubt is to suggest that the patient will limit himself to three drinks a day, no more, no less, for a period of three months. I do not think any addict could pass this test. I think that even a heavy drinker could do so if he really wanted to. The ordinary social drinker might find it occasionally inconvenient but should not have any real difficulty in sticking to the rule for such a limited period.

I think it is most important to make the diagnosis with absolute certainty because while a heavy drinker may be advised to restrict his intake, an addict must accept complete abstinence. It is important, too, to make the diagnosis before gross physical and mental changes appear. The pattern of a patient's drinking, the presence of "blackouts," and above all the subtle changes in his personality which will be quite apparent to those in his near environment, should be sufficient grounds on which to base a diagnosis.

Needless to say, it is only the beginning for the doctor or the patient's relatives to be convinced that he is an alcoholic—the patient himself must be convinced before treatment can be begun with any hope of success.

Aetiology

The aetiology of addiction to alcohol is uncertain. Why can some people drink moderately or even excessively for a lifetime and still be in control of their consumption, while the drinking pattern of others shows the characteristics of addiction? Some show these characteristics almost from the beginning, others only after years of intemperance. The answer to this problem does not lie in the type or quality of the alcohol. In whatever medium it is prescribed the ultimate result is the same. Environmental influences, social customs, occupation, all play their part in determining how much a person drinks. It is doubtful if any of these in themselves are decisive in producing an alcoholic.

Some people feel that the answer to the problem lies in the psychological make-up of the individual. Here again, the emotionally immature, the unstable psychopathic personality, the over-anxious or the recurrent depressive, may all drink too much on account of their mental state. While undoubtedly addiction is commoner in people of unstable personality, alcoholics are not by any means drawn only from the ranks of the psychologically abnormal.

Freud believed that latent homo-sexuality was the underlying psychopathology, but more recent control studies indicate that such tendencies are no more common among alcoholics than among the general population. Alcohol loosens inhibitions, and latent sexual anomalies of all kinds are apt to become more apparent in both heavy drinkers and alcoholics, but their aetiological significance must be regarded as doubtful.

My own preference is towards the belief that the fundamental defect which produces an addict as opposed to a symptomatic drinker, is more constitutional than psychological. Genetical research is notoriously difficult but it seems clear from the various studies which have been undertaken that there is a hereditary predisposition to develop addiction in many cases. Bleuler (1954) found that the incidence of alcoholism in the parents and siblings of alcoholics was approximately 2½ times greater than in the parents and siblings of a controlled group of surgical patients.

The fact that many alcoholics who show all the unpleasant characteristics of the addict when they are drinking, become stable, normal citizens indistinguishable by any special characteristics from their fellows when they are teetotal, seems to favour the view that this constitutional anomaly is a physical rather than a psychological one. Personality studies carried out in large series of alcoholics have failed to reveal any special characteristics peculiar to the abstinent addict. In this respect, Jellnick (1951) in the second report of the Alcoholism Sub-committee of the World Health Organization states

> By and large, these reactions to excessive drinking—which have quite a neurotic appearance—give the impression of an "alcoholic personality", although they are secondary behaviours superimposed over a large variety of personality types which have a few traits in common, in particular a low capacity for coping with tensions. There does not emerge, however, any specific personality trait or physical characteristic which inevitably would lead to excessive symptomatic drinking. Apart from psychological and possibly physical liabilities, there must be a constellation of social and economic factors which facilitate the development of addictive and non-addictive

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alcoholism in a susceptible terrain.

It seems to me that the "susceptible terrain" may well be some hidden physical anomaly which comes to light after a variable amount of over-indulgence in alcohol. There is the well-known experience of the alcoholic who has been a contented abstainer for many years; on some festive or other occasion he deliberately or accidentally takes some alcohol, and immediately the old craving returns and within a matter of days or weeks the addictive pattern of drinking is re-established and complete relapse follows. It is important to remember that this so-called craving for alcohol is only present when the patient is drinking. This phenomenon of immediate relapse and re-awakened craving seems to me to be more easily explained if one presupposes a physical basis for addiction.

If addiction was entirely due to primarily psychological causes then one would expect that when the patient had achieved stability and happiness, as many of them do, he could become a normal social drinker. I have not known a single alcoholic, however stable, who successfully achieved moderation. I think it is a hopeful approach to suppose that alcoholism has a physical basis because I feel that one day the biochemist, the endocrinologist or even the neuro-physiologist may find the hidden anomaly which separates the addict from his fellows. Until some such underlying metabolic disturbance has been found and corrected, alcoholism must remain an incurable disease. No such corrective has yet been found and so-called "cures" are merely aids to keeping the patient abstinent.

One further phenomenon which emphasizes the reality of a constitutional factor in the aetiology is the racial variation, not only in social customs where drinking is concerned, but in tendency to addiction. Liability to addiction is marked in our own race, and the fact that such a tendency is found in successive generations after emigration to America suggests that it is due to an inherent racial characteristic rather than social custom or environment. Writing on this subject Pullar-Strecker (1952) states

> Not only individuals, but whole nations or races have better heads for alcohol than others. At the top of the scale come the Irish, who are notoriously prone to pathological alcoholism; at the bottom comes the Jewish race in which alcoholism is remarkably low.

Whether or not there is an organic basis to account for the addict, where treatment is concerned the correct psychological approach to the problem is of prime importance. The first essential is a correct attitude of mind in both doctor and patient.

The Doctor

Even if one is intellectually convinced that alcoholism is a disease and that the addict is a sick man, the emotional reaction of most doctors, like most laymen, tends to be tinged with a certain amount of impatience and sometimes it is one of ill-concealed contempt. Too often the reproaches of the patient's family and friends are repeated by his doctor, who lends the weight of his authoritative position to threaten the patient with the dire sequelae, both physical and mental, of his continued intemperance. The patient, already fully aware of his failure, laden with guilt and self-disgust, is easily driven to further excesses by such reproaches. The threats of physical catastrophes may be welcomed as a way of escape from undesirable reality.

If one is to treat alcoholism successfully it is necessary to feel as well as believe that the patient is ill. To extend sympathy and understanding to an alcoholic, at first may require a conscious effort. The practitioner who bristles with righteous indignation and upbraids and exhorts his patient does as much harm as his more urbane colleague who evades the issue and tells his patient "to ease up", "cut out spirits", "stick to beer", "nothing before six". Addiction is a chronic illness and treatment must be on a long-term basis. Tiding the patient over a drinking bout is only the beginning, although often a useful one, because the state of remorse following such an episode may make the patient more receptive to information about his illness. Much can be done by the practitioner who is prepared to take the time and trouble to get his patient's confidence, to give him an intellectual understanding of his addiction and to help him to find new outlets for his emotional energy. Psychotherapy of this kind is difficult and time-consuming, but the success of treatment often depends upon it. It cannot be replaced by any magic pill or injection, although physical measures may make its application easier.

The treatment of the average alcoholic lies well within the scope of the general practitioner, provided he understands the extent of the problem and is willing to devote himself to its solution. He is in a position to spot the incipient addict among his patients at a stage when friendly advice and information may still be successful. He may influence the patient indirectly by teaching his family that their relative is ill and in need of the sympathy and care which they would normally extend to a sick person. The education of the relatives is a necessary part of the treatment of every case of alcoholism.

In most cases the specialized physical aids to treatment are better carried out in hospital, but when the patient returns to ordinary life again he is fortunate if he has the support and guidance of a sympathetic and understanding physician, whom he should visit regularly.

Doctors should be slow to prescribe alcohol to a neurotic patient; it is a dangerous drug in most neuroses. It is especially inadvisable to encourage a teetotaller to drink, since abstinence may be an unconscious defence against a constitutional predisposition to addiction. I have treated a number of addicts who took alcohol in the first instance on the advice of a doctor as a sedative, tonic or pick-me-up.

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The Patient

Until the patient realizes that his drinking has got out of control and that he needs help to deal with his problem, nothing in the way of curative treatment can be attempted. A patient brought to see a doctor unwillingly, through force of circumstances such as domestic or financial crises, or legal trouble, is unpromising material. Efforts may be made to convince him of his need by explaining some of the characteristics of addiction. An explanatory talk such as one might give to a patient suffering from a physical ailment is a useful beginning. The analogy of some physical illness, e.g. diabetes, may be used—the diabetic may be healthy and happy if he sticks to his insulin and avoids certain foods; the alcoholic, if he avoids alcohol and adjusts himself to living contentedly without it. This first interview is of vital importance and may determine whether the patient co-operates in treatment or is driven to further excesses. If all suggestion of disparagement and reproach is kept from the conversation, and explanations are given in an objective and unemotional way, the patient will often respond with confidence and co-operation. In the case of the unconvinced and unwilling patient it may be wiser, when explanations have been given, not to try and insist on treatment but to encourage him to come back when he himself feels the need of help.

In some countries laws exist which enable patients to be treated compulsorily. It is doubtful whether these powers should ever be employed, except in the case of grossly deteriorated or psychotic alcoholics. In these cases, the downward progress may be halted temporarily and the relatives given a much needed respite. Early cases are likely to be outraged by such high-handed measures as certification. The hospital doctor, too, finds himself with an angry, hostile, rebellious patient with whom it is difficult, if not impossible, to establish friendly relations. Since the patient's relatives must play a part in certification, family relationships are too often permanently disrupted by such a measure. During the eight years in which certification of addicts has been possible in Ireland (Mental Treatment Act, Eire, 1945) I have learnt that coercion is of small value in dealing with the recoverable alcoholic.

Alcoholics Anonymous

As in every form of illness, prevention is better than cure. I think the greatest advance in the treatment of alcoholism has not been the discovery of any new " wonder drug " or cure, but the spread of a more enlightened attitude towards the problem both among the medical profession and the general public. Novels, films, periodicals and articles in the popular press have had as their theme the drunkard, his downward path and his eventual cure. Although not all this propaganda has been enlightened, on the whole it has been good and in the main the alcoholic has been depicted as a sick person for whom treatment is possible, rather than a figure of fun, an object of ridicule or a creature to be upbraided and despised.

Still further propaganda is needed before we can completely emancipate ourselves from our inherited attitude to the drunkard. This attitude is much the same as the reaction to mental illness generally. Ignorance about its causes produces fear, and fear characteristically produces either aggressive rejection or ridicule. Thus, there is a tendency in all of us to wish to punish or disown the alcoholic, or to hide our fear by laughing at him. He is still sometimes an object of disgust as well as the subject of a music-hall joke. Only the knowledge that we are dealing with a sick person in need of help and sympathy and understanding, will enable the problem to be met with in the same unemotional, objective way that physical illness is now accepted.

Here I should like to pay tribute to the work of the Alcoholics Anonymous organization. One of its members to-day will tell you about the work it is doing, its aims and methods. I think it has been the most important means of spreading enlightened propaganda about the illness, and deserves the support and help of our profession. I give all my patients Alcoholics Anonymous literature to read, encourage them to attend a meeting, or if they wish arrange an introduction to a member of the organization. If the patient is fortunate enough to feel at home in this organization, his subsequent treatment is rarely a problem.

I think we must confess that in recent progress more help has come from the layman than from our own profession. Some excellent popular books have been written, usually by ex-alcoholics, about the problem of addiction. The information contained in such books as *Primer on Alcoholism*, by Marty Mann (1950), should be the property of doctor, patient and relatives. An intelligent addict will often identify himself in the pages of such a book, learn of his need for treatment and save much time for the doctor and painful experience for himself. The insight displayed by the author, a recovered alcoholic, often appeals much more than anything a doctor can say. I have found this book of great value.

The Psychiatrist

Although the treatment of alcoholism may reasonably be undertaken by the general practitioner, in recent years there has been an increasing tendency to pass these cases on to the psychiatrist. There are two reasons for this. First of all, the alcoholic sooner or later manifests symptoms of mental ill-health. Apart from gross psychotic symptoms, there are usually neurotic symptoms at a comparatively early stage: morbid anxiety, depression, insomnia, phobias, irritability, lack of concentration and efficiency, and all the problems posed by the resulting personal, domestic and business worries. The presence of such symptoms has led many workers to assume that they indicate a primarily emotional disorder which in turn has led to excessive drinking. My own experience is that in the majority

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of cases these symptoms disappear once the patient stops drinking and regains his physical health.

From the psychiatric point of view, all that is required is simple psychotherapy directed towards giving the patient insight into the nature of his illness. Most abstinent alcoholics, in my experience, once they understand the nature of their problem and accept the fact of their addiction, can find new interests in life and new outlets for their energy without any intensive or prolonged psychotherapy. There is a minority of cases where excessive drinking is secondary to some well defined psychosis or personality disorder, and here of course the prognosis is directly related to the success of psychiatric treatment.

Alcoholics come to the psychiatrist secondly because, by the nature of his training, he more readily accepts the alcoholic as a sick man, and he has more experience of dealing with patients lacking in insight and hostile to the idea of treatment.

With the spread of a more enlightened attitude and better teaching in the medical schools, I believe the treatment of alcoholism in the future will be shared by every branch of the medical profession.

The psychiatrist is interested in the problem of alcoholism for another very important reason. It is generally accepted that the environment in the early years of an individual's life plays a vital part in determining the personality of the adult. In particular the seeds of adult neurosis are sown in the first five years of life. Anyone whose daily work involves taking psychiatric case-histories cannot fail to be impressed by the frequency with which one gets a history of insecurity in early life, most often in parental relationships. From my own experience, I believe that the commonest single cause of neurosis in this country is the kind of tension and disharmony which is inevitable in a household where one parent is an alcoholic. Thus as a prophylactic measure in dealing with one of our major problems we are interested in the early treatment of the alcoholic.

Physical Methods of Treatment

In most cases when the patient comes to a doctor he is still drinking. Treatment must therefore have a twofold objective—the use of some physical method to achieve immediate and complete abstinence, as well as the employment of some psychological approach which will elicit the patient's co-operation and later enable him to remain a contented abstainer.

If the patient is unable to stop drinking even temporarily by his own unaided effort, then he must be admitted to some form of institution, preferably one which specializes in the treatment of alcoholism, whether it be nursing home, general hospital or mental hospital. In many cases, entering a mental hospital or psychiatric clinic as a voluntary patient is a worthwhile procedure. Provided the alcoholic is not allowed to mix with chronic cases and provided he is treated with sympathy and understanding, the regimen of a well-run hospital is well adapted to the management of an alcoholic. Certainly an alcoholic is best treated along with other alcoholics. In hospital, one usually finds they gravitate to one another, discuss their symptoms, compare notes, find they are not alone in their experiences and often form lasting and valuable friendships. The insight gained in these talks may achieve more for the patient than anything his doctor can do for him.

Early cases who can stop drinking temporarily of their own accord may be treated as out-patients. Although these patients are apparently the most favourable type for treatment, results are sometimes disappointing and, in my own experience, many of them relapse and eventually require to enter hospital. It almost seems as if in many cases the psychological surrender involved in admitting defeat to the extent of entering hospital and putting himself entirely in the hands of his therapist, is a necessary emotional experience before the patient can achieve true insight and lasting stability.

On admission to hospital, alcohol must be stopped immediately except in the presence of grave physical disability, such as cardiac failure or pneumonia. Provided adequate sedation is given, I have never seen any untoward result such as delirium tremens follow immediate withdrawal and it is much quicker and easier for the patient than a tedious tapering off. The patient should be kept in bed in a darkened room and heavily sedated. Formerly I used a combination of Sodium Amytal 3 to 6 gr. four-hourly supplemented by Paraldehyde in 2 dr. doses sufficient to keep the patient asleep for the greater part of the 24 hours. During the past year I have replaced this technique by giving Largactil. An initial intramuscular injection of 50 mgm. is given and followed by 50 mgm. four-hourly by mouth. If the patient is restless, further intramuscular injections are given. Additional sedation with one of the barbiturates may be necessary at night.

In a series of 50 consecutive cases at St. Patrick's Hospital, including two cases of delirium tremens, Largactil has proved an eminently satisfactory drug, and it is less toxic than large doses of barbiturate, and the patients are much more easily nursed. Copious fluids are given and intake and output carefully measured. Vitamin B complex both orally and parenterally should be given in large doses.

Usually in three to five days, sedation can be withdrawn and the patient allowed up and about and encouraged by occupation and recreation to get physically fit. At this stage, after alcohol has been successfully withdrawn and the patient's health restored, the craving for alcohol is completely lost. Almost invariably patients express surprize that they feel no desire for drink—" If there was a bottle of whisky beside me I would not touch it ", is a stock remark.

Discharge from hospital at this period is liable to be followed by quick relapse, unless the patient is given some insight into the nature of his illness

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and provision made for medical supervision over a long period. It is a help if this can be given by a doctor who has insight into the problems of the alcoholic.

Despite the best intentions many alcoholics do relapse and there are a number of ways of reinforcing their desire to be abstinent.

Disulfiram Treatment (Antabus)

The rationale of this treatment is as follows. The patient ingests a drug which behaves like an inert chemical except in the presence of alcohol. When alcohol is taken after the ingestion of the drug, unpleasant symptoms appear almost at once —flushing, tachycardia, breathlessness, nausea and vomiting; there is often a sense of great anxiety and impending doom. The reaction is so unpleasant that having once experienced it few people attempt to take alcohol again while they are having Disulfiram.

While the drug is relatively non-toxic in the doses used in the treatment, some patients show an idiosyncrasy and symptoms such as diarrhoea, constipation, insomnia, somnolence, dizziness and palpitations, have been attributed to it. In practice it is rarely necessary to stop the treatment on account of these symptoms, which are often merely rationalisations on the part of the patient, produced to justify stopping the drug. The drug must be used with caution in the presence of cardiovascular or hepatic disease. A number of deaths have been described in patients who have taken alcohol after the ingestion of Disulfiram. In most cases there was some physical defect present, but Jones (1949) has reported a death occurring in a Disulfiram reaction in a young healthy adult.

The principle of treatment must be explained to the patient and his co-operation invited. It is both wrong and dangerous to use Disulfiram secretly. The practice of prescribing it casually for patients, in some cases even giving it to the relatives to administer without the knowledge or consent of the patient, is highly dangerous. On one occasion I was called to see a moribund patient who had taken a drink a few hours after his breakfast porridge in which his wife had dissolved a Disulfiram tablet. This patient recovered, but deaths in similar circumstances have been described.

The patient is given 1 g. of the drug daily for three days and on the morning of the fourth day, after a 0·5 g. dose, his reaction is tested by giving him some alcohol. This has the twofold purpose of teaching the patient the symptoms of a Disulfiram reaction and indicating how sensitive he is to the drug. One or two glasses of beer provide sufficient reaction in most cases; spirits are only used if the reaction is considered unimpressive.

The patient is encouraged to continue taking the tablet daily. In most cases it is wise, once the patient's physical health has been restored, to get him back to work and normal life as quickly as possible. He should be told he must not discontinue his tablets except on the advice of his doctor. After a period on the drug, many patients feel they are "safe" and discontinue taking it—an accidental lapse often follows. The patient is encouraged to report such a lapse at once and, either unaided or with the help of a short readmission to hospital, the bout must be terminated and a return made to the daily tablet. Such lapses, whilst undesirable, are not necessarily bad prognostic omens. Many patients appear to require a few such experiences to convince them that they are addicts.

I have found Disulfiram of great value to the co-operative addict who wishes to remain abstinent but who is prone to relapse impulsively in a moment of tension or in convivial company. Such patients often feel happy in the knowledge that they cannot drink because they have taken the drug. They need no longer live in constant dread of a momentary impulse. Alcoholics who are basically psychopathic personalities will not continue the drug; those who are basically psychotic should not be given it. Its use is therefore limited to the most favourable therapeutic group.

In a series of 71 patients treated with the aid of Disulfiram at St. Patrick's Hospital, and successfully followed up by letter or interview for periods varying from six months to two years and five months, it was found that 51 per cent had remained completely abstinent and 32 per cent were now abstinent but had had one or more relapses. (Moore and Drury, 1951.)

"Aversion" Techniques

The principle of the conditioned reflex as a basis for the treatment of alcoholism has attracted a number of workers and a variety of techniques has been evolved. The aim is to establish a conditioned reflex so that the sight, taste and smell of alcohol acting as the conditioned stimulus will induce nausea and distaste. The nausea-producing drugs most used are emetine or apomorphine. The drug is given along with alcohol on a number of occasions until a conditioned reflex is set up so that thereafter alcohol alone will produce nausea and distaste.

Dent (1949) treats his patients with injections of apomorphine coincidental with the ingestion of alcohol repeatedly administered over a period of several days until a state of exhaustion is produced. He claims that his method is not dependent upon the production of a conditioned reflex but that following treatment many patients lose their need for alcohol. However, as with other methods of treatment, alcohol taken in even small amounts subsequently will cause a relapse.

An advantage of the emetine and apomorphine techniques is that they are short, dramatic and, when employed by an enthusiastic expert, have strong suggestive value. The emotional state accompanying the hardships of the treatment seems to satisfy an unconscious desire for punishment in some guilt-laden addicts. After such an ordeal a patient may feel a sense of achievement

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and be able to refer to his " cure " with pride.

Some therapists have an elaborate treatment room in which a spotlight plays on a colourful array of bottles. This somewhat theatrical staging of the treatment combined with physical exhaustion and its emotional accompaniments may give forceful suggestion a long-term effectiveness.

Hormone Treatment

The view that alcoholism is a metabolic disease has suggested a possible endocrine basis for the condition. On the hypothesis that the disturbed behaviour of the problem drinker is conditioned by circumstances in the internal or cellular environment, rather than by circumstances in the external environment, Smith (1948 and 1950) has used various steroid hormones in the treatment of alcoholism. He found that both adrenocortical extract (A.C.E.) and ACTH were effective in the treatment of acute alcoholism and more effective than sedation in tiding the patient over an acute alcoholic crisis.

Similarly, ACTH was found to be an effective agent in the treatment of delirium tremens, whilst A.C.E. gave good results in Korsakoff's psychosis. Results so far do not encourage the earlier hope that hormone therapy will alter the physical basis of alcoholism and enable the addict to become a normal drinker again.

If proof were needed that there is no specific " cure " for alcoholism, one has only to compare the results of the various techniques employed. As with every malady for which there is no specific remedy, the results from different methods of treatment are surprisingly uniform. The enthusiasm of the therapist and his skill in eliciting the co-operation of the patient are more important that the technique he employs. The basic personality of the patient is a more important determinant of the outcome than any mental or physical change which can be brought about by treatment.

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The Rehabilitation of the Alcoholic*

By

A MEMBER OF

ALCOHOLICS ANONYMOUS

I CONSIDER IT a great priviledge to be allowed to say something about the subject of rehabilitation of alcoholics, as I have had personal experience of this important and sometimes difficult process. I came to St. Patrick's Hospital as a patient in November 1946 after a hectic alcoholic career of fifteen years' compulsive drinking during which I found myself in several police courts and a good many nursing homes and was sacked from about eighteen different jobs. When I came to Dublin I was heavily in debt, unemployable, and apparently completely worthless, but I am thankful to say that I have had no alcoholic drink whatsoever since I entered St. Patrick's and will soon have completed nine years of membership of Alcoholics Anonymous. In addition to having experienced personal rehabilitation I have been fortunate enough to be allowed to visit a large number of alcoholic patients in St. Patrick's and elsewhere, and by bringing them to Alcoholics Anonymous I have been able to keep in touch with them for a number of years, thereby acquiring additional experience of the problems of recovery.

I have had the opportunity of examining the procedure suggested by Messrs. Allis Chalmers, Dupont, Standard Oil, and Consolidated Edison for coping with alcoholism. All, of course, are American firms, and while they all have fairly elaborate techniques for discovering and treating what is known as the " halfman " and the " hidden man ", in the final analysis their systems amount to this: the alcoholic, or suspected alcoholic, is warned that unless he makes use of the treatment and rehabilitation facilities provided by special consultation clinics or by A.A., he will not be kept on as an employee. We unfortunately have no special consultation clinics in this country, but we have A.A.

Naturally, having been a member of the Dublin Group of Alcoholics Anonymous ever since it was formed in November 1946, I am strongly in

* Read to a Joint Meeting with the A.I.M.O. of Ireland, in Dublin, on 14th July, 1955.

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