A study of ten alcoholic patients admitted to the Washingtonian Hospital who accepted the conditioned response treatment.
A STUDY OF TEN ALCOHOLIC PATIENTS ADMITTED TO THE WASHINGTONIAN HOSPITAL WHO ACCEPTED THE CONDITIONED RESPONSE TREATMENT

A thesis

Submitted by
Eugene Phillip Milstone
(B.A., Brooklyn College, 1951)

In Partial Fulfillment of the Requirements for the Degree of Master of Science in Social Service

1955
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of Study.</td>
<td>1</td>
</tr>
<tr>
<td>Scope of Study.</td>
<td>1</td>
</tr>
<tr>
<td>Sources of Data</td>
<td>2</td>
</tr>
<tr>
<td>Methods of Procedure.</td>
<td>3</td>
</tr>
<tr>
<td>Limitations of Study</td>
<td>4</td>
</tr>
<tr>
<td>II. SURVEY OF THE LITERATURE ON ALCOHOLISM</td>
<td>5</td>
</tr>
<tr>
<td>III. THE SETTING</td>
<td>12</td>
</tr>
<tr>
<td>History and General Setting of the Washingtonian Hospital.</td>
<td>12</td>
</tr>
<tr>
<td>Treatments Offered.</td>
<td>13</td>
</tr>
<tr>
<td>IV. PRESENTATION AND DISCUSSION OF STATISTICAL DATA</td>
<td>21</td>
</tr>
<tr>
<td>V. PRESENTATION AND DISCUSSION OF CASE MATERIAL</td>
<td>33</td>
</tr>
<tr>
<td>VI. SUMMARY AND CONCLUSIONS</td>
<td>47</td>
</tr>
<tr>
<td>APPENDIX</td>
<td>52</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>54</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Marital Status of Patients</td>
<td>22</td>
</tr>
<tr>
<td>II. Extent to Which Patient Assumed Financial Responsibility for the Conditioned Response Treatment</td>
<td>22</td>
</tr>
<tr>
<td>III. Basis for Decision to Recommend Conditioned Response Treatment</td>
<td>24</td>
</tr>
<tr>
<td>IV. Gains Expected by Patients from Conditioned Response Treatment</td>
<td>27</td>
</tr>
<tr>
<td>V. Follow-up Treatment with Patients and Relatives</td>
<td>29</td>
</tr>
<tr>
<td>VI. Length of Follow-up Treatment with Patients and Relatives</td>
<td>31</td>
</tr>
</tbody>
</table>
CHAPTER I.

INTRODUCTION

Purpose of the Study

This is a study of the conditioned response treatment as administered to a selected group of patients. The purpose is to see whether there were any discernible differences between the group of patients who took the treatment successfully and those whose treatment was unsuccessful.

The major areas of this study will be around the following questions:

1. What were the considerations which led to the selection of these ten patients for conditioned response treatment?

2. Were there any outstanding differences, and in what areas did these differences occur, between the "successful" and the "unsuccessful" group?

3. What was the role of the social worker during the treatment and follow-up with these two groups of patients?

Scope of the Study

The study has been done at the Washingtonian Hospital, Boston, Massachusetts. It includes ten patients: five who took the treatment successfully and five who took it without success. The ten patients included had completed treatment at least two years before the time of the study.
In view of the fact that a criterion must be established in order to study this proposed thesis, Dr. Joseph Thimann, Medical Director of the Washingtonian Hospital, has formulated the following definition:

A patient who used to drink and relapse several times during a year and has now since the beginning of the treatment managed to keep from alcohol for a period of two years or more may be considered successful.

This study will involve the ten patients out of the twelve who took the conditioned response treatment in the years 1951 and 1952. The hospital records do not reveal the alcoholic status of two patients at the end of the two year period. Therefore, they have been excluded from this study.

Sources of Data

The sources of data for this study are as follows:

1. An analysis of case records which will contain:
   a. "Face sheet" information, i.e., sex, age, religion, etc.
   b. Material from the medical therapist.
   c. Material from the resident physician.
   d. Material from the social worker.

2. Conferences with the Medical Director.

3. Conferences with the Director of Social Service.

---

1. Dr. Thimann accepts the formulation of the Seattle Group that a patient who relapses only once during the first two years and abstains thereafter be considered successful.
4. Pertinent literature about alcoholism.

Methods of Procedure

Chapter II will contain a general picture of alcoholism as seen through a survey of the literature.

Chapter III will be devoted to the setting of the hospital and will contain a short history of the Washingtonian Hospital and a comparison of the conditioned response treatment with the other treatments offered.

In Chapter IV all ten cases will be described and discussed as a group. Some specific areas will be investigated which would seem to have some bearing on these situations. The data were compiled with the use of a schedule and were then classified and discussed. See Appendix for schedule.

In Chapter V there will be a presentation of three "successful" case illustrations and three "unsuccessful" ones. They will be presented individually and a discussion will follow each presentation. They are to demonstrate more fully the individual motivation of patients for treatment and abstinence and the diagnostic picture of them as seen by the therapist.

The final chapter, Chapter VI, will deal with a summarization of the information found in this thesis and the conclusions that can be drawn from this.
Limitations of Study

The study deals with a small number of cases. Therefore the conclusions drawn can be applicable to this study only and not to conditioned response treatment or the treatment of alcoholics in general. In addition, case records were not always adequate in their information for this study. Finally, the study has been limited to certain specific factors as outlined in Chapter IV and the underlying dynamics have not been thoroughly investigated.
CHAPTER II.
SURVEY OF LITERATURE ON ALCOHOLISM

A little over forty years ago William Graham Sumner said, "If a drunkard is in the gutter, that is where he belongs." Since then much has happened in the understanding of alcoholism.

In an advertisement published by the Metropolitan Life Insurance Company in several leading magazines recently alcoholism was defined as follows:

Alcoholism is the abnormal and uncontrollable use of alcohol to an extent seriously detrimental to physical and mental health. This condition is now recognized as an important medical and public health problem.

In describing the course of alcoholism the advertisement stated in part:

Authorities have found no one cause for this condition. Research shows, however, that alcoholics are usually people who do not seem able to face life in a mature manner because of some underlying mental or emotional condition which the alcoholic himself may not clearly recognize. They seem to seek escape by excessive drinking—and eventually they become dependent on alcohol just to go on living.

On October 21, 1954, Dr. Joseph Thimann, Medical Director of the Washingtonian Hospital, delivered a lecture to a group of visiting sociology students from Tufts University. He categorized the various types of drinkers into the following generally accepted classifications:

1. Social drinkers - those who can drink in a socially accepted setting and have the ability to abstain if they so desire.

2. Alcohol-dependent people - those whose anxiety feelings before important engagements or going to sleep, etc., cause them to drink.

3. Alcohol addicts - those who desperately want to stop drinking but can't do it.

The alcohol addict can be categorized into the following types:

1. Ex-social drinkers - formerly successful people (emotionally and socially relatively mature) who have a better chance of returning to "normal" life.

2. Psychoneurotic alcoholics - more basically disturbed and need psychotherapy. The young psychoneurotic has had little time for life training, marriage, etc. and therefore has a difficult success level in handling his everyday problems.

3. Symptomatic drinkers - the addictions to drinking is an expression of underlying psychosis. They often drink to forestall onset of a psychotic episode.

Mr. Howard W. Haggard and Professor E. M. Jellinek of Yale estimate that fifty-one million Americans are drinking and that three million of them are chronic alcoholics and excessive drinkers. Alcohol is like sugar for it just provides calories. There are no vitamins, minerals or proteins

2. Ibid., p. 29.
in this substance. The alcoholic often may have a nutrition disease. Alcohol depresses the brain in the sense that it decreases its activity. While the tension and inhibitions may have been removed, the faculties of criticism and awareness have been dulled.

Drinking does not affect the germ cells of the body and resulting heredity traits. "Children of alcoholic parents do more often become alcoholics than children of moderate or non-drinkers, but the reason is 'alcoholic environment'."  

The personality difficulty or "escape" theory of alcoholism has by no means total acceptance. Dr. Abraham Myerson, for one, has pronounced it inadequate. According to Dr. Myerson, personality difficulties rising from an alcoholic's environment are often as great as the non-alcoholic's.  

During the war Myerson observed at the Boston Induction Center Psychological Screen that draftees who, in terms of the cultural milieu, should have had the fewest personality disturbances relatable to their environment, had the highest rate of alcoholism. These, according to Dr. Myerson, were the Irish. In contrast, Boston Jewish draftees had almost no alcoholism. "And why," he asked in effect, "after the psychological conflicts have been removed, if they are the cause of alcoholism, cannot the alcoholic drink and

3. Ibid., p. 31.
4. Ibid., p. 32.
drink normally without harm? Something, of course, the alcoholic never can do."

Another theory about the cause of alcoholism is "allergy." According to this theory the drinker has no apparent personality conflicts. However, he is unable to resist the compulsive craving for alcohol. What is behind this allergy is no more understood than are the reasons for an allergy to certain flowers or foods.

Some researchers on alcoholism hold the theory that the basic cause may be almost entirely physiological. They state that there is something wrong with the alcoholic's bodily mechanism. Like the diabetic who cannot handle sugar, the alcoholic's metabolism may be peculiar in a different way. The alcoholic may just not be able to integrate another substance, alcohol. Professor Roger J. Williams, Director of the Biochemical Institute at the University of Texas, is the leading exponent of this idea. A study of one thousand drinkers revealed that almost 7 per cent of them were still sober with .4 per cent alcohol concentration in the blood; but 10.5 per cent who had only .05 per cent concentration were quite intoxicated. The difference, according to Dr. Williams' theory could be due to the different effect of the alcohol upon the metabolism of the brain cortex of the

5. Ibid., p. 32.
6. Ibid., p. 32.
different individuals concerned. 7

A high rate of consumption of alcohol does not necessarily mean that the individuals who are consuming these large quantities are alcoholics that society has a corresponding high rate of alcoholism. The major point of difference between a drinker of alcohol and an alcoholic is the most important element of a compulsive drinker. According to the value judgments of a majority of Americans, drinking becomes a serious problem when it becomes a chronic and compulsive condition.

Urbanized America is becoming a society of impersonal, secondary group associations. When the individual turns to recreational groups designed to satisfy his strong needs for primary group fellowship, he often finds himself frustrated by feelings of tension in himself and other group members.

Something is needed to bring relaxation to these individuals who, conditioned by secondary group interactions, are seeking primary group values. Alcohol becomes the most readily available and effective relaxing agent. Thus, the 'social drinker' is born. 8

Most social drinkers remain in that category. Others tend to lean on alcohol more and more strongly. Such individuals often become the alcoholics. However, value conflicts can exist in the alcoholic's thoughts. Many are

7. Ibid., p. 32.

definitely aware of the damage alcohol has on their physiological, psychological and social functionings.

But the anxieties for which alcohol originally offered "escape value" become less rather than more bearable during sober periods. And whatever counteranxieties existed for the individual before he became a compulsive drinker lose strength as the alcoholic habit becomes more fixed and the will to resist drinking deteriorates.9

Brown speaks of the "social definition" that makes drinking a sin.

Many people feel superior when they transcend social requirements. Where there is a pattern for drinking this is not important; there is no need to demonstrate an emancipation from conventional controls. The social definition makes drinking a sign of emancipation in the United States and leads to a self-definition that doubtless is one of the most important aspects connected with the habit.10

"Alcohol...from a medical point of view is more a symptom than a disease."11 It may be symptomatic of many kinds and degrees of personality problems. Osborn describes its victims as sick people. They are vastly insecure and threatened from within. These people are much in need of help and understanding from others.

Help in controlling the secondary complications brought about by alcohol itself is, of course, important; but beyond that there is usually need for help with the underlying problems. Adequate understanding of these

9. Ibid., p. 189.
problems calls for extensive knowledge of man in his personal, interpersonal and social aspects.12

The wide divergence of opinion concerning the problem can be easily seen when an article, appearing in the same journal as Osborn's, takes a supplementary but differing viewpoint than that of Osborn and states:

Alcoholism is a symptom which has taken on disease significance. Though starting as a symptom of underlying factors, it gains momentum until it becomes a disease in itself. To insist on treatment of the original causes is like focusing upon the cause of life-threatening fever or upon the irritation leading to cancer. The cause and the origins are irrelevant to the immediate danger...Experience repeatedly proves that no amount of probing and unraveling allows a return to normal drinking. Once the state of alcoholism has supervened, it seems to remove any possibility of controlled drinking.13

12. Ibid., p. 60.

CHAPTER III.

THE SETTING

History and General Setting of the Washingtonian Hospital

An American Hospital Association report contains the following description of the Washingtonian Hospital:

The Washingtonian Hospital in Boston is probably the oldest American institution for the treatment of chronic alcoholism exclusively, having been opened in 1857 under the hopefully descriptive name "The Home for the Fallen." The moralistic and religious lines on which its earlier efforts were founded were gradually superseded by medical ones, culminating in a recent reorganization whereby a constructive program of medical rehabilitation and experimentation was adopted and a social-service department introduced...

Unlike most special institutions for the treatment of alcoholics, the Washingtonian Hospital does not charge a flat rate for its course of treatment but has a schedule of prices on a weekly basis. These are within the range of the middle-income group and are subject to scaling down for those who cannot afford the regular charge. The average in-patient stay is not a long one; after an initial period of a few weeks or less, during which the alcoholic is confined to the institution, the patient is encouraged to return to his job and to spend his leisure hours--night and weekends--at the hospital. Out-patient services are available for those who have graduated from in-patient care. A social-service department is another feature of this institution...it represents a forward step in the treatment of alcohol addiction, since it offers treatment on terms that are acceptable to a large group of middle-classed alcoholics and, at the same time, aims to maintain a scientific attitude toward its work. If both the quantitative and qualitative points of view are taken into consideration, this is probably the most outstanding of all institutions concerning which information has been made available to us.1

---

In this chapter the following treatments will be described and discussed:

1. the antabuse treatment
2. the adrenal cortex hormone treatment
3. the part-time hospitalization, "working parole", or "night hospitalization" treatment
4. psychotherapy
5. the conditioned response treatment.

The Antabuse Treatment

The antabuse treatment is one that invokes a fear reaction in the patient. The patient takes the antabuse tablets and realizes that he will have uncomfortable physical reactions if he drinks within twenty four hours.

These patients must...have a thorough examination... They sometimes undergo five "test sessions" for which they are hospitalized from one to two days. These sessions are to test the patient's tolerance for the drug and to give him the experience of what his reaction might be should he drink after having taken the medication. Following the test sessions this treatment is given on an outpatient basis for an indefinite period of time. It is usually supplemented by psychotherapy.²

The Adrenal Cortex Hormone Treatment

The alcoholic addict is often found to have an adrenal

cortex deficiency in his body. He is given the adrenal cortex hormone treatment to overcome this deficiency.

It can be given to most patients without risk and can be administered entirely on an outpatient basis. It usually promotes a feeling of well-being on the part of the patient...It is usually supplemented by psychotherapy.³

**Part-time Hospitalization**

Part-time hospitalization (often referred to as "working parole" or "night hospitalization") is almost always considered a supplementary treatment. It is often used in conjunction with one of the other treatments (including the conditioned response treatment).

It is a plan whereby the patients live in the hospital and go out to work daily at their regular jobs. This plan is often beneficial for patients who would otherwise be living alone or whose family situations are a marked strain on them.⁴

**Psychotherapy**

Psychotherapy may be thought of as a systematic utilization of psychological agents or methods by a therapist to produce intra-psychic change and adjustment modification in another person.⁵ Casework and psychiatry both may well be

---


⁵. Lecture delivered by Dr. Valenstein at Boston University.
included within this broad concept.

Psychotherapy...is for the purpose of treating the patients' emotional difficulties. We offer both group and individual (psychotherapy). The kind or intensity of this treatment given here varies from one hour a week on the couch to supportive therapy on an environmental level.6

The social worker often works with the ambivalent patient helping him to form a constructive attitude toward the acceptance of treatment. "The chief focus has continued to be that of integrating the patient's hospital experience with the patterns of his family life."7 The social worker also works with the patient in the areas of non-personal environment. That is, through environmental manipulation he helps the patient in areas such as job seeking and living arrangements. He also interprets the treatment and the patient's problems to relatives and when therapeutically advisable and feasible treats them in the casework relationship.

The Conditioned Response Treatment

The conditioned response treatment "consists of establishing a reflex eliminating the compulsive craving for alcoholic beverages."8

8. Ibid., p. 17.
It consists usually of twelve treatments spread throughout the year. The initial series usually takes a week and must be followed by four weeks in bed in the hospital. The reason for this rest in bed is that of a precaution against the possible side effects of the drug used.

Careful observations of large numbers of patients have confirmed the impression that the psychopathology of alcohol addiction resembles, in certain aspects, that of addiction to narcotics. If a person suffering from gallstones is given morphine for a certain length of time and happens to be predisposed to addiction, the addiction will develop. In such cases it is agreed that removal of the gall bladder will in most cases eliminate the pain, but not the addiction to morphine. By then, the addiction will have developed into an autonomous disease, independent of whether the underlying cause, the gallstone colic, still exists or has been removed. I think that there is reason to assume that the uncontrollable desire for alcoholic beverages is governed by similar laws. It may, of course, be precipitated by an underlying neurosis or some combination of inner and outer factors. From the point at which the addictive pattern has become established, however, it is as autonomous as morphine addiction...

He (the alcoholic) drinks because he is addicted, because the established addiction is self-perpetuating and causes the compulsive need for more and more alcohol. Thus, the impulse for alcohol can best be described as an abnormal conditioned reflex.

The description of the conditioned response treatment can best be given in terms of a vivid association between an unpleasant sensation and alcoholic beverages.

You know that ingestion of tainted food may cause a severe nausea and subsequent dislike for that kind of food. This mechanism has been studied by Pavlov, who fed dogs to the sound of a bell in order to develop a reflex association between both. We use a nauseant


drug instead of the food and alcoholic beverages in place of the bell, thus inducing the reflex associations between alcohol and nausea. If this is done with observance of certain physiologic laws, the victim of the treatment experiences an amazing extinction of the old reflex—'reach for the bottle'.

The Annual Report of the Washingtonian Hospital for the year 1948 has this to say about the conditioned response treatment (referred to here as the conditioned reflex therapy):

There is growing evidence that the habituation to alcoholic beverages becomes, after a certain period of time an autonomous disease, independent of the underlying causes. This leads to the understanding of why in many cases psychotherapy alone has not proven beneficial as the sole instrument for establishing lasting abstinence.

The recognition of this fact promoted the development of a treatment designed for the specific purpose of eliminating the craving for alcoholic beverages. This treatment is known as the Conditioned Reflex Therapy. The principle of it is rather simple. For example, a child who is bribed by means of a chocolate soda to drink castor oil, may soon develop a vivid association between the chocolate and castor oil with the result that the once coveted chocolate loses all of its attraction.

The Conditioned Reflex Therapy makes use of this mechanism by inducing nausea in connection with the sight, smell and taste of alcoholic beverages to which a patient is addicted. This simple principle, to be effective in practice, requires an intricate technique and thorough clinical experience. It consists of an initial series of six conditioning sessions and is followed up by six or seven one-day preventive reinforcements applied in increasing intervals during the first year. The initial series established the reflex association between the nausea and the alcoholic

beverages; the reinforcements, as the name indicates, serve the purpose of preventing the reflex from gradually fading out.

This Conditioned Reflex Therapy, although involving relevant psychotherapy in itself, is even more successful if combined with group therapy in the form of semi-monthly meetings of the "graduates" comprising the Hospital Abstinence Club.

It would be appropriate at this point to discuss why certain patients benefit more from this treatment than from other treatments. Dr. Thimann feels that it is clinically useful to divide patients into three personality categories. He identifies the first two categories into the following types. 12

First there is the patient who shows traits of being overly relaxed, gluttonous, complacent, socialized, and dependent on people; second, there is the patient who is aggressive and assertive, energetic, dominating, fond of risk, combative, ruthless, loud, hypomanic, and overly active.

Dr. Thimann feels that people in these two groups are relatively well adjusted and often have successful working histories and good social and professional backgrounds.

For this type of patient psychotherapy as the main treatment is not indicated; here the conditioned reflex treatment is the therapy or at least the main therapy. The elimination of the craving for alcohol by means of the conditioned reflex treatment often even without supportive psychotherapy, is sufficient for full rehabilitation. 13


13. Ibid., p. 108. Underlining is this writer's inclusion.
Patients of these two groups seem to respond most favorably to the conditioned response treatment (also known as conditioned reflex treatment).

Dr. Thimann described the third type of patient as having the following personality syndrome: 14

The third group is represented by the patient who is overly tense and restrained, oversensitive, overly secretive, exclusive and inhibited, high-strung— in one word, schizoid—and who will hardly have a history of decades of social drinking. In his case the compulsive drinking developed relatively early and is a mere expression of underlying neurotic traits.

Dr. Thimann feels that the main treatment for this group would be psychotherapy. In this case the drinking is a symptom, and the conditioned response treatment would just remove the symptoms and leave the underlying traits. The Medical Director does feel, however, that often,

...the psychotherapy of such patients is made easier and has more chance of success if the patient has first undergone the conditioned reflex treatment. The psychotherapy is not then interrupted by drinking bouts and the emotional reactions involved, and is facilitated by the patients regained self-assurance. 15

At this point we can now see how the conditioned response treatment differs from the other treatments enumerated in this chapter. The hypothesis is accepted that the alcohol addiction of many patients is one of an autonomous nature, i.e., is on the level of an abnormal conditioned

15. Ibid., p. 109.
reflex. An attempt is made in this treatment to outweigh the craving for alcohol by artificially establishing a revulsion toward it. This is done on the level of establishing new reflex associations in the human body. A new response of revulsion replaces the former response of craving.
CHAPTER IV.

PRESENTATION AND DISCUSSION OF STATISTICAL DATA

The ten cases will now be studied for the purpose of analyzing the following area: the marital status of the patients; the source from which the conditioned response treatment is financed; the concomitant treatment with patients; family participation during the conditioned response treatment; the Medical Director's decision to recommend the conditioned response treatment; the verbalized gains expected by the patient from the treatment; the type of follow-up treatment with patients and relatives; and the length of follow-up treatment. The writer will want to see whether there are outstanding characteristics in any of these areas which might have some bearing on the outcome of treatment. The ten cases fall into two groups, "successful" and "unsuccessful" as set forth in Chapter I in accordance with Dr. Thimann's definition.

For the purpose of clarity the tables in this chapter are presented so that each category, "successful" and "unsuccessful", can be analyzed separately and compared.

All patients were males, and with the exception of one "unsuccessful" patient who was twenty-two years old, all were between thirty-six and fifty-one years of age.
TABLE I.
MARITAL STATUS OF PATIENTS

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>&quot;Successful&quot;</th>
<th>&quot;Unsuccessful&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Married</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Five or 100 per cent of the "successful" patients were married and four out of five patients had one or more children. Only two or 40 per cent of the "unsuccessful" group were married. The one widowed patient stated that he began drinking very heavily when his wife died. All the married patients indicated increased marital difficulties as a result of their drinking. The obvious difference seen in this table is that a greater number of "successful" patients were married.

TABLE II.
EXTENT TO WHICH PATIENT ASSUMED FINANCIAL RESPONSIBILITY FOR THE CONDITIONED RESPONSE TREATMENT

<table>
<thead>
<tr>
<th>Source</th>
<th>&quot;Successful&quot;</th>
<th>&quot;Unsuccessful&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
Eighty per cent of the "successful" patients either paid outright for the treatment or worked out some arrangements whereby they, themselves, would pay for it on an installment basis. In the "unsuccessful" group 40 per cent arranged to pay for the treatment from their own resources, 60 per cent had the treatment paid for by a parent or a social service agency. It is interesting to speculate, at this point, on the possibility that the patients who are strongly motivated toward a successful treatment demonstrate this in their desire to participate personally in the payment of their treatment.

Other Concomitant Treatment during Treatment

Every patient received psychotherapy with the psychiatrist during the conditioned response treatment. In addition, one "successful" patient received casework service in connection with financial arrangements for the treatment and insight into his marital problems.

Family Participation in Treatment

In the "successful" group the wives of two patients came in to see the social worker to discuss marital problems and financial arrangements for the conditioned response treatment. In one of these two cases, the wife was extremely negative and withdrawn.
In four out of the five "unsuccessful" cases there was some sort of family participation during the conditioned response treatment. In two cases the relatives of patients came in for short contacts with the social worker, and in another case the mother (a physician) of a twenty-two year old single patient maintained contact with the psychiatrist via the mail and telephone. In the fourth case the wife of a patient continued seeing the caseworker during the conditioned response treatment of her husband and for six months in follow-up treatment.

### TABLE III.

**BASIS FOR DECISION TO RECOMMEND CONDITIONED RESPONSE TREATMENT**

<table>
<thead>
<tr>
<th>Medical Director's Evaluation</th>
<th>&quot;Successful&quot;</th>
<th>&quot;Unsuccessful&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good ego strength</td>
<td>A B C D E</td>
<td>F G H I J</td>
</tr>
<tr>
<td>Moderate ego strength</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Strong super-ego</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Good intellectual insight</td>
<td>X</td>
<td>X X</td>
</tr>
<tr>
<td>Good emotional insight</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Good rapport with psychiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good work history</td>
<td>X</td>
<td>X X</td>
</tr>
<tr>
<td>Married (considered adult pattern)</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>Aid psychotherapy by eliminating compulsive drinking</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>&quot;Last resort&quot; treatment after other treatments tried</td>
<td></td>
<td>X X X</td>
</tr>
</tbody>
</table>
Four of the "successful" patients were considered by the Medical Director to have had good ego strength. Dr. Thimann defines good ego strength as follows:

A patient is considered having good ego strength if he has a good degree of the following traits: good common sense, discretion, good judgment, adequate amount of faith in himself, responsible pattern of living in the past, capacity to suppress immature or non-constructive impulses for the sake of an ultimate goal.

No patient in the "unsuccessful" group was considered by the Director to have had good ego strength while he did consider three patients as having moderate ego strength.

Dr. Thimann defined this category in the following way:

A patient is considered as having moderate ego strength if he has the above traits described in good ego strength to a lesser degree in the appraisal of the patient by the Medical Director.

Dr. Thimann considered the fact that patients were married an adult pattern. That is, it is a step toward leaving an adolescent role and adopting a role which is considered an adult one by society. All of the "successful" patients and two "unsuccessful" patients were married.

One patient out of each group was considered to have a strong super-ego. That is, these patients showed a high degree of guilt over their drinking problem and a strong, driving urge to do something about it.

Two patients in each category seemed to have good intellectual insight into their drinking. However, no patients in the "unsuccessful" group had emotional insight. There
were two patients in the "unsuccessful" group that the Medical Director felt had good emotional insight into their alcoholism.

Only two of the ten patients had good rapport with the psychiatrist and they were both in the "successful" group.

One patient in the "unsuccessful" group had a good work history while three of the "successful" group had a good work history.

Three of the "unsuccessful" patients had been exposed to many other forms of treatment which had failed to check their alcoholism. These three were generally weak in other areas. They were given the conditioned response treatment as a "last resort." One of these three patients was a twenty-two year old schizophrenic whose drinking bouts interfered greatly with psychiatric help in the area of his psychosis. It was felt by the Director that if the compulsive craving for alcohol were checked by the conditioned response treatment, this patient would then benefit more from his individual psychiatric treatment. No "successful" patients were selected as a "last resort."

The largest number of patients that met any one criterion was seven. This was in the criterion of "good work history". The largest combination of factors that any one patient had was five. This was patient "E". The smallest combination that any one patient had was two. Patient "I" of the "unsuccessful" group had this. The average number
of factors for the "successful" group was four, for the other
2.6.

All the factors in the Medical Director's evaluation
were a priori criterion for selection of patients for the
conditioned response treatment.

TABLE IV.
GAINS EXPECTED BY PATIENTS FROM
CONDITIONED RESPONSE TREATMENT

<table>
<thead>
<tr>
<th>Areas of Anticipated Satisfaction</th>
<th>&quot;Successful&quot;</th>
<th>&quot;Unsuccessful&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Family relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social relationships</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Employment goals</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Feeling of self-satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relief from fear of killing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>while driving under the influence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relief from fear of becoming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychotic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desire to eliminate compulsive</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>craving and to have total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>abstinence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With the exception of two patients in the "unsuccess-
ful" group who were extremely ambivalent about their desire
for abstinence all the patients indicated a strong desire to
eliminate the frightening compulsive craving for alcohol and
to achieve total abstinence.

All five patients in the "successful" group and two of the five in the "unsuccessful" group desired better family relationships as a result of the treatment.

Only one patient in each group indicated a desire for improved social relationships.

One patient in the "unsuccessful" group verbalized his anticipation of a feeling of self-satisfaction as a result of the conditioned response treatment.

One patient in the "successful" group stressed the strong hope that the treatment would cure his addiction and free him of the fear of killing someone in his car while driving in an intoxicated condition.

The young schizophrenic in the "unsuccessful" group hoped that the treatment would aid him in overcoming his fear of becoming psychotic and being committed to a state hospital for the mentally ill.

All in the "successful" group hoped for gains in three significant areas: family relationships; employment goals; and a desire to eliminate the compulsive craving and to have total abstinence. Eight patients indicated these three areas.

In Table V, three out of five "successful" patients utilized group therapy and consultations with the psychiatrist as follow-up treatment.
### TABLE V.

**FOLLOW-UP TREATMENT WITH PATIENTS AND RELATIVES**

<table>
<thead>
<tr>
<th>Type of Follow-up</th>
<th>&quot;Successful&quot; Patients and Relatives</th>
<th>&quot;Unsuccessful&quot; Patients and Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A (Pt Rel)</td>
<td>B (Pt Rel)</td>
</tr>
<tr>
<td>Group therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation with psychiatrist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Consultation with social worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night-hospitalization plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: "X" denotes the presence of the type of follow-up.
One patient in the "successful" group continued in follow-up treatment with consultations with the psychiatrist and the social worker.

One patient from both the "successful" and the "unsuccessful" groups utilized group therapy, consultations with the psychiatrist and the night-hospitalization plan for follow-up treatment.

One patient in the "unsuccessful" group had consultations with the psychiatrist and "lived in" during the nights under the protective atmosphere of the night-hospitalization plan.

Two patients in the "unsuccessful" group had only consultations with the psychiatrist. And one patient in this group received no form of follow-up treatment.

A relative of one patient from each group saw the social worker in the follow-up treatment plan. One relative of an "unsuccessful" patient saw a psychiatrist as part of follow-up treatment.

In Table VI, one patient in the "successful" group continued in follow-up treatment for a period of thirty-seven to forty-five months.

Four out of the five patients in the "successful" group and none in the "unsuccessful" group stayed in follow-up treatment between ten and eighteen months.

Four out of the five patients in the "unsuccessful" group stayed in follow-up treatment for a period of not less
TABLE VI.

LENGTH OF FOLLOW-UP TREATMENT WITH PATIENTS AND RELATIVES

<table>
<thead>
<tr>
<th>Months of Treatment</th>
<th>&quot;Successful&quot; Patients and Relatives</th>
<th>&quot;Unsuccessful&quot; Patients and Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A Pt Rel</td>
<td>B Pt Rel</td>
</tr>
<tr>
<td>37 - 45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 - 36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 - 27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 - 18</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>1 - 9</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>None</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
than one month and no more than nine months. This was true, also, of one patient in the "successful" group.

Only one patient out of the ten, who was in the "unsuccessful" group, did not spend any time in follow-up treatment.

Two patients in the "unsuccessful" group each had a relative receiving follow-up treatment for a period of one to nine months. This was true, also, of a patient in the "successful" group.

A majority of the patients who took follow-up treatment received individual psychotherapy with the psychiatrist and one other type of treatment. A majority of the relatives in follow-up treatment received psychotherapy with the social worker.
CHAPTER V.
PRESENTATION AND DISCUSSION OF CASE MATERIAL

Six cases will be presented in this chapter that are illustrative of the two categories under study in this thesis. The first three cases will be from the "successful" group and the next three will come from the "unsuccessful" group. All names used in the following case material are, of course, completely fictitious.

The focus of the presentation of the cases will be on the following areas:

1. Description of patient.
2. Basis for the decision to recommend conditioned response treatment.
4. Other concomitant treatment, if any, during the conditioned response treatment.
5. Follow-up treatment.

"Successful" Group

Case A

Mr. Murray Carill

Mr. Murray Carill was a thirty-eight year old white male. He was married, without children and was employed as a mill worker earning fifty dollars a week. His drinking was constant and intense. The patient's relationship with his wife was at the
breaking point and the mill job was threatened because of his alcoholism.

Mr. Carill established an easy and good rapport with the psychiatrist. He showed good insight into his problem, recognizing the compulsive element. He frankly admitted to the psychiatrist that he needed help. The psychiatrist discussed with Mr. Carill the possibility of his taking the conditioned response treatment. The patient showed much interest in this treatment and believed the conditioned response treatment might break the compulsive factor in his drinking.

Mr. Carill indicated a strong desire to do something about his drinking. He felt that this alcoholism was the cause of his difficult and stormy relationship with his wife. He knew that this was resulting in his inability to hold his job at the mill. Mr. Carill showed good ego strength in that he was willing to take the conditioned response treatment to eliminate the compulsive craving for alcohol and to seek gains in the areas of family relationships and employment goals. He arranged to pay for the treatment through his own resources.

The hospital records reveal that Mr. Carill completed the treatment successfully abstaining from alcoholic indulgence for at least the minimal two year period.

Mr. Carill continued taking follow-up treatment for one year, receiving group therapy and psychotherapy with the psychiatrist. Mr. Carill's wife also received casework services from the social worker for one year, discussing problems in the area of family relationships.

**Interpretation**

Mr. Murray Carill presented a picture of good ego strength. For example, he showed a good deal of common sense and discretion in relation to doing something about his problem. He also showed a strong interest in self-participation for his treatment by working out the fee payments through
his own resources. This appears to be an indication that the patient was motivated toward achieving successful treatment. He showed an adult pattern in that he was married and had been working in a full-time position as a mill worker. Mr. Carill showed many positive strengths by establishing a good rapport with the therapist, by showing good insight into the compulsive factor in his alcoholism, and by desiring very strongly to do something about his disturbed marital relationships and employment goals.

The patient showed a strong motivation to maintain his successful abstinence after the conditioned response treatment. This was manifested especially by his return for one year to the hospital on a regular basis, seeking individual consultations with the psychiatrist and attending the group therapy meetings.

Mr. Carill's emotional support in his abstinence was strengthened by his wife's participation in understanding the conditioned response treatment through her contacts with the caseworker. Thus, he felt that his wife really cared about his getting well. In addition, Mr. Carill's wife continued seeing the caseworker for a year after her husband's treatment, seeking help in working out her marital problems.

Case B

Mr. Joseph Devens

Mr. Joseph Devens was a forty-seven year old
white married male who had three children, two daughters and one son. He was an unemployed factory worker who has been earning about fifty dollars a week. His drinking had reached the point where he was unable to remain sober when working. Often he would come to work inebriated or would not appear at all. As a result of all this the patient lost his job.

Although, at the time of hospital admittance, he was unemployed, Mr. Devens presented a picture of a good work history. In discussions with the psychiatrist the patient appeared conscientious and realistic in his desire to face his problem of compulsive drinking and to do something about it.

A constructive therapeutic relationship was established with the psychiatrist. Mr. Devens was able to recognize his inability to control his compulsive craving for alcohol. From his statements concerning his sincere desire to do something about drinking the psychiatrist believed that Mr. Devens appeared capable of sustained effort in reaching his goal of abstinence. Mr. Devens told how he wanted to improve his family relationships, his social relationships, and a chance for steady employment.

Mr. Devens decided, after discussing the psychiatrist's suggestion of conditioned response treatment, that he would take the treatment. He arranged to pay for the treatment through his own resources after discussing this with the caseworker. He also discussed with the caseworker his marital problems and his feelings about taking the conditioned response treatment.

The hospital records reveal that Mr. Devens completed the treatment and successfully abstained from alcoholic indulgence for at least the minimal two year period.

Mr. Devens received follow-up treatment for one year, receiving psychotherapy in the form of casework services with the social worker.

Interpretation

Mr. Joseph Devens was a patient who presented to the psychiatrist a pattern of positive strengths. He had a good
work history, being employed for many years as a factory worker. He appeared conscientious and realistic in his awareness that he needed help in solving his alcohol addiction. He realized with good insight that he was a victim of a compulsive need to drink that he was unable to control.

Mr. Devens had a great need to do something about his family relationships that were stormy as a direct result of his drinking. He wanted to control his drinking, so that he could return to work and once again support his family. He desired to regain the friends that he had lost through his inability to maintain sobriety. Behind all this conscious motivation of the patient the psychiatrist sensed a good ego strength capable of much sustained effort toward an ultimate goal of the control of his addiction to alcoholic beverages.

As in the case of Mr. Carill, Mr. Devens showed a strong interest in self-participation for his treatment by working out the fee payments through his own resources.

Also, as in Case A, Mr. Devens showed a strong motivation to maintain his successful abstinence after the conditioned response treatment. He returned to the Washingtonian Hospital for one year following the completion of the treatment, seeking casework services in the area of his family relationships.
Case C

Dr. Bernard Drew

Dr. Bernard Drew is a fifty-one year old married white male and is the father of two children. He was employed in a nearby state in a local government agency as a physician earning one hundred and thirty-five dollars weekly. The patient's heavy drinking made him incapable of being sober and rational in his medical work. His alcohol addiction led to his being relieved of his professional duties.

Dr. Drew established a good rapport with the psychiatrist and indicated a good intellectual and emotional insight into his compulsive craving for alcohol. He presented to the psychiatrist a picture of good work history on a professional level.

The patient realized the compulsive element in his drinking and the need for help. He believed that the conditioned response treatment might break this factor in his drinking. Dr. Drew expected gains from the treatment in the areas of family relationships and employment goals. The patient's brother, a successful businessman, arranged to pay for the treatment.

The hospital records reveal that Dr. Drew completed the treatment and successfully abstained from alcoholic indulgence for at least the minimal two year period.

Dr. Drew has been receiving follow-up treatment for three and one-quarter years up to the time of this writing in group therapy and psychotherapy with the psychiatrist. He also was in the night-hospitalization program for several months after completion of the treatment.

Interpretation

Dr. Bernard Drew admitted his compulsion for alcoholism and his need for help. He believed that the conditioned response treatment might break this compulsive factor and thus save his career and family relationships. He showed good ego
strength in his willingness to undertake an unpleasant treatment in order to achieve the ultimate goal of sobriety.

He presented many personality strengths to the psychiatrist. He established a good rapport with the psychiatrist and presented an adult pattern in the sense that he had been able to get married and was the father of two children. At the same time he had a good work history that included study and graduation from a medical school and work as a physician in a respected position with a local government agency.

Unlike the other two patients presented in this group Dr. Drew was involved in financial difficulties of a legal nature and was unable to arrange to pay for his own treatment.

Dr. Drew showed an extremely strong motivation to continue his abstinence. Up to the time of this writing Dr. Drew has continued in follow-up treatment for a period of three and a quarter years. He has received group therapy, night hospitalization and individual psychotherapy with the psychiatrist.

"Unsuccessful" Group

Case D

Mr. Arthur Dale

Mr. Arthur Dale was a forty-one year old single white male. He was a lawyer who earned over one hundred dollars a week. However, his drinking had become so heavy that he often would be unable to complete his legal duties in a case. He found his drinking was
causing him to lose the respect and friendship of his associates.

The psychiatrist found in Mr. Dale a rigid, ambitious personality with much drive. The patient was an intelligent man with poor ego strength. He was unable frankly to face his inability to control the compulsive element in his drinking without great emotional ambivalence. In talking with the psychiatrist, however, Mr. Dale did show a very rigid super-ego structure in which there was a strong drive to alleviate his guilty feelings concerning his drinking.

The psychiatrist felt that the conditioned response treatment should be tried as a "last resort" since the patient seemed unable to resolve his alcohol addiction by other treatments. Mr. Dale agreed to try the conditioned response treatment, stating that he hoped it would help him in maintaining his excellent professional job. He verbalized an anticipated feeling of self-satisfaction that he would get out of being exposed to this prolonged treatment. Mr. Dale hoped that if he could overcome the compulsive character of his drinking and become an abstainer he would be able to settle down and get married.

Mr. Dale arranged to pay for the conditioned response treatment through his own resources.

During the treatment Mr. Dale was seen by the caseworker who attempted to build a positive relationship with the patient and discuss his plans upon leaving the hospital.

The hospital records reveal that Mr. Dale completed the treatment and was unable to abstain successfully from alcoholic indulgence for at least the minimal two year period.

Mr. Dale returned for an irregular one-half year follow-up treatment. He received individual therapy from the psychiatrist and occasionally attended the group therapy meetings.

Interpretation

Mr. Arthur Dale was a rigid, ambitious personality who had a great deal of drive. He presented to the psychiatrist
a rigid super-ego structure with much guilt about his drinking. This same guilt drove Mr. Dale to do something about his compulsive addiction to alcoholic beverages. He was an intelligent man with intellectual insight into his drinking problem. However, the patient had poor emotional insight into his problem. His ego strength was poor in that he could not truthfully admit to himself that he was a victim of alcoholism.

Mr. Dale did not present much in the way of personality strengths to the psychiatrist who felt that, after trying other treatments, the conditioned response treatment was worth trying since all other treatments had failed.

The patient readily accepted the recommendation of the psychiatrist, stating a desire to receive ultimate help in the following areas: employment goals, a feeling of self-satisfaction and a desire to get married. Mr. Dale did show an interest in self-participation for his treatment by arranging to pay for his treatment.

The patient received casework services during the administration of the conditioned response treatment.

The lack of motivation for a more "permanent" cure may be seen in Mr. Dale's behavior when he returned on an irregular basis for only six months in follow-up treatment, receiving some group therapy and consultations with the psychiatrist. In general, the negative factors of a weak ego
structure with poor emotional insight appeared to outweigh the positive factors of intelligence coupled with much energy.

Case E

Mr. Harold Garner

Mr. Harold Garner was a forty year old white male who was married and had two children. Mr. Garner was employed as a meat salesman earning eighty dollars a week. Both his job and family relationships became threatened by his heavy daily drinking. The patient was warned he would be fired if he could not stay sober while working. The patient was inebriated nightly and his wife refused to have sexual relations with him because of this condition.

Mr. Garner showed a good intellectual insight into the compulsive element of his drinking. However, on the emotional level, the patient revealed a marked degree of ambivalence regarding the reality of his problem and his need to do something about it. Mr. Garner did conscientiously keep his appointments with the psychiatrist in the Outpatient Department Clinic. However, at the end of this time he was still unable to reduce his drinking relapses.

The psychiatrist felt that the patient's strong dependence on alcohol must be broken by means of response conditioning. At the end of a year in the Outpatient Department Mr. Garner's ambivalence toward doing something constructive about his problem was resolved to the point where he agreed that the conditioned response treatment might help him to overcome his compulsive drinking. Although he agreed to take the treatment, the patient's ambivalence was still seen in his attempt to pay a fee far lower than necessary in his financial situation. The treatment was finally paid by his father.

Mr. Garner was having trouble at home where he and his wife were constantly arguing about his drinking. He was also having trouble holding down his job because of his inability to remain sober for any sustained period of time. He hoped that the conditioned response treatment would help him to overcome the
problems in these two areas.

The hospital records reveal that Mr. Garner completed the conditioned response treatment and was unable successfully to abstain from alcoholic indulgence for at least the minimal two year period.

He did return on an irregular basis after the conditioned response treatment initial series for a period of nine months, receiving individual therapy with the psychiatrist.

**Interpretation**

Mr. Harold Garner showed moderate ego strength in that he attempted to do something about his problem of drinking by faithfully attending the Outpatient Department of the hospital seeking psychotherapy. However, he was extremely ambivalent and the alcoholic relapses continued up to the time of the conditioned response treatment. The patient's ambivalence toward taking the conditioned response treatment might be interpreted in his unwillingness to cooperate in the setting of fees for the treatment.

He did show an adult pattern in that he was married and had a family. The insight into his problem of drinking was mainly an intellectual one and he could not emotionally accept his inability to stop his compulsive drinking. That is, he could not earnestly say to the psychiatrist that he was frightened at his inability to stop drinking and wanted help.

Mr. Garner verbalized the positive hopes that the conditioned response treatment would help him to overcome the
problems that he was having with his wife and his job situation.

The patient did return for follow-up treatment for nine months. However, he did not take part in group therapy and only saw the psychiatrist for individual psychotherapy. This inability to participate fully in the follow-up treatment perhaps is an indication of the patient's lack of sufficient motivation or full acceptance of the treatment plan. Essentially Mr. Garner's pattern of behavior was one of marked ambivalence wherein he could not completely submit himself to total and successful treatment.

Case F

Mr. Milton Brockton

Mr. Milton Brockton was a twenty-two year old white male. He was single and unemployed. His drinking was heavy and continuous. Often he would suffer from hallucinatory episodes while under the influence of alcohol.

According to the examining psychiatrist, Mr. Brockton was a very regressed and aggressive individual with homosexual preoccupations. No treatment seemed able to eliminate his alcoholic compulsion. The psychiatrist was conscious of the fact that the patient was a schizophrenic personality. Every alcoholic relapse suffered by the patient aggravated his psychotic status. The patient revealed to the psychiatrist that he was a user of opiates. This could easily vitiate such treatment as the conditioned response treatment since any narcotic can often abolish a "reflex". However, the psychiatrist believed that the conditioned response treatment was worth a "last chance". If the alcoholic relapses could be eliminated the patient might become more amenable to psychiatric
treatment for his schizophrenia.

Mr. Brockton frankly stated that the understanding of all his problems was an intellectual one. He readily agreed to take the conditioned response treatment hoping that soon he could "start an active responsible life." Mr. Brockton hoped that the conditioned response treatment would stop his drinking and aid in overcoming his fears of becoming psychotic.

Mr. Brockton's mother, a physician, arranged for the payment of the treatment.

The hospital records reveal that he completed the treatment and was unable to abstain from alcoholic indulgence for at least the minimal two year period.

He continued for three months in follow-up treatment remaining in the hospital under the night-hospitalization program and receiving individual therapy with the psychiatrist.

Interpretation

Mr. Milton Brockton was a very regressed and aggressive individual who had suffered from schizophrenic episodes. The patient's ego strength was poor and he was unable to clearly think about his problem and the need to control his addiction. He showed no personality strengths to the psychiatrist that might have indicated a good prognosis for treatment.

He showed a strong fear of eventually being hospitalized in a state hospital for his schizophrenia. He stated several times his fear of becoming psychotic. He did state that he wanted to "start an active and responsible life" and hoped the conditioned response treatment would help toward this goal. However, he readily admitted that his insight into his problem was an intellectual one.
Mr. Brockton's mother paid for the treatment of her son, who was unemployed. He was unable to participate in his own treatment by arranging to pay for it himself.

The patient's poor motivation for treatment was seen in his meager return for follow-up treatment. It was only for a period of three months wherein he utilized night-hospitalization and therapy with the psychiatrist.

Basically, Mr. Brockton may be classified as a symptomatic drinker whose drinking was an expression of underlying psychosis. In general, this type of patient has a poor prognosis for successful treatment.
CHAPTER VI.

SUMMARY AND CONCLUSIONS

The purpose of this thesis was to examine two groups of patients at the Washingtonian Hospital who took the conditioned response treatment "successfully" and "unsuccessfully". In approaching this problem three questions were raised:

1. What were the considerations which led to the selection of these ten patients for the conditioned response treatment?

2. Were there any outstanding differences and in what areas did they occur between the "successful" and the "unsuccessful" group?

3. What was the role of the social worker during treatment and follow-up with these two groups of patients?

It was seen in Chapter II that the conditioned response treatment differs from the other treatment in eliminating the craving for alcoholic beverages by means of a vivid association between the alcohol and the unpleasant emetine. The conditioned response treatment "makes use of this mechanism by inducing nausea in connection with the sight, smell and taste of alcoholic beverages to which the patient is addicted."¹ An attempt is made to establish a response

association between the nausea and the alcoholic beverages.

A general survey of the literature in Chapter III revealed that the nature of the causality of alcoholism and its development within the individual are not unanimously agreed upon by the researchers in the field. The theories range from a disturbed body metabolism to cultural factors influencing rates of alcoholism among different ethnic groups.

In Chapter IV the ten cases were studied for the purpose of statistical comparison. We saw that a greater number of "successful" patients were married than were the "unsuccessful" ones. Being married was considered an adult pattern by the Medical Director of the Washingtonian Hospital. All but one, or 80 per cent of the "successful" patients, arranged to pay for the conditioned response treatment through their own resources. Only two, or 40 per cent of the "unsuccessful" group were able to do this.

It was seen in the Medical Director's decision to recommend the conditioned response treatment that most of the patients in the "successful" group had good ego strength while none were considered to have this in the "unsuccessful" group. The fact that a patient had a good work history was an indication to the Medical Director that the individual had a mature pattern in his past life. This indicated a stronger motivation and therefore a better prognosis toward successful use of the conditioned response treatment. Most
of the patients in the "successful" group had a good work history while only one member in the "unsuccessful" group presented this picture. None of the "successful" patients were considered for the conditioned response treatment as a "last resort" treatment while most of the "unsuccessful" patients were put in this category.

Concerning the gains expected from the conditioned response treatment by the patients it was seen that a majority of both groups desired to eliminate the compulsive craving for alcoholic beverages and to have total abstinence. It is significant to observe that only in the "successful" group did all indicate a desire to improve family relationships. It is to be remembered here that all of the patients in this group were married while only two out of the five in the "unsuccessful" group were married.

In discussing the bearing follow-up treatment has on continued abstinence it was observed that all the patients in the "successful" group received follow-up treatment for more than ten months, and that one patient in this group continued for a period of forty-five months. None of the patients in the "unsuccessful" group stayed for treatment for more than nine months. One patient in this group did not return for any follow-up treatment. It would seem significant to observe at this point that those patients who returned for follow-up treatment were more strongly motivated for total abstinence.
In the ten cases presented in this thesis the social worker was seen to have more contact in follow-up treatment with a relative than in other areas. Marital relations and family adjustments after the conditioned response treatment were most discussed. To a lesser degree there was concomitant casework with a patient receiving the conditioned response treatment. Here, financial arrangements, feelings concerning treatment, future plans and family relationships were discussed. Also, there was some casework in the area of follow-up with a patient where marital relationships were discussed.

In summary it can be stated that the "successful" patients presented the following pattern wherein at least four out of the five patients in this group were involved in each factor:

1. Responsible for payment of treatment.
2. Married.
4. Motivated by desire to improve family relationships.
5. Employed.
6. Desire to eliminate the compulsive craving for alcohol.
7. Stayed in follow-up treatment for more than a year.
8. Follow-up treatment consisted primarily of group therapy and consultation with the psychiatrist.

Conversely, the "unsuccessful" group presented no pattern
of factors with the exception of the following:

1. Follow-up treatment of nine months or under.

2. Follow-up treatment consisted primarily of consultation with the psychiatrist.

It is interesting to observe in the ten cases studied that collateral work with relatives was done in only two cases. Social service to relatives and family where prognosis for the patient himself is not encouraging is an area that may bear further investigation.

Approved 7/27/55

Rose Bernstein
APPENDIX

SCHEDULE

I. IDENTIFYING INFORMATION
   A. Age
   B. Religion
   C. Marital status
   D. Occupation and income
   E. Source from which CRT is financed

II. ALCOHOLIC STATUS OF PATIENT AFTER TWO YEARS

III. BASIS FOR DECISION TO RECOMMEND CONDITIONED RESPONSE TREATMENT
   A. Strengths and Weaknesses in personality of patient
      1. Ego strength
      2. Other

IV. CONSCIOUS MOTIVATION OF PATIENT
   A. Does patient verbalize his understanding of treatment?
      1. How readily does he accept it?
   B. Gains expected from treatment
      1. Family relationship
      2. Employment goals
      3. Feeling of self-satisfaction
      4. Other areas

V. FAMILY PARTICIPATION IN CONDITIONED RESPONSE TREATMENT

VI. OTHER CONCOMITANT TREATMENT DURING CONDITIONED RESPONSE TREATMENT

VII. FOLLOW-UP TREATMENT
   A. Length of follow-up treatment
   B. Type of follow-up treatment
SCHEDULE (continued)

1. Group therapy
2. Consultation with psychiatrist
3. Consultation with social worker

C. Who gets follow-up treatment
   1. With patient
   2. With relatives
   3. With others

VIII. COMMENTS BY STAFF MEMBERS
BIBLIOGRAPHY


Annual Report of the Washingtonian Hospital, Boston 1948.


"The Conditioned Reflex Treatment for Alcoholism," Current Therapies of Personality Disorders, Glueck, Bernard, M. D., ed.
