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A study of nine non-voluntary male alcoholics admitted to the Washingtonian Hospital, 1948

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Boston University
A STUDY OF NINE NON-VOLUNTARY MALE ALCOHOLICS
ADMITTED TO THE WASHINGTONIAN HOSPITAL

1948

A THESIS

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CHAPTER I

INTRODUCTION

Purpose and Scope

This is an intensive study of nine male alcoholic patients admitted, non-voluntarily, to the Washingtonian Hospital in Boston in 1948. The purpose is to determine the following:

1. What appear to be the emotional responses of the non-voluntary patient to his forced confinement?

2. What are the basic factors which tend to make case work difficult with the non-voluntary patient?

3. What adaptations in case work treatment seem to be necessary for working with the non-voluntary patient?

It is necessary to point out that this study of nine cases is suggestive rather than representative of the non-voluntary patients admitted to the Washingtonian Hospital in 1948 and known to the Social Service Department of the Hospital.

Source of Data

The confidential files at the Washingtonian Hospital provided the source for the case material and extreme care was taken by the writer to eliminate any identifying material in the cases presented. The writer has also incorporated into this study supplementary
material from the extensive literature on Alcoholism where relevant to the study.

Method of Selection

The writer found that there were 421 non-voluntary patients admitted to the Washingtonen Hospital in 1948 and 100 cases of the total number were selected at random for this study. This random selection revealed forty cases known to the Social Service Department of the Hospital and thirty-one of these were eliminated for the purpose of this study for the following reasons:

1. Cases where the social worker had contact with the family or other agencies but not with the patient.

2. Cases where direct contact with the patient by the social worker consisted of a notification of a referral to the Out Patient Department or of a subsequent contact with a member of the family.

3. Cases where the patient was known to the Social Service Department of the hospital from another agency referring the patient and where contact with the patient in such cases was not possible due to the sudden release of the patient by his family.

The criteria for selecting cases for study was based on a non-voluntary confinement including direct contact with the patient by the social worker for one or more interviews. Non-voluntary patients admitted to
the hospital in 1948 were considered suitable for study if the patient had been previously known to the Social Service Department as a non-voluntary patient but contact was not continued in 1948 by the social worker for one reason or another.

The writer considers it important to call attention to the fact that non-voluntary patients are frequently released by their families after three days of confinement for various reasons which accounts for the small number of cases known to the Social Service Department out of the 100 cases selected at random.

**Reasons for the Study**

In 1948, a total of 871 patients were admitted to the Washingtonian Hospital and 421 of these were non-voluntary patients which is an indication of the prevalence of forced confinements. No study has been done, to the writer's knowledge, to determine if case work with the non-voluntary alcoholic is hampered because of his feelings regarding a forced confinement. The writer felt that the questions posed for study would shed some light on the reactions of the non-voluntary patient to his confinement and would also determine if the forced confinement was a deterrent preventing effective case work with the patient.

Wives, parents or relatives of alcoholics often turn to the Washingtonian Hospital when they become
frightened by the extent and the continuation of drinking at a period when the patient is not aware or does not care what happens to him. These patients awaken from their alcoholic stupor in the hospital and find themselves confronted with the fact that they are not free to leave the hospital until released by the person responsible for confinement.

In this country, alcoholism is still recognized as a crime by the legislature when drinking results in neglect of responsibility and disturbance of the peace. The families of alcoholics consider confinement in the Washingtonian Hospital less threatening than detention in jail as the solution for the alcoholic whose drinking has extended beyond his control.

The director of the Rocky Meadows Farm in Wakefield, Rhode Island, states his observations of the effect of an individual's drinking on his life.

If drinking jeopardizes his family life, his work or his social relations but he cannot stop of his own accord, then -- regardless of how much or how little a man drinks, and whether continuously, occasionally or periodically -- alcohol is a problem to him.

A problem drinker is any individual to whom his drinking is a problem and who is in serious trouble because of it.

Limitations of the Study

The writer recognizes that this study is limited by the incompleteness of the records and that no impartial objective measuring devices could be applied in examining the case material. This study is limited to case work with non-voluntary patients and only indicates some facets of case work attempted with non-voluntary patients in 1948.

A further limitation of this study is that all of the nine cases presented were carried by students. Since student workers were only in the hospital three days a week contact with patients was limited.
CHAPTER II
THEORIES REGARDING FORCED CONFINEMENT FOR THE ALCOHOLIC

In this chapter the writer will discuss a few of the current and past thinking concerning the effectiveness of forced confinement for alcoholics. The writer is of the opinion that it is important to observe objectively some of the advantages as well as the disadvantages of a forced confinement as presented by professional people engaged in the task of finding a solution for the alcoholic and his problem. The extensive problem of alcoholism is gaining more and more interest from the public which brings into focus the need for facilities to care for the alcoholic. The effectiveness of forced confinement will need more consideration than it has been given in the past in the effort to determine what facilities are suitable for work with the alcoholic. Alcoholism is now classified as the nation's fourth major Public Health Problem\(^1\) and the following paragraph clarifies the reason.

In calling alcoholism a public health problem cognizance is taken of the fact that this particular illness has a wide spread effect. It is not only costly to the individual but to everyone concerned

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\(^1\) Boston Committee for Education on Alcoholism, You and Alcoholism Radio Broadcast, Station WORL, Boston, March 20, 1948.
with the alcoholic and to the community at large. When the alcoholic is a family man, the effects are particularly significant. Apart from the emotional and mental hazards of living in such a situation, earning power is affected and the family is quite likely to become indigent. Social agencies may need to be called upon, and the problem will indeed become a public one.²

The literature on alcoholism presents many and varied theories concerning the effectiveness of complete withdrawal of alcohol by means of confinement in a hospital. Strecker's reflection on the question of confinement for the alcoholic is:

So, too, though it is sometimes imperative in a given instance, yet detention by legal force in a hospital or sanatorium will rarely be helpful for the individual, nor will it make any preventative impression on the problem of alcoholism.³

Durfee seems to share the above opinion in his discussion of forced confinement for the alcoholic in the following abstract from his book.

The very restrictions usually imposed in the care of the alcoholic constitute a symbol of his inadequacy held constantly before his eyes. If he has within him the self honesty necessary for any regeneration, he himself knows that he has failed; and nothing is gained by emphasizing this fact. People grow strong in freedom and not under restriction. Drinking often follows an inner sense

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³ Edward Strecker, Alcohol One Man's Meat, p. 20.
of failure. To shut a man away and so prejudice him incapable of governing himself, far from helping him, only intensifies his sense of failure. 4

Durfee, in the above abstract, is referring to alcoholics who have passed through the acute stage of alcoholism where restriction is no longer necessary for the protection of the alcoholic as well as for the safety of others. The alcoholic in the acute stage of alcoholism is irrational and incapable of sufficient judgment to make a decision regarding treatment. The advocates of institutional therapy emphasize the necessity of keeping the patient away from alcohol and the need for temporary removal from an environment which presents temptations as well as emotional stress. 5

The question as to whether or not immediate withdrawal of alcohol is tangible proof to the alcoholic that there is not a medical need for alcohol is an area open for further study and has not been adequately investigated or explored in the literature on alcoholism. The concept that delirium tremens would be the result of sudden withdrawal of alcohol has now been disproved on the basis of observations of

4 Charles Durfee, To Drink or Not To Drink, p.20.
thousands of alcoholics who were admitted to state hospitals where the incidence of delirium tremens was small enough to be considered insignificant. Jellinek noted that Graf and Reynell favored home treatment for the alcoholic but advocated hospitalization for the acute stage of alcoholism; Strong advocated institutionalization only for cases requiring continuous hospital care and where temperance organizations had failed; and Strassed tended to limit institutionalization to those who were dangerous to society. Jellinek also pointed out that Simmell, Menninger, Knight and I. D. Williams were all of the opinion that institutional facilities had certain psychological effects on the alcoholic. They have for example:

utilized some features of institutions for the specific requirements of the treatment of alcohol addicts. Simmell found that the putting to bed of the patient and the circumstances attendant on it are a gratification of the unconscious desires of the victim of morbid cravings, namely to be a child again, and to have a kind mother feed him and be present whenever anxiety seizes him. This situation is transformed back into the analytic situation as the treatment progresses and the

6 E. M. Jellinek, Alcohol Addiction and Chronic Alcoholism, p. 52.
7 Ibid., p. 54.
8 Ibid., p. 68.
infantile phase spontaneously disappears. The value of the hospital personnel as father and mother substitutes has also been stressed by I. D. Williams. Institutional treatment based on psychoanalytic principles adapts the patient's activities to his unconscious needs; outlets for aggressive drives are provided, anxieties are made endurable, praise and affection are given at appropriate times.

Thus, there are other reasons for institutionalization which take into consideration the personality of the alcoholic, and therefore extend beyond the advantages of removal of the alcohol for the convenience of treatment.

Jellinek, in his critical exposition of the knowledge of alcoholism, offers the following conclusions regarding institutional care for the alcoholic and the immediate withdrawal of alcohol.

The question of the treatment environment (open or closed institution or outside of an institution) cannot be decided in a general way, but must be reconsidered in each individual case.

Arguments against immediate withdrawal of alcohol are not substantiated by facts; on the other hand, a quick tapering off, rather than immediate withdrawal, seems to do no harm. The question must be regarded as a minor one as long as the object of the treatment is total abstinence and this is

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9 E. M. Jellinek, op. cit., p. 68.
actually the case in all treatments.\textsuperscript{10}

At the present time, statistical data supporting either intramural or extramural care for the alcoholic is not available and the theories postulated by various authors remain theoretical without facts based on scientific investigation.

\textsuperscript{10} Ibid., p. 78, 79.
CHAPTER III
THE WASHINGTONIAN HOSPITAL

Introduction

In Chapter II, the writer presented some of the theories regarding intramural and extramural care for the alcoholic. The Washingtonian Hospital recognizes the necessity of intramural care for the alcoholic in the sub-acute and the acute stages of alcoholism in order to offer the alcoholic the opportunity to view his problem when he is completely rational. The Washingtonian Hospital does not, however, consider treatment beyond this stage effective if the alcoholic is not willing to participate fully in planning for his own treatment.

The internal structure of the services offered at the Washingtonian Hospital is designed and equipped to treat the alcoholic on an individual basis depending upon the problem presented in each case. The director of the Washingtonian Hospital writes:

The Washingtonian Hospital attempts an individualized and scientific approach to the treatment of the alcoholic patient, employing an eclectic system of study and therapy.¹

Brief History of the Hospital

In the year 1840, six men formed the Washingtonian Society in Baltimore, Maryland, and they signed a pledge which developed into a wide spread movement to convert inebriates to sobriety. This movement was called the Washingtonian Movement.

Temperance movements had been active long before the formation of the Washingtonian Society but the society introduced the emotional elements of drinking to replace the moral and religious convictions. The Boston Society moved a step beyond the pledge signing of other societies by developing boarding houses where alcoholics were provided with meals and lodging.

The "Home for the Fallen" was established in Boston in 1857 as a result of the Washingtonian Movement, and the building was chartered under the name of the "Washingtonian Home". As the original name of the Washingtonian Hospital implies, treatment was focused on the moral and religious aspects without an attempt to rehabilitate the alcoholic.

A scientific attitude toward alcoholism began to be noted from the doctor's reports in 1866. In 1876, the superintendent of the Washingtonian Home declared,

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"alcoholism is to be a disease instead of a moral perversion".3

On February 7, 1939, the Washingtonian Home became the Washingtonian Hospital. In contrast to the early religious approach to the alcohol problem, the Washingtonian Hospital in 1941 offered scientific treatment for the alcoholic through psychiatry, social service, and therapy in medicine. The Conditioned Reflex Treatment for the alcoholic, now offered at the Washingtonian Hospital was started in February, 1942.

The medical director of the hospital describes the therapies offered for the treatment of the alcoholic as follows:

There are three distinct groups of alcoholic patient: (1) Symptomatic drinkers with underlying psychoses; (2) those who are, roughly speaking, purely habituated drinkers; and (3) problem drinkers. Patients in the first group are not treated in this hospital but are referred to a mental hospital for treatment of the basic disease. Treatment of patients in the other two categories depends on the group to which they belong. In case of pure habituation, the patient may be given conditioned reflex therapy, followed by the required reinforcements, superficial psychotherapeutic interviews, and if necessary, adjustment of environmental factors. With the problem drinkers, in addition, it is necessary to try to find the underlying causes of the alcoholism and help them by means of systematic psychotherapy, either to eliminate them or to adjust to them. Often relaxation therapy, in the form of manual hobbies, etc.; is an important adjunct in this type of case.4

3 Ibid., p. 59.

4 Corwin and Cunningham, op. cit., pp. 52-53
The Washingtonian Hospital is forced by its limitations to accept only male alcoholics at the present time, and any future transition to reduce this selectivity by including hospital care for female alcoholics, would require a larger, more suitably located building. The hospital is unique in that the financial planning for treatment is within the range and limits of the middle class group, and it does not exclude patients in the lower income brackets. The policy of the hospital at the present time is to accept four free patients per month and there is a special reduced rate for social agencies.

Admission Policies and Discharges

According to the Department of Mental Health, an alcoholic can be committed to the Washingtonian Hospital for a fifteen-day period by the nearest relative, police officer or a physician. The non-voluntary patient cannot be released prior to the completion of the fifteen-day confinement unless the person who originally signed the commitment papers signs the patient out.

Patients enter the hospital voluntarily to terminate or to prevent a drinking bout, to take the Conditioned Reflex Treatment or the reflex reinforcement treatment. The voluntary patient can be discharged on request after submitting a three day notice.
The Detoxication Treatment

The process of detoxication usually extends anywhere from eight to fifteen days and the Washingtonian Hospital uses a sub-shock dosage of insulin which is followed by neutralization with dextrose. Along with the detoxication the patient is given vitamin therapy, regular nutritious meals, medication and rest, all of which help to build the patient up physically. It is typical of many alcoholics to consider the facilities of the hospital as mainly that of detoxication and they refuse to consider treatment beyond this initial stage. The hospital has recently consented to accept patients for detoxication purposes only when plans have been prearranged with an alcoholic clinic to return the patient to the clinic when he would be more amenable for therapy. This adds an additional burden to the other functions of the hospital but it is necessary when considering the inadequate facilities of general hospitals.

A survey of hospital facilities for alcoholics pointed out:

For numerous reasons -- frequent overcrowding of hospitals coupled with the magnitude of the problem of chronic alcoholism, the difficulties encountered in managing alcoholic patients, social inertia, and what is perhaps most important, the defeatist attitude of the medical profession -- hospitals have been reluctant to assume responsibility for the care of the
alcoholic.\textsuperscript{5}

The Working Parole Plan

This plan consists of part-time hospitalization for the patient which affords him the opportunity to contribute voluntarily to the financing of his own rehabilitation through working on the outside. This plan also gives the patient a chance to locate work while receiving the protection of the hospital during the discouraging and depressing period of job-hunting. The social worker is also on hand during this period and active in helping the patient to readjust his working environment if it were not proving satisfactory for his particular needs. This plan develops the patient's feeling of self-confidence through achieving or maintaining self support and thus the patient is an active participant in his own planning and the treatment becomes his own if he has worked and saved the money. The director of the hospital says of this plan;

Long time hospitalization is expensive and tends to create dependency in an artificial environment which does not prepare a patient for functioning in his natural environment without alcohol thus the part-time protective environment of the Washingtonian Hospital alleviates this problem.\textsuperscript{6}

\textsuperscript{5} Corwin and Cunningham, \textit{op. cit.}, p. 27.

The Conditioned Reflex Treatment

Briefly, the theory of the Conditioned Reflex Treatment is based on Pavlov's experiment on dogs in developing reflex responses and this is made applicable to the development of conditioned responses in the alcoholic in regard to alcohol by the use of nauseant drugs simultaneously with alcohol. The aim of this treatment is the elimination of the craving for alcohol, but it is important to follow up the initial conditioning with reinforcements at different intervals. Dr. Thimann states:

The establishment of a conditioned reflex is only one element in a tripartite plan of treatment, the other two elements of which are a part-time protective environment and supplemental psychotherapy.7

This treatment is often sufficient for patients whose only difficulty is the addiction to alcohol developed from the habitual use of alcohol without any underlying emotional disturbance. The Conditioned Reflex Treatment succeeds in merely removing a symptom if the etiology of the addiction for alcohol is based on some underlying emotional instability. Such cases require psychotherapy which can be carried on without

interruption because of drinking after the removal of the craving for drink. Certain patients are excluded as candidates for the Conditioned Reflex Treatment, namely psychotics, mental defectives, drug and alcohol addicts, and those whose profession keeps them constantly exposed to alcohol.  

The Out-Patient Department

This department is currently utilizing the services of two psychiatrists who come into the hospital at different times during the week for interviews with patients by appointment. Women are accepted in the out-patient department for psychotherapy. The social worker works closely with the psychiatrist and carries on case work with wives whose husbands are receiving psychotherapy or vice versa.

The Social Service Department

An important element in the alcoholic's life which may or may not contribute to his disease is the family. The social worker in the hospital has the major task of working with the family which often requires long and intensive case work with a wife or mother. The director of the Social Service Department explains the function as follows:

8 Thimann, op. cit., p. 110.
But the patients, and even their families, will testify that dedication to a plan is one thing and realization of their goal is quite another; for the road to successful rehabilitation of the alcoholic patient is beset by bumps and rough spots, both real and imagined. It is the task of the social worker to help the patient over these disturbances to treatment.9

The social worker's chief focus at the Washingtonian Hospital is on the families plus early contact with the patient in an effort to help him adjust to the hospital and to plan for further treatment that the psychiatrist has recommended. The families of alcoholics need help in making constructive use of the facilities of the hospital.

CHAPTER IV

CASE WORK WITH THE ALCOHOLIC

In this chapter the writer will present some general aspects of case work with the alcoholic as a framework for understanding some of the adaptations of case work techniques with the non-voluntary patients in the case presentations of this study.

Case work with the alcoholic does not deviate from that basic concept of an accepting, non-judgmental, non-condemning approach to the individual with a problem needing assistance. It is essential to bear continually in mind the lack of understanding and the criticism that the alcoholic has been forced to contend with from those in his external environment.

The case worker can as Boggs says

Act as a sustaining and guiding person while helping the client to get what relief he can from sharing his problem and from experiencing acceptance by someone who can see his real self behind his false front and help him, in a measure, to see it, who respects him as a person even though not approving of all his behaviour; who can be counted on to back him up when he needs it but not to take over his burdens for him.¹

Alcoholics have one thing in common -- emotional

immaturity -- although they do not necessarily present the same etiology underlying their addiction.\(^2\) The alcoholic as an immature person has not reached the mature capacity for accepting interdependence, responsibility, and self acceptance on an adult level.

Scientific treatment cannot be forced onto the alcoholic which means that the decision must belong exclusively to him. The patient, however, must have confidence in the psychiatrist and the social worker in order to accept the treatment recommended in his particular case. The case worker has as his goal, in initial contacts with the alcoholic, the task of mobilizing his concern and his awareness which leads to a realization of the problem with which he is confronted and which prevents him from operating and functioning in society as a responsible, reasonably independent, individual. Once this realization has been aroused in the alcoholic, he tends to offer his own solutions for combatting his problem, namely, will power, group activities or a change of vocation. At this stage in the alcoholic's thinking, the case worker needs to point out any incongruities existing in the alcoholic's plans based on a knowledge of the patient's educational background, drinking patterns, previous

\(^2\) Ibid., p. 558.
attempts to use will power as well as the environmental situation in which he functions as an individual. The alcoholic is not ready for treatment for his drinking until he is convinced of his own inability to solve his drinking by whatever method he has chosen to attempt as a solution.

Resistance to accepting the proclivity for drink is commonly noted in all alcoholics, a fact which must be recognized and understood by all those in professional fields engaged in the task of helping the alcoholic. Tiebout clearly emphasizes this point:

Probably without exception, every true sufferer from the disease of alcoholism passes through a long period when he is completely resistant to the idea that he is sick and should have help. Often, despite a conscious awareness that aid should be welcomed, the alcoholic finds himself stubbornly unwilling and even unable to acknowledge that he is in trouble and should seek advice. As one patient expressed it, "I know it in my head, but not down here" -- pointing to his heart. He was displaying neatly and concretely his real lack of inner conviction about his need for help.

The outstanding element in resistance is the idea maintained by the social worker that scientific treatment for the alcoholic is necessary for abstinence which is opposed to the alcoholic's method of using will power or some other futile solution to his

problem. Thus, it is apparent that the case worker must thoroughly understand and analyze the resistance which is presenting an obstacle to scientific treatment. It is useless, therefore, for the case worker to attempt to alter the patient's conviction that will power is the solution to the problem by an intellectual discussion of the merits of scientific treatment. Often the alcoholic has to prove to himself the futility of his plan to use will power in order to emotionally accept the need for treatment outside of his own plans for remaining abstinent. The social worker has the task of paving the way for the patient's psychological acceptance of the need for scientific treatment which is often threatened by a neurotic wife attempting to satisfy her own emotional needs. This point is clarified in an article by Thimann and Price:

Other common signs of resistance on the part of the relatives are precipitation of a crisis at home, observation that the patient is "leading the life of Riley" in contrast to her additional burdens of household tasks in his absence, and, once she has grasped the idea of emotional involvement in his drinking, a preoccupation with the fear that he may change and no longer need or want her. These wives have developed inferiority feelings which they compensate by feelings of superiority brought about by their husband's dependence during periods of drinking. Thus, their own stake in his problem is great.4

4 Thimann and Price, op. cit., p. 222.
In working with alcoholics, the case worker must not only be familiar with the concepts of guilt, hostility, resistance, projection and other defense mechanisms, but he must be exceptionally adroit in the handling and in the recognition of these manifestations of behaviour.
CHAPTER V

CASE PRESENTATIONS

Since this is a qualitative study involving a small number of cases, the writer abstracted case material for the purpose of gaining some perspective regarding the reactions of a non-voluntary patient to his confinement, the factors which seemed to make case work difficult with the non-voluntary patient, and any adaptations of case work techniques which might be indicated for work with the non-voluntary patient.

In order to examine the emotional responses to confinement consistently, the writer studied the following reactions to confinement in each of the nine cases:

Reactions to the Hospital

1 Use of the hospital for detoxication purposes.

2 Acceptance of psychotherapy from the Out-Patient Department of the hospital, or the Conditioned Reflex Treatment or the Protective Plan of the hospital or a combination of all three plans.

3 Immediate desire to leave the hospital.

Reactions to the Person Responsible for Confinement

1 Criticism of the person responsible for confinement in relation to behaviour in the home.
2 Obstreperous behaviour on the part of the patient in order to frighten the individual responsible for confinement into releasing the patient.

3 Projection of hostility onto another person in the external environment.

Reactions to the Psychiatrist

1 Lack of confidence in the psychiatrist as indicated by failure to see the value of treatment and by criticism of the Conditioned Reflex Treatment recommended by the psychiatrist.

2 Direct or indirect hostility expressed toward the psychiatrist.

The basic factors which might tend to make case work difficult with the non-voluntary patient were examined in each of the cases according to the following:

1 Resistance to accepting drinking as a problem as evidenced by:

   (a) Length of hospitalization in 1948.
   (b) Number of previous hospitalizations as a non-voluntary patient.
   (c) Minimization of the drinking or denial of the drinking as a problem.
   (d) Rationalized reasons for the drinking.

2 Preoccupation with the forced confinement.

3 Conception of will power as the only solution to the drinking problem.
The abstracted case material revealed the possibility of three adaptations of case work techniques with the non-voluntary patient and these will be examined in the cases studied. They are the following:

1. Immediate contact with the person responsible for confinement to prevent the sudden removal of the patient from the hospital.

2. Change in the focus of treatment depending upon the problems involved.

3. Helping the patient to verbalize his hostility toward the person responsible for confinement, as well as expression of feeling regarding confinement in general.

Case #1

Brief History

The patient, a seventy-two-year-old male alcoholic, was admitted to the Washingtonian Hospital for the first time. The commitment paper was signed by the patient's daughter who wished to participate in a plan for the patient to live at the hospital under the Protective Plan of the hospital. The wife and daughter of the patient considered him a problem to them and they wished to get him out of the house because of his compulsive drinking. The patient's wife was an invalid.
incapacitated by arthritis. The patient was employed part time but his daughter contributed to the major part of the financial support of the family. The daughter hospitalized the patient with the intention of confining him for fifteen days but she released him at the end of twelve days. The patient was seen by the social worker six days after he was admitted which meant that he was no longer in the sub-acute stage of alcoholism.

Reaction to the Hospital

The patient was interested in the hospital for de-toxication purposes and he did not see his need for treatment. The patient commented on the excellent care that he received at the hospital and he felt that he was well enough to be discharged. The patient placed emphasis on his need to leave the hospital because he had to get back to his work. When the patient learned that he could not leave the hospital until his daughter consented to the release, he mentioned how neglected he felt in the hospital and expressed a wish to see his daughter ostensibly to secure shaving equipment from her. Since shaving equipment was supplied by the hospital, the writer assumed that the patient was mainly interested in seeing his daughter in order to coerce her into releasing him.
Reaction to the Person Responsible for Confinement

The patient tended to sympathize with his daughter because of her responsibilities in caring for an invalid mother and he did not express any resentment about the step being taken to confine him in the hospital. The patient, however, was very resentful toward his wife in regard to her demanding, critical approach to the patient. The patient objected to washing the dishes and performing various other household duties in the home which his wife would have done under ordinary circumstances.

Reaction to the Psychiatrist

The patient did not make any comments about the psychiatrist and he concentrated on the fact that he did not need any treatment for his drinking because it was still within his own power to control.

The Factors Which Seemed to Make Case Work Difficult With This Patient

The patient expressed his determination to remain abstinent by means of will power, and his increasing old age was his reason for remaining abstinent in the future as he wished to prolong his life. The patient said that he had never decided to stop drinking and he now had a logical reason -- that of preserving his health. The patient did not face the reality of the problem in the home in relation to himself as a reason
for his abstinence, but placed the emphasis on his old age rather than consider the effect his drinking might have on the critical, complaining attitude of his wife. The patient attributed his drinking to sedulous working hours during the war and his wife's illness, thus placing the cause entirely on external factors rather than on the possibility of the cause arising within himself. The patient rationalized his drinking without a comprehension of his problem in all of its manifestations. It was not possible to determine from the case material if the patient's desire to stop drinking was an intellectual one based on the possibility of securing a premature release from the hospital. The writer is of the opinion that the patient was determined to leave the hospital by convincing everyone concerned of the fact that he did not need treatment because he was going to stop by himself. The writer bases this opinion on the fact that the patient was not able to express his feelings regarding confinement aside from suggesting reasons why he should leave and his verbalized expression of his satisfaction concerning his hospital care.

Adaptations of Case Work Techniques

The case worker had only two contacts with the patient, which was not sufficient to create a secure
relationship wherein the patient would feel free to express himself. More interviews would have been possible with the patient if he had remained in the hospital for the entire fifteen days but he was released three days before his confinement would have been legally terminated. The daughter was contacted but she did not want to come into the hospital because she was afraid her father would influence her to release him. The patient, however, was successful in obtaining his release from his daughter which occurred on the week-end when the worker was not in the hospital to see the daughter when she did come to the hospital. The focus in the interviews with the patient was on the patient's plan of using will power as a means of remaining abstinent in the future and the rationalized reasons for his drinking. The basic immaturity residing in alcoholics was pointed out in in Chapter IV, and it would be important in this case to understand the dynamics behind this patient's resentment toward his wife's illness which forced the patient to perform certain household duties.

Case #2

Brief History

The patient had a total of four admissions to the hospital, three of which were non-voluntary and one voluntary. The social worker had the first and only
contact with the patient when he was admitted for the third time. The patient was referred to the Social Service Department because he seemed to be establishing a pattern of remaining in the hospital for one week and using the hospital for detoxication purposes. The worker had contact with the patient after he had been in the hospital for three days and he was still in the sub-acute stage of alcoholism. The receptionist at the hospital had noticed that the patient's wife had reported at the hospital to visit her husband well under the influence of alcohol and her request to see the patient was denied. The patient's wife was the one responsible for the confinement on all three non-voluntary admissions, and she seemed to be using the hospital for detoxication purposes without showing any interest in the facilities provided by the hospital for helping the alcoholic with his drinking problem.

Reaction to the Hospital

The patient was satisfied with the hospital for the use that he was making of it, since he considered one week the required amount of time for sobering up in his particular case. The patient would not give any consideration to confinement extending beyond the one week and he knew that his wife would release him at the termination of the week.
Reaction to the Person Responsible for Confinement

The patient only mentioned his wife in connection with her distrust of him and her suspicions regarding his possible promiscuous behavior with other women. The patient did direct his hostility at the social worker because he felt that the social worker was attempting to force him to stop drinking by means of the Conditioned Reflex Treatment. The case material did not indicate that the worker placed unnecessary stress on the Conditioned Reflex Treatment but it seemed to be the patient's own interpretation of the reason for the interview.

Reaction to the Psychiatrist

The patient clarified his position to the psychiatrist in a succinct manner by stating that he enjoyed drinking and intended to pursue this pleasure without any interruption and he was interested in the hospital as a place to sober up temporarily. The patient was not aggressive with the psychiatrist, and he just wanted it clearly understood that he was not interested in treatment.

Factors Which Seemed to Make Case Work Difficult With This Patient

The patient had not reached the stage of accepting his drinking as a problem to him and therefore, was not ready to consider any form of treatment since the
need to abstain was not apparent to the patient. This resistance to recognizing the proclivity for alcohol as presented by the patient was the chief factor which would make case work difficult in helping him to accept himself as an alcoholic. Furthermore, the patient was not interested in talking with either the psychiatrist or the social worker as he had every intention of leaving the hospital when he considered himself sufficiently dealcoholized. The patient's wife seemed to present another obstacle to effective case work with the patient in view of her own tendency to drink evidenced by her arrivals at the hospital intoxicated.

Adaptations of Case Work Techniques

The patient's wife seemed to need help with a problem similar to her husband's problem which made her resistant to accepting and recognizing the facilities at the hospital for helping alcoholics. She had preferred to use the hospital as a convenient way of controlling the drinking of her husband when it had gone beyond control. It takes a patient anywhere from eight to fifteen days to recuperate from the sub-acute stage of alcoholism. The patient was not sufficiently freed from the effects of the alcohol to view his problem rationally in order to gain some insight and judgment.
into his problem even though he still refused treatment. There is a definite advantage in seeing a patient in spite of the sub-acute stage of alcoholism according to the speculations made by Lolli.

Other elements of more general significance can be gathered during the hang-over period, especially in its early phases when the depression of the central nervous system, due to the lingering presence of alcohol, weakens resistances and facilitates abreacts. There is still a chance that the alcoholic, spontaneously or under mild pressure, will produce facts about his life history which he would conceal from the doctor, and sometimes form his conscious ego, during periods of abstinence. 1

This patient was preoccupied with the fact that someone in the hospital was going to force him to take some form of treatment which he was consciously resisting.

Case #3

Brief History

This patient had been admitted to the Washingtonian Hospital twice as a non-voluntary patient and his wife signed the commitment papers. The patient's occupation was a proprietor of a tavern which meant that he had access to alcohol constantly during the day.

Reaction to the Hospital

The patient thought that he was in the hospital for a nervous condition which he did not relate to his drinking. The patient was certain that the hospital was only interested in money without having much concern about the patients as individuals. The patient was angry because he could not have sedatives whenever he requested them, and he attributed his increased nervousness to the confinement.

Reaction to the Psychiatrist

The patient mimicked the psychiatrist and said that he did not have any interest in seeing the psychiatrist again, because his knowledge of alcoholics came from reading material and was not based on actual experiences. The patient was also very angry at the psychiatrist for sending a letter to the patient's private physician and recommending the Conditioned Reflex Treatment, and he felt sorry for the patients who had submitted to it because it had been detrimental to their health. The patient was interested in leaving the hospital as soon as possible.

Reaction to the Person Responsible for Confinement

The patient reacted toward his wife in his usual pattern of a demanding, dominating, aggressive behavior. The patient's wife had always been afraid of the patient and usually gave in to his wishes when
he threatened her by saying that he would drink after leaving the hospital if she did not sign his release. The patient finally succeeded in gaining his release from his wife by banging on the door and demanding to see the head nurse and the director of the hospital.

The Factors Which Seemed to Make Case Work Difficult With This Patient

The patient was preoccupied with his confinement and consistently referred to the inconvenience hospitalization was causing him in regard to his work. The patient felt that self determination was the only solution for the alcoholic and he mentioned taking extensive walks to use up some of his excessive energy as a solution to his drinking problem. The patient minimized his drinking and he was continuously inconsistent in stating the amount of alcohol he consumed. The patient presented his own plans for remaining abstinent but he also emphasized the fact that his drinking was not a problem. This patient had not accepted, emotionally, the need to stop drinking and the plans he formulated to abstain after leaving the hospital were strongly motivated by his urgent desire to leave the hospital.

Adaptations of Case Work Techniques

From the case material, it was evident that the wife was not able to control her husband when he
reacted violently to a denial of the release which he requested. The case worker saw the wife to impress her with the importance of a longer hospitalization for the patient and to help her accept her husband's behavior in a manner that would be less threatening for her. The patient's wife, however, was convinced that her husband would not calm down until he was released. In the interview with the social worker, the wife agreed to keep the patient in the hospital for further hospitalization. She was not able to carry out her plans when she was confronted with the patient's aggressive determination to leave. The wife needed more than an interpretation of the facilities of the hospital in order to gain her participation in planning for the patient which included, at least, a two-week hospitalization. The wife needed case work to relieve her anxieties and her obvious fear of her husband before she would be able to cooperate in a plan for keeping her husband in the hospital. In this case it was imperative that the patient remain in the hospital in view of his diagnosis of acute alcoholic psychosis. The patient also suffered from visual and auditory hallucinations with aggressive paranoid content. All efforts to help the patient, at this particular time, to accept his hospitalization would be abortive since his mental condition was not amenable
for such an understanding. Noyes describes one of the symptoms which can be observed in a patient who has consumed large amounts of alcohol over a prolonged period in the following:

One of the earliest mental symptoms of the abuse of alcohol is an increased tendency to act impulsively in accordance with primitive instinctive forces and the momentary affectivity.²

Case #4

Brief History

This patient, a forty-one-year-old single man, was admitted to the hospital once in 1947 and twice in 1948. The patient's father signed the commitment papers for all three admissions. The patient was grossly intoxicated when he was admitted to the hospital and his father released him at the end of a three day confinement at the time when the social worker had contact with the patient. The father was seventy years old and his chief reason for confining the patient was because he felt that the patient needed discipline.

Reaction to the Hospital

The patient did not see any logical reason for his hospitalization and stated that he could have sobered up just as easily in the home. The patient was

under the impression that his hospitalization would prevent him from obtaining the vocational guidance program from the Veterans Administration in spite of the fact that he was informed that the hospital did not have any connection with the Veterans Administration. The patient was concerned about the expense of his hospitalization and frequently mentioned the inadequate financial status of the family. The patient spent his time thinking up reasons why he should not be in the hospital, such as losing time from work. The patient was not able to accept the hospital even for detoxication purposes.

Reaction to the Person Responsible for Confinement

The patient did not express any direct hostility and only stated that he thought his father had been unwise to confine him. The patient thought his father had confined him in the hospital as a punishment for his excessive drinking.

Factors Which Seemed to Make Case Work Difficult

With This Patient

The patient was preoccupied with his confinement and the inconvenience it was causing the family as well as himself. The patient was very resistant to accepting his drinking as a problem and denied any existence of a problem. The patient minimized his drinking by stating that he went on a drinking spree
once every two years. However, the admission six months after the initial commitment indicated that the patient's periodic drinking was not spaced according to his statement. The fact that the patient was still in the sub-acute stage of alcoholism when he was seen by the worker would have a bearing on the difficulty of helping him to see that he had a problem with drinking, but it is doubtful if detoxication would succeed in altering his conception of confinement as a punishment imposed on him by his father. Neither the father nor the son recognized the hospital as a place which offered scientific treatment for the compulsive drinker and the father was actually using the hospital as a means of forcing restrictions and discipline on his son.

**Adaptations of Case Work Techniques**

Since the patient regarded his hospitalization as a punishment from his father he would normally harbor some resentment against the person punishing him but he was not able, in the interview, to express his feelings concerning his father. The social worker did see the father of the patient for one interview, and the father was only interested in a method which would force his son to stop drinking as he felt that discipline was the solution to his son's problem. This father and son relationship was not a mature one for a
man who was forty-one years of age, and it seemed as if the patient's problem was centered around his inability to become a mature, independent person. The father's attitude toward the son was not one which would encourage growth. The father released the son from the hospital after he thought the son had received enough punishment as well as detoxication. Case work treatment in this case would need to take into consideration the situation in the home of a man who had not been able to separate himself from his family. The son was not willing to remain in the hospital and the father needed more interviews with the case worker to help him accept the hospital as more than an instrument of punishment and also help in understanding his need to assume this punishing approach to his son. If the father had permitted his son to remain in the hospital long enough to recover from the sub-acute stage of alcoholism, the case worker might have been able to help the patient verbalize his feelings, thus affording him enough release to discuss his problem rationally. Although steps were taken in this case to help the father recognize the possibilities of treatment for his son, the father could not emotionally accept the need for treatment other than his own authoritative approach. The patient seemed to present
a neurotic wish to remain dependent and the drinking
was a mechanism to that end. Hospitalization would
have to be enforced in order to give the patient
opportunity to gain judgment as well as his cooperation
in planning for himself.
Case #5
Brief History

The patient was admitted to the hospital as a
non-voluntary patient remaining one week and was
readmitted as a voluntary patient twenty-one days later
when he remained for two weeks. The commitment papers
were signed by the patient's wife for the non-voluntary
admission. The patient's wife reported to the hospital
on one occasion intoxicated, and she was referred to
the social worker. The wife accepted the fact that
she could not see her husband because she had been
drinking. The social worker interviewed the patient
after he had been in the hospital for five days when
he was rational enough to consider his drinking problem.
Reaction to the Hospital

The patient recognized the fact that he did have a
drinking problem which needed treatment beyond the use
of his own will power. The patient used his first
confinement in order to give his physical condition
an opportunity to improve. On the fifth day of
confinement, the patient felt that he was well enough
to leave the hospital and he wanted to return home
to straighten out his affairs in preparation for his
return to the hospital for further treatment. The
patient, however, did not attempt to force his wife to
release him and he accepted her suggestion of
remaining in the hospital for the full week. The
patient agreed to accept Out-Patient care as a tie to
the hospital until he returned as a voluntary patient.

Reaction to the Psychiatrist

The patient had confidence in the psychiatrist and
accepted the recommendations for extensive treatment
for his drinking problem. The patient was not ready
to accept further treatment at the time of his non-
voluntary confinement because of the pressing family
situation as well as the very real financial problem.

Reaction to the Person Responsible for Confinement

The patient was very critical of his wife and he
felt that she could not be trusted to assume the
responsibilities in the home during his absence because
of her drinking which went on in the home while the
children were present. The patient's critical attitude
toward his wife had a real basis and cannot be justly
interpreted as arising out of his feelings regarding
confinement.
Factors Which Seemed to Make Case Work Difficult With This Patient

The family situation in this case seemed to be one of the chief contributing factors resulting in what can be termed a pseudo-resistance to the acceptance of treatment at the time of his non-voluntary confinement. Boggs writes in regard to the environmental pressures which often confront the alcoholic:

To be sure, these environmental pressures are often a part of the vicious circle of the alcoholic's own making; but they are things he consciously does not want and that do cause him concern even while they provide rationalization for his drinking. The mere alteration of these factors might do little else than force him to find different excuses, but combined with a total program of rehabilitation they may have considerable ego-enhancement value.

The patient had recognized his need for treatment and this is exemplified by his return to the hospital as a voluntary patient when slightly intoxicated and remaining for a two-week period. The patient presented some resistance to following through on his plan to return to the Out-Patient Department after his discharge as a non-voluntary patient. He broke his appointment with the Out-Patient psychiatrist and he

attributed his failure to keep the appointment to the theft of his son's bicycle which necessitated a report of the theft to the police department at the same time as the appointment. The briefness of contact with the social worker the first week did not permit a preparation for the psychiatric interview, which might account for the patient's resistance.

**Adaptations of Case Work Techniques**

A well-timed interview with the patient's wife prevented the removal of the patient from the hospital before he had completed one week of hospitalization. The extra two days of hospitalization gave the patient the opportunity to consider seriously plans for treatment which were recommended to him by the psychiatrist, even though he did not accept treatment immediately. This patient had already accepted his drinking as a problem and the mental attitude of the patient regarding his drinking was conducive to planning for treatment and this planning could not have been sufficiently explored with the patient if it had been suddenly interrupted by his discharge. The patient's wife revealed information in her interview with the social worker which indicated a marital conflict in this case. The wife married her husband because her family had approved of the marriage and her submissiveness to her family did not permit her to
marry the man of her choice. More extensive case work would need to be carried on with the wife in order to understand her problems in accepting a marriage which she was emotionally rejecting.

Case #5

Brief History

This patient was a twenty-three-year-old epileptic committed by his father to the Washingtonian Hospital for a two-week period of observation. The patient began drinking during his first year of high school at the time when his epileptic seizures began to appear. The patient submitted to a forced marriage in his second year of high school which caused him to leave school and assume the responsibilities prompted by the marriage. The couple had two children when the wife's family intervened and succeeded in obtaining a divorce because of the patient's excessive drinking and inability to support his family. The wife was granted custody of the children and the patient returned to his home and continued to live with his parents. This was the patient's first confinement in the Washingtonian Hospital but he had previously been confined in the New Hampshire State Hospital. The patient's father committed his son to the Washingtonian Hospital for an observation of the patient's problems in order to determine if anything
could be done to relieve the additional complication of alcoholism in the entire situation. After one week of confinement the patient's mental status was classified as homicidal, violent and paranoid which led the psychiatrist to transfer the patient to the Boston State Hospital for observation which the Washingtonian Hospital was not equipped to handle. The patient's drinking was an acute problem since his condition was aggravated by the consumption of alcohol. The age of this patient would tend to rule out the possibility of alcohol as the determining factor in the etiology of his epilepsy. The following opinion was presented by three authors in considering the relation of alcoholism to epilepsy. "Epilepsy due more or less to alcoholism would not manifest itself before the age of forty". There is, however, an acceleration of epileptic seizures in genuine epileptics through the use of alcohol.

Reaction to the Hospital

The patient accepted his hospitalization and he did not make any aggressive demands to leave. One explanation for the patient's ease in adjusting to the

4 E. M. Jellinek, Alcohol Addiction and Chronic Alcoholism, p. 151.

5 Ibid., p. 149
hospital was his previous confinement in a state mental hospital which would tend to allay inward fears regarding confinement.

Reaction to the Psychiatrist

When seen by the psychiatrist, the patient was willing to accept the recommendations for part-time hospitalization plus the subsequent Conditioned Reflex Treatment if neurologically permissible, indicating that he recognized the hospital as a place where he could get help with his drinking problem beyond the detoxication period.

Reaction to the Person Responsible for Confinement

The patient expressed considerable resentment toward the lawyer who participated in the divorce proceedings, claiming that the lawyer had misrepresented the facts in the case. This could be interpreted as a projection of the patient's feelings regarding his father, but the writer does not consider such an interpretation valid because of the lack of evidence in the case material. The social worker on the case noted in the record that the patient seemed to be very disturbed because of the critical attitude of his family in regard to his drinking.

Factors Which Seemed to Make Case Work Difficult With This Patient

The patient's epilepsy and all of the psychological
connotations of the disease plus the underlying psychosis seemed to be the outstanding factors inhibiting case work with the patient.

Adaptations of Case Work Techniques

The patient needed, above all, to feel accepted by the worker in spite of his physical defects which, no doubt, contributed to his inability to make a normal adjustment. The patient had married when he was very young and at a time when he was not prepared or ready to assume the prodigious responsibilities of a wife and child. Thus the patient had failed in marriage as well as any occupation he had attempted to pursue. The patient drank to relieve the tension he experienced prior to his attacks and the alcohol gave him temporary release, but at the same time it precipitated an epileptic seizure. The framework of a good relationship with the worker would provide the patient with the propitious climate for accepting the relationship of his drinking to the epileptic seizures. The psychotic episode interrupted the worker's contact with the patient and it was not possible to determine how the patient would have responded to the worker in subsequent interviews.
Case #7

Brief History

This patient has had a total of ten admissions to the Washingtonian Hospital and only three of these were voluntary admissions. The patient's wife signed the commitment papers for the seven non-voluntary admissions. The case was referred to the Social Service Department because the patient was so consistently resistant to accepting treatment. The psychiatrist in referring the patient to the Social Service Department recommended that interpretation was indicated for the wife regarding her husband's hospitalization. The patient's usual pattern was to remain in the hospital for seven days but he stayed two weeks on one non-voluntary admission and left after three days on another non-voluntary admission. The patient's wife was afraid to force confinement on the patient when he demanded his release in spite of the possibility of a more complete recovery for him.

Reaction to the Hospital

The patient came to the hospital in order to satisfy his wife and he did not intend to submit to any treatment that the hospital had to offer him. The patient usually considered one week a sufficient amount of time for the detoxication period. The patient was not able to accept the hospital on his three
voluntary admissions.

Reaction to the Psychiatrist

The patient was suspicious and hostile to the psychiatrist and the hostility was the reaction to the patient's suspicions regarding the psychiatrist's subtle attempt to persuade the patient to remain in the hospital to take the Conditioned Reflex Treatment. The psychiatrist did not attempt to persuade the patient to undergo further treatment or any follow-up treatment after leaving the hospital, but the patient would consistently argue about the efficacy of the treatment available at the hospital. The patient depersonalized his feelings regarding the psychiatrist by commenting on the fact that he had heard rumors to the effect that the psychiatrist was the most hated man in Boston. The patient frequently referred to alcoholics who had relapsed after submitting to the Conditioned Reflex Treatment and would not consider accepting treatment unless the results could be sufficiently guaranteed to satisfy him.

Reaction to the Person Responsible for Confinement

The patient did not express any resentment toward his wife, but he objected to the worker's contact with the wife. The patient insisted that there were not any problems connected with the home situation,
indicating the futility of the social worker seeing his wife. The patient was always able to secure his release from his wife and he might have been afraid of having the worker influence his wife by encouraging her to keep the patient in the hospital, but there was nothing in the case material to substantiate this supposition of the writer.

**Factors Which Seemed to Make Case Work Difficult With This Patient**

The number of hospitalizations for the patient is an indication of his resistance to accepting his drinking as a problem. The patient's fear of the Conditioned Reflex Treatment could have represented one of the factors preventing him from accepting help for his drinking, but this is only the speculation of the writer and not based on facts. The patient's resistance was further evidenced by his refusal to see the worker on one occasion because he felt that the worker would concentrate on the drinking which the patient wanted to avoid. The patient did not change his opinion when the worker assured him that he would be free to talk about anything he wanted to in the interview. The patient rationalized his drinking by attributing the drinking episodes to a quarrel with his wife. The patient considered himself a high strung individual and drinking relieved
the tension. The worker was not able to establish a good relationship with this patient due to the patient's inability to accept help, and he seemed to fear the consequences of a close relationship. The worker noted that the patient was uncomfortable when talking with him and he also presented signs of strain and uneasiness. The patient's drinking started after his marriage and he consistently went on a drinking bout whenever his wife went to the hospital to have a baby, which is an indication of an emotional problem centering around the marital situation. The patient refused to face the reality of his problem and he stated emphatically the absence of any connection between his marriage and his drinking.

Adaptations of Case Work Techniques

The patient's fear of the Conditioned Reflex Treatment could be interpreted as a resistance to accepting the need for treatment and in this case the goal would be to help the patient recognize his drinking as a problem. In the case material, the patient placed considerable emphasis on his fear of the treatment and he mentioned his lack of courage in facing the brutality of the treatment. The case material did not indicate whether or not the patient had any distorted ideas regarding the Conditioned Reflex Treatment causing his fear, and perhaps an
alleviation of this fear would render the patient more amenable for a consideration of the treatment. The patient's preoccupation with the Conditioned Reflex Treatment did not arise from either the worker's or the psychiatrist's concentration on the subject but it arose from the patient's own misinterpretation of the hospital staff's intention of forcing something onto him which he feared and did not want. It is the writer's opinion that a focus on and an exploration of the fear would have been a more appropriate goal for the case worker.

Case #8

Brief History

This patient has had only one admission to the hospital and his wife forced the confinement for a two-week period. The patient's wife committed her husband to the hospital because he was undernourished and exhausted from his prolonged drinking. The patient's wife refused to have anything to do with the social worker who contacted her by phone, and stated that she had made plans with the director of the hospital for the care of her husband. The patient operated a drug store which he inherited from his father but he detested pharmacy and spent a considerable amount of time playing billiards and drinking in order to spend a minimum amount of time at his occupation.
The patient had been married twice and secured a divorce from his first wife on the grounds of her immoral behavior with other men.

Reaction to the Hospital

The patient wanted to leave the hospital as soon as possible because his confinement was forced on him without his consent and said that his attitude would have been the reverse if he had come into the hospital of his own volition. The patient felt that the hospital had nothing to offer him because he was capable of his own abstinence. The patient had joined the Alcoholics Anonymous one month before his admission and he was convinced that they could help him. The patient said that he had to leave the hospital because no one else was authorized to sign the bills for the store.

Reaction to the Person Responsible for Confinement

The patient felt that his wife had tricked him by committing him to the hospital at a time when he did not know what was happening to him. The patient was not able to express any real hostility toward his wife but a considerable amount of hostility was directed at the patient's first wife. The patient decided that his first wife was the person responsible for his giving up a musical career for pharmacy. The patient was also hoping that his first wife would have a fatal
accident because she prevented his present marriage from being recognized by the Catholic Church. The patient frequently commented on the beauty of his present wife and he stressed the fact that she had been a model before her marriage.

Reaction to the Psychiatrist

In the interview with the psychiatrist, the patient displayed complete lack of judgment in regard to alcoholism and just reiterated his need to leave the hospital.

Factors Which Seemed to Make Case Work Difficult With This Patient

The patient was preoccupied with his confinement and his chief interest was to leave the hospital. The patient's determination to reject anything the hospital had to offer was a barrier in any effort to help him accept the hospital. Furthermore, the patient had not recognized the fact that he was an alcoholic in the true sense of the word.

Adaptations of Case Work Techniques

The worker had only one short contact with this patient after he had been in the hospital for nine days and there was every indication that he was still in the sub-acute stage of alcoholism. He was not able to concentrate on any particular subject aside from his forced confinement and his thinking in general
was irrational and at times he strayed from reality completely when making plans for his future which consisted of fishing, reading and hunting. The patient was not interested in working, and his planning was not in keeping with his financial situation. Contact with the patient's wife might have helped her to accept the hospital as a place which could help her husband with his drinking problem rather than a place for physical treatment only. More contact with the patient by the social worker with the aim of paving the way for a future voluntary admission to the hospital might have been helpful since the non-voluntary confinement had been threatening to the patient.

Case #9

Brief History

This thirty-four-year-old single man was committed to the hospital by his brother for his first admission for a fifteen-day period. The patient had a total of twenty-two interviews with the social worker, nine of which occurred during the fifteen-day period of non-voluntary confinement. One brother who was particularly interested in the patient, came into the hospital for a number of interviews with the social worker and cooperated completely with plans for the patient. This brother succeeded in locating employment for the patient, which made it possible for the patient
to continue living at the hospital under the Working Parole Plan. At the end of the patient's non-voluntary confinement, he was readmitted the next day as a voluntary patient. The patient lived at the hospital for six months working steadily, but relapsed immediately following his discharge at the end of six months. The patient's parents were dead. One single brother, a married brother with his wife and children and the patient all lived together. The patient was regarded by his family as irresponsible and they treated him accordingly, which meant that his position in the home was subordinate to his more responsible brothers and sister-in-law. The patient felt even more inferior in the home because he did not have a high school diploma while his brothers were college-trained and engaged in professional occupations.

Reaction to the Hospital

During the first few days of confinement, the patient frequently inquired about his confinement and claimed that he had to leave in order to get back to work. The patient told the worker after his first day of confinement that he would get out within three days. The patient said that he enjoyed the hospital but he considered it a waste of money and felt that he did not need to worry about the expense since he was not paying for the confinement. The patient gradually
began to accept the hospital as a place equipped to help him with his drinking problem during the fifteen-day confinement. The patient was not ready to accept the Conditioned Reflex Treatment but he did consent to the working-parole plan of the hospital as a means of providing the protective, neutral environment apart from the emotional stress in the home.

Reaction to the Psychiatrist

The patient was impressed by the psychiatrist and appreciated the frankness of the psychiatrist in telling him that the Conditioned Reflex Treatment could not be guaranteed. The patient relaxed when he learned that he would not have to take the treatment until he was ready to accept it himself. The patient referred to a patient in the hospital who was being forced to take the Conditioned Reflex Treatment which was an indication of his feeling about the treatment.

Reaction to the Person Responsible for Confinement

After the first day of confinement, the patient did express some hostility toward his brother by refusing to see him but changed his mind when he learned that his brother could reduce the length of confinement. The patient did not, however, attempt to get his brother to release him when he did see him.
Factors Which Seemed to Make Case Work Difficult

With This Patient

The patient became very dependent on the worker and some of his dependency needs were met by the frequency of the interviews which motivated him to demand more and more of the worker's time. The patient actually was resistant to accepting scientific treatment for his drinking and left the hospital after a six month working parole and immediately relapsed. Work with this patient was made easier because of the immediate cooperation of the brother responsible for the confinement and the ease with which the patient was able to accept the worker.

Adaptations of Case Work Techniques

The goal of the case worker in this case, which materialized after several contacts, was to accept the patient as he was since all his relatives had the prestige that came with college training and professional status. Any attempt to push this patient into learning a trade from the veterans program would be repetitious of the type of thing the patient received from his family. The case material produced the fact that the case worker was aware of the advantages of mental testing for this patient in order to determine his mental capacity to avoid directing him toward
future ambitions beyond his capacity. The worker, however, realized that such a step would be threatening to the patient until he felt secure enough in the relationship with the worker. The Protective Plan of the hospital was imperative for this patient in order to remove him from an environment where he was made to feel inadequate and treated like an irresponsible child. The case worker helped the patient's brother to see the advantages of the Protective Plan of the hospital and also helped him to understand the effect the home environment had on the patient. The worker succeeded in obtaining the full cooperation of the brother who confined the patient which made it possible for the patient to make plans to live at the hospital. The patient's brother tended to assume a protective fatherly attitude toward the patient and if the brother had not participated in the planning and accepted the advantages of hospitalization as well as the Protective Plan, the patient might also have rejected any further plans for treatment. During one interview with the patient when he was wondering about the length of confinement, the worker responded by mentioning the fact that treatment would not be very constructive for the patient if he was confined against his will. This statement by the worker was
made questioningly which gave the patient an opportunity to verbalize his feelings about confinement if he chose to do so. Every effort was made by the worker to help the patient to accept his confinement as something which would help him and be useful to him.
CHAPTER VI
SUMMARY AND CONCLUSIONS

This thesis was undertaken to make an intensive study of nine non-voluntary male alcoholics known to the Social Service Department and admitted to the Washingtonian Hospital in 1948 in order to determine (1) the emotional responses of the non-voluntary patient to his confinement, (2) the basic factors tending to make case work difficult with the non-voluntary patient, and (3) the adaptations of case work techniques which seem to be necessary for working with the non-voluntary patient.

In order to provide a framework for an understanding of the implications of a forced confinement, the writer presented some of the current and past theories from the literature on this subject. The theories were varied and conflicting and the conclusion was drawn that sufficient statistical data is not available at the present time to support either extramural or intramural care for the alcoholic.

A brief summary of the Washingtonian Hospital was included in this study to provide an understanding of a treatment program which incorporates both intramural and extramural care as well as the additional feature of the Working-Parole Plan for the treatment
of alcoholics. The advantages of the Working-Parole Plan were stressed as it provides a neutral protective environment which affords the patient the opportunity to work steadily, and to develop dependabilities and responsibilities apart from the emotional stress of the home. At the same time, the plan keeps the patient in contact with a more natural environment than a prolonged full time hospitalization could provide. It was pointed out that treatment at the Washingtonian Hospital is on an individual basis.

The writer presented some of the general aspects of case work with the alcoholic as background material for considering the adaptations of case work techniques indicated for work with the non-voluntary patient. This emphasized the alcoholic's resistance to treatment as a prolonged period when he is completely unable to accept his disease of alcoholism. The inevitable resistance has to be recognized in all of its connotations in order to understand the environmental barriers which might be enhancing the resistance in order that steps may be taken to obviate these factors whenever possible. Case work with the alcoholic must of necessity include the family. A patient's psychological acceptance of the need for scientific treatment is often threatened
and prevented by a neurotic wife attempting to satisfy her own emotional needs.

The emotional responses of the patients were categorized into (1) reaction to the hospital (2) reaction to the person responsible for confinement, and (3) reaction to the psychiatrist. The reactions to the hospital were based primarily on the attitude the patient had toward the hospital such as acceptance of the hospital for treatment, acceptance of the hospital for detoxication purposes only, or a complete rejection of the hospital. Although this is not a comparative study, the writer considers it significant to note that one patient out of the nine studied was able both to accept and follow through on a plan for treatment, five of the patients accepted the hospital for detoxication or other physical reasons, and two did not see any reason for being in the hospital. The writer does not consider the above observations representative in view of the small number of the cases studied but they are suggestive of the reactions of the non-voluntary patient to the hospital. It was apparent from this study that the sub-acute stage of alcoholism did have a bearing on the patient's use of the hospital, but a general statement cannot be made concerning the cases studied due to the varying degrees
of environmental problems plus the individual personalities involved in each case. Since the presence of the sub-acute stage of alcoholism seemed to be one of the barriers to a patient's rational acceptance of the hospital, the writer feels that this factor needs to be given serious consideration in work with the non-voluntary patient. The reactions to the person responsible for confinement and to the psychiatrist seemed to be dependent upon the individual personalities and were closely allied to the reactions to the hospital and the resistance to accepting the drinking as a problem. The writer feels that these reactions cannot be accurately determined and understood as isolated responses and demand more knowledge of a patient's emotional maturity and psychosexual development.

The factors tending to make case work difficult with the non-voluntary patient were studied in each case in terms of the resistance to accepting the drinking as a problem, preoccupation with the forced confinement and the conception of will power as the only solution to the drinking problem. It was noted in the study that the preoccupation with the confinement seemed to be an additional problem in working with the non-voluntary patient along with the resistance to
accepting the drinking as a real problem needing help.

The writer attempted to examine the adaptations of case work techniques which might be indicated for work with the non-voluntary patient. The study of the nine cases emphasized the importance of immediate contact with the person responsible for the confinement to avoid the sudden removal of the patient before he had recovered from the sub-acute stage of alcoholism.

In addition to the importance of immediate contact with the person responsible for confinement, this study indicated the problems involved in any attempt to elicit cooperation in cases of a punishing parent or a neurotic submissive wife. This problem of gaining the cooperation of the families as revealed in the study is a difficult one because of the time limitations and the fact that one brief contact is hardly sufficient to attempt to alter a neurotic pattern of dealing with the patient.

The study indicated the feelings regarding confinement which a social worker has to handle. The writer does not regard the forced nature of the confinement an insurmountable barrier to case work with the non-voluntary patient, but it is an additional problem. One important factor to consider on the question of a non-voluntary confinement is the opportunity for contact which is made possible by a
forced confinement.

This study has suggested the complexity of problems involved in working with the non-voluntary patient, and only indicates some facets of case work attempted with non-voluntary patients in 1948.

Approved,

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Dean
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