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A study of concurrent clinic and social service treatment of alcoholism

Teague, Doran

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Boston University
BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF CONCURRENT CLINIC
AND SOCIAL SERVICE TREATMENT OF ALCOHOLISM

A THESIS

Submitted by
Doran Teague
(A.B., University of Nebraska, 1948)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
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* These tables were quoted from the following reference:

CHAPTER I
INTRODUCTION

Purpose and Scope

This is a qualitative study of thirteen alcoholic patients treated concurrently in the Alcoholism Clinic and Social Service department of the Quincy City Hospital. The purpose of this study is to determine the following:

1. What etiological factors producing alcoholism were seen in the cases studied?
2. How has clinic and social service treatment affected the patient's adjustment?
3. What social factors responded best to social service treatment?

It is necessary to point out that this study of thirteen cases is suggestive rather than representative of patients receiving treatment for alcoholism in the Alcoholism Clinic of the Quincy City Hospital.

Source of Data

The confidential files of the Quincy City Hospital Social Service Department provided the source for the case material presented herein, and was supplemented by follow-up contacts with eleven of the thirteen cases studied. Identifying material in the cases presented has been carefully disguised to insure confidentiality.
Supplementary material from the extensive literature on alcoholism has been incorporated into the study where relevant to the study.

**Method of Selection**

The thirteen cases selected for study represent the total number of cases that received concurrent clinic and social service treatment at the Quincy City Hospital, from April, 1948, until December 1, 1949.

**Reason for Study**

Treatment of alcoholism on an outpatient basis as a community service of a general hospital is a recently developed method of treating and rehabilitating alcoholics. This study is attempting to evaluate the effectiveness of concurrent clinic and social service treatment of alcoholism as reflected in the social adjustment of the cases studied.

The mounting awareness of accidents, crimes, divorces, broken homes, and increase in the number of mental and physical disorders as the social and emotional product of alcoholism, has resulted in the development of Commissions on Alcoholism by various states. The purpose of these commissions is to study the problem of alcoholism and to establish adequate and effective treatment facilities within easy availability of its people.

Already thirteen states have initiated programs concerned with alcoholism while in fifty cities throughout the United States, voluntary committees are surveying the
local problems and taking action to meet it.¹

It is becoming nationally recognized that the Yale Laboratory of Applied Physiology is a leader in the field of studying alcoholism as a medical, psychological and social problem. The results of this research have been put to test in Yale Plan Clinics for the treatment of alcoholism.

Through the stimulus and scientific enlightenment of the Yale plan, much in the way of understanding of the alcoholic has been forthcoming. Dr. Robert Fleming, an outstanding individual in the understanding and treatment of alcoholics, states:

Psychologically, all sorts of conditions and situations may develop. The individual who has done much drinking over any period of time is certain to get into trouble. As his drinking increases he gets into more and more difficulty. Everybody, so to speak, has a whack at him; his parents, his wife, his friends, even his children (if he has older children), the local vicar, his employer, his neighbors and the police. It is not at all surprising that as this situation continues the drinker develops certain rather definite psychological changes. It is a rare alcoholic who does not ultimately develop certain feelings of inferiority and inadequacy. These are perhaps the most striking psychological changes, especially the feelings of inferiority.²

**Limitations**

The writer recognizes that this study is limited by the

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incompleteness in detail of case records and the unavoidable element of subjectivity of the material gathered and presented.
CHAPTER II
DEVELOPMENT AND GROWTH OF THE CLINIC

Setting

The Quincy City Hospital is a modern, well staffed and progressive general hospital of 324 bed capacity and sixty bassinets. It serves the medical needs of the city of Quincy and is in easy access to the extensive medical, psychiatric and social resources of Boston, eight miles to the north. Quincy had a census in 1940 of 75,810 persons, with an increase in 1948 to an estimated 88,000 persons. Quincy's population consists predominantly of Canadian, Scottish, Italian and Finnish nationalities.¹

Quincy is an industrial and residential community. The city boasts of ninety-seven manufacturing establishments whose chief activities are in quarrying, shipbuilding, and granite cutting and finishing.² By virtue of its proximity to Boston, many of its citizens maintain their homes in Quincy, but are employed in Boston.

Quincy is a progressive city of forty-one churches representing fifteen denominations, modern schools, civic

¹ H. A. Manning Company and Quincy Chamber of Commerce, Quincy Directory, 1949, p. 15
² Ibid., p. 15
organizations, and recreational facilities.

Development of the Clinic

Early in 1947, a Quincy City Hospital staff neuro-psychiatrist, Dr. Elsie Neustadt, achieved through a long-time personal interest in alcoholism, the establishment of the Quincy outpatient Alcoholism Clinic by volunteering her services. Dr. Neustadt attributes the clinic's development to the help and timely assistance of various interested persons located in strategic positions, who gave support and co-operation to her project. These persons included the hospital director, probation officer of the court, and the secretary of the committee on alcoholism of the Greater Boston Community Council. Public interest was gained through the local Committee for Education on Alcohol. Local social, recreational and welfare agencies recognized the need for the establishment of such a clinic and encouraged its development.

The Alcoholism Clinic was patterned along the lines of the Yale Plan Clinic in New Haven, Connecticut, and the already existing clinic headed by Dr. Robert Fleming, at the Peter Bent Brigham Hospital, Boston. It was envisioned at the time, that the Quincy Alcoholism Clinic might later fit into a proposed state sponsored plan for the treatment of alcoholics throughout the Commonwealth.

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3 Ibid., p. 15
In November 1949, the Massachusetts Commission on Alcoholism through funds appropriated by the General Court, effected an allocation of money to the Quincy City Hospital to provide the services of a psychiatrist or a physician interested in alcoholics. Prior to November 1949, Dr. Neustadt volunteered her services to a three hour clinic on Saturday mornings. Patients attending the clinic were given treatment, in most instances, free of charge. Under the program of allocated funds, the Quincy Alcoholism Clinic now holds two weekly sessions of three hours each. The clinic sessions are held at a time that best serves employed men and women, avoiding wage loss to the marginal income groups.

The Quincy City Hospital's Alcoholism Clinic has now become a part of a state plan that had its beginning early in 1947. The thinking of a twenty member committee of the Greater Boston Community Council was reported by John G. Harris as follows:

A group of citizens working as a volunteer committee of the Greater Boston Community Council [United Community Services of Greater Boston] is about to ask our state Legislature to tackle chronic alcoholism on a scientific official basis.

They stress that action is urgent because:

1. The Bay State has a minimum of 20,000 chronic alcoholics.

2. Our state laws archaically treat these individuals as criminals rather than medical patients.

3. The field of medical and psychiatric treatment is
being rapidly developed and the state could make the best methods known and available to the public.

4. Cost of alcoholism to the state is conservatively estimated at $60,000,000 annually.

5. State Commissioner of Mental Health, Dr. Clifton T. Perkins, believes "there has been a tremendous increase in dependence on alcohol."

6. Facilities for treatment of alcoholics with a view to rehabilitation, are inadequate or regionally non-existent.

The committee has filed a proposed law now before the Legislative Committee on state administration.

It envisages a five member unpaid commission appointed by the Governor. The commission would make a continuous study of methods for treating alcoholism. It would also co-ordinate present treatment agencies in the Commonwealth and investigate, from a medical viewpoint, all factors relating to the problem of alcoholism.

In the future there is hope this course of action will lead to establishment of state-sponsored clinics and hospitals designed for rehabilitation of alcoholics.4

Legislative action approved June 7, 1947, adopted the recommendations of the volunteer committee on Alcoholism of the Greater Boston Community Council, for appointment of a five member Commission on Alcoholism.

There shall be a commission, to be known as the Commission on Alcoholism to consist of five members, to be appointed by the Governor, with the advice and consent of the Council, for four year terms. At least two members of the Commission shall be members of the medical profession, and one of the members shall have had training as a psychiatrist. The commission shall make a continuous study of methods for treating alcoholism and of other factors

4 The Boston Globe, February 23, 1942, reprint
relating to the problem of alcoholism in the Commonwealth. The commission may require of any department, commission, board or officer of the Commonwealth which has or can obtain information in relation to the subject matter of its study, such assistance as may be helpful to it. The commission shall report annually to the General Court and to the Governor its findings and recommendations. The members of the commission, except as hereinafter provided, shall receive no compensation for their services, but shall receive their necessary expenses incurred in the discharge of their official duties. The commission may appoint a secretary who may be one of its members, and he shall receive such salary as the commission, with the approval of the Governor and Council, may fix.

The program of establishing clinics throughout the Commonwealth is currently going forward as quickly as facilities and personnel are available. To date, the clinics are being staffed with a paid physician or psychiatrist. Each clinic functions for as many clinic hours as the physician can give, or is needed in giving treatment to patients. It is hoped that these clinics may develop to include psychiatric social workers and adequate clerical assistance.

The Massachusetts Commission on Alcoholism envisages the development of hospitals or state owned farms where patients suffering from alcoholism can be treated on an inpatient basis. Existing facilities of this type of treatment are inadequate. They are as follows:

1. A twenty-six bed ward at the Boston City Hospital.
2. Private hospitals with limited bed space.

5 Mass. G. L., Ch. 6, s. 63 (amended 1947, Ch. 513)
3. Treatment in state mental institutions if patients are declared psychotic.

4. Referral to Deer Island, Bridgewater or Sherborn, the Charles Street Jail if arrested for drunkenness more than four times a year.6

It should be noted that the twenty-six bed ward at the Boston City Hospital is crowded and rehabilitation cannot be attempted. In the private hospitals, the fee charged is out of reach of patients without funds.7

Individual citizens who realistically face the incidence of drunkenness in their communities cannot help but be concerned with the great expense and social liability resulting from the drinking of alcohol. Considering the cost involved in handling the "drunk" in court, jail, and police man-hours alone, would be appalling to the average citizen. This of course is only a small part of the total cost, when one considers the dollar value of crime, accidents, and divorces resulting from alcohol.

6 The Boston Globe op. cit., reprinted

7 Ibid., reprint
TABLE I
MONTHLY ARRESTS OF MEN AND WOMEN FOR DRUNKENNESS JANUARY 1, 1949 TO NOVEMBER 30, 1949

<table>
<thead>
<tr>
<th>Month</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td>5</td>
<td>59</td>
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<tr>
<td>February</td>
<td>42</td>
<td>1</td>
<td>43</td>
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<tr>
<td>March</td>
<td>50</td>
<td>1</td>
<td>51</td>
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<tr>
<td>April</td>
<td>61</td>
<td>5</td>
<td>66</td>
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<tr>
<td>May</td>
<td>59</td>
<td>3</td>
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<tr>
<td>June</td>
<td>61</td>
<td>4</td>
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<tr>
<td>July</td>
<td>70</td>
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<td>73</td>
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<td>August</td>
<td>51</td>
<td>3</td>
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<td>September</td>
<td>77</td>
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<td>October</td>
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<td>5</td>
<td>60</td>
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<tr>
<td>November</td>
<td>48</td>
<td>2</td>
<td>50</td>
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<tr>
<td>Total arrests</td>
<td>623</td>
<td>37</td>
<td>665</td>
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</tbody>
</table>

Table I and Table II show the incidence and disposition of drunkenness in the City of Quincy for the eleven month period of January 1, 1949 to November 30, 1949. These statistics were compiled from the East Norfolk County Court's "Day Book", that lists the arresting charge and the court disposition of the case.
TABLE II
MONTHLY DISPOSITION OF ARRESTS MADE FOR DRUNKENNESS, CITY OF QUINCY, MASSACHUSETTS JANUARY 1, TO NOVEMBER 30, 1949

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
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<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Total</th>
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<td>Filed</td>
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<td>39</td>
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<td>27</td>
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<td>Probation</td>
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<td>2</td>
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<td>6</td>
<td>7</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
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<td>7</td>
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<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>5</td>
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<td>4</td>
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<td>1</td>
<td>1</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>43</td>
<td>51</td>
<td>66</td>
<td>62</td>
<td>65</td>
<td>73</td>
<td>54</td>
<td>82</td>
<td>60</td>
<td>50</td>
<td>665</td>
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CHAPTER III
ETIOLOGY AND TREATMENT OF ALCOHOLISM

The concept of alcoholism as a disease has done much to further research into the physical, psychological and social reasons behind alcoholism, as well as the advancement of the treatment methods employed.

The growing concern over the increased use of alcoholic beverages in the United States along with a more scientific understanding of the alcoholic and his problem, has focused attention upon alcoholism as a grave public health problem.

Much of the mounting concern about alcoholism may be due, in part, to the published accounts of economic and social liabilities resulting from alcoholism. Not only is this concern and awareness found among the professional groups concerned with the human physical, mental health and welfare, but it is becoming the concern of administrators in industry.

Leading business concerns throughout the United States are tackling the problem of alcoholism among their employees as a serious economic and medical problem. The economic loss attributable to alcoholism is authoritatively estimated to run over $1,000,000,000 annually and the annual wage bill chargeable to alcoholism is about $432,000,000. Estimates have been made that indicate up to 28,000,000 work-days are lost annually throughout industry. The National Safety
Council estimates show that mishaps cost industry $120,000,000 annually. Of these mishaps, at least 1500 preventable accidents every year are caused by intoxicated workers. Economists have pointed out that substantial losses in efficiency due to alcoholism have reduced the over-all national productivity around 2.6 per cent. Other losses chargeable to alcoholism, paid in whole or in part by industry, included an estimated $188,000,000 for crimes committed under the influence of liquor, around $35,000,000 for hospital care of alcoholics and $25,000,000 for maintenance of drunkards in local jails. Alcoholism ranks fourth among the country's public health problems.1

From a study based on a scientifically prepared sample of the total adult population of the United States, twenty-one years of age and over, the social patterns of alcoholic drinking were studied. This study was conducted for Rutgers University by the National Opinion Research Center of the University of Denver. The study investigated the current drinking habits; kinds of alcoholic beverages drunk, incidence and frequency of drinking of urban and rural people, rich-poor, educated-non-educated, and the difference in drinking habits of persons of different religious affiliations.

This very enlightening study found that almost two out

1 *The Boston Globe*, January 8, 1950, p. 34
of every three adults in postwar America reported that they drank some kind of alcoholic beverage. In other words, 65 per cent of the respondents said they sometimes drank alcoholic beverages whereas only 38 per cent said they did not.2

The investigation attempted to measure the frequency and type of drinking that was done. The data indicated how often people drank but not the quantity drunk. The distinction made was between abstainers, occasional drinkers and regular drinkers. The "regular" drinkers were defined as those who drank at least three times a week and all other drinkers were designated as "occasional" drinkers.3

The term "regular" drinker is not to be confused with the more general term of "alcoholic" or "alcoholism" as used herein. "Alcoholism" or "alcoholic" connotes social and/or personality problems as a part or result of excessive use of alcohol, whereas "regular" drinker is used to distinguish the frequency of alcoholic beverages drunk apart from any problem aspects.

The data showed that 17 per cent of the total population or better than one out of every four drinkers consumed some alcoholic beverage at least three times a week, while 48 per


3 Ibid., p. 266
cent were occasional drinkers and 35 per cent were abstainers.4

The study was able to measure the kinds and combinations of alcoholic beverages used by the drinking population. This is shown in Table III,5 which is the first of four tables presented herein, quoted from the study.

TABLE III

PER CENT OF POPULATION DRINKING VARIOUS KINDS OF BEVERAGES

<table>
<thead>
<tr>
<th>Types of Beverage</th>
<th>Per Cent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wine only</td>
<td>4</td>
</tr>
<tr>
<td>Beer only</td>
<td>15</td>
</tr>
<tr>
<td>Wine and Beer only</td>
<td>6</td>
</tr>
<tr>
<td>Liquor only</td>
<td>7</td>
</tr>
<tr>
<td>Wine and Liquor</td>
<td>3</td>
</tr>
<tr>
<td>Beer and Liquor</td>
<td>11</td>
</tr>
<tr>
<td>Wine, Beer and Liquor</td>
<td>16</td>
</tr>
<tr>
<td>other (Cordials, Liqueurs, etc.)</td>
<td>3</td>
</tr>
<tr>
<td>Total per cent who drank</td>
<td>65</td>
</tr>
</tbody>
</table>

Table III shows that 31 per cent of the population drinks distilled spirits either exclusively or intermittently with wine or beer. This is significant in the light of the fact that there is the general belief that most drinkers are drinkers of hard liquors. Roughly, two-fifths of the drinking population reported using no distilled spirits.6

4 Ibid., p. 266
5 Ibid., p. 267
6 Ibid., p. 266
The drinking habits of men and women differ somewhat. Seventy-five per cent of the male population are drinkers, whereas 56 per cent of the women are drinkers. The study found that while the same proportion (48 per cent) of both sexes drank occasionally, over three times as many men (27 per cent) as women (8 per cent) were regular drinkers.7

The drinking habits between the urban and rural populations differed markedly. This difference is shown in Table IV.8

| TABLE IV |
| INCIDENCE AND FREQUENCY OF DRINKING BY SIZE OF PLACE |
|-----------------|-----------------|-----------------|
| Population      | Abstainers      | Occasional Drinkers | Regular Drinkers |
| Per Cent        | Per Cent        | Per Cent          |
| Over 1,000,000  | 25              | 52               | 25              |
| Under 1,000,000 | 28              | 53               | 19              |
| 2,500 to 50,000 | 39              | 46               | 15              |
| Rural non-farm  | 43              | 41               | 16              |
| Farm            | 54              | 38               | 7               |

The social factors involved in the difference in the drinking habits of the rural-urban population could well be the basis of a fascinating study, indeed. Just what it is in either of the two environments that affects the drinking

7 Ibid., p. 267
8 Ibid., p. 269
habits would perhaps be quite revealing and be of assistance in the treatment of alcoholism from its genetic basis.

The same directional increase in the overall incidence and in the frequency of drinking is noted from the farm to city, as is seen within the range of economic status as one moves from the "poor" to the "prosperous" level. This is shown in Table V.9

TABLE V

INCIDENCE AND FREQUENCY OF DRINKING BY ECONOMIC LEVEL

<table>
<thead>
<tr>
<th></th>
<th>Abstainers</th>
<th>Occasional Drinkers</th>
<th>Regular Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Cent</td>
<td>Per Cent</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Prosperous</td>
<td>30</td>
<td>49</td>
<td>21</td>
</tr>
<tr>
<td>Average</td>
<td>34</td>
<td>49</td>
<td>17</td>
</tr>
<tr>
<td>Poor</td>
<td>38</td>
<td>46</td>
<td>16</td>
</tr>
</tbody>
</table>

The study revealed that the educational breakdown yielded similar results: 70 per cent of the respondents who had at least a high-school education and 62 per cent of those who had not graduated from high-school said they sometimes drank alcoholic beverages; 18 per cent of the more educated respondents, however, and almost as many (17 per cent) of the less educated were classified as regular drinkers.10

9 Ibid., p. 269
10 Ibid., p. 270
A comparison based on the place of birth of respondent's parents and grandparents pointed up ethnic differences in drinking customs, although racial differences were discovered to be relatively insignificant. It was found that 75 per cent of respondents with foreign-born parents and grandparents, 73 per cent of those with mixed backgrounds, and only 55 per cent of those with native backgrounds were classified as drinkers. A greater difference was noted when frequency of drinking was taken into account. One out of every four respondents with foreign parentage, with only 12 per cent of those having native backgrounds, were classified as regular drinkers.\textsuperscript{11}

The attention given to the different drinking habits of persons of different religious affiliations was very interesting. It was found that the proportion of drinkers and abstainers according to broad religious groupings tended to reflect the differences in outlook or emphasis given to drinking by the respective religious group. Only 59 per cent of the Protestant respondents, with 79 per cent of the Catholic and as high as 87 per cent of the Jewish respondents said they drank alcoholic beverages. This is shown in Table VI.\textsuperscript{12}

\textsuperscript{11} Ibid., p. 270

\textsuperscript{12} Ibid., p. 270
TABLE VI
INCIDENCE AND FREQUENCY OF DRINKING BY RELIGIOUS AFFILIATION

<table>
<thead>
<tr>
<th></th>
<th>Abstainers</th>
<th>Occasional Drinkers</th>
<th>Regular Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Cent</td>
<td>Per Cent</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Protestant</td>
<td>41</td>
<td>46</td>
<td>13</td>
</tr>
<tr>
<td>Catholic</td>
<td>21</td>
<td>52</td>
<td>27</td>
</tr>
<tr>
<td>Jewish</td>
<td>13</td>
<td>64</td>
<td>23</td>
</tr>
</tbody>
</table>

The contrast that exists between the prevalence of drinking to the low incidence of alcoholism among the Jews has been of especial interest. The Rutgers University study pointed out that the majority of explanations that have been given for this phenomenon has stressed either: 1) the realization among the Jews of the danger inherent in the excessive use of alcohol and the necessity of avoiding social scandal of all kinds, or 2) the religious and ritualistic factors connected with use of wine among Jews.\(^{13}\)

Whatever the reason, it suggests that moderation can become a central and powerful force within the morals of drinking.\(^{14}\)

It is only natural that authorities in the field who are studying and treating the alcoholic, differ somewhat in their area of emphasis, but basically they agree as to

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13 Ibid., p. 270
14 Ibid., p. 270
the psychological basis for alcoholism. Likewise, different systems of categorization may be used. Essentially, three types of drinkers are recognized. These are roughly: 1) the social drinker who drinks for the companionship that it gives him. His drinking seldom interferes with his normal activities nor does he "need" a drink; 2) the symptomatic drinker who drinks to relieve an organic or psychological problem. The drinking itself is a "solution" of the deeper disorder; and 3) the addicted or compulsive drinker who "needs" a drink and after the first drink is unable to stop until oblivion overtakes him. It is the compulsive drinker who goes on "lost week ends" and then repeats the pattern again and again.

... three broad types of alcoholics: the symptomatic alcoholic, the reactive alcoholic and the essential alcoholic. In the symptomatic alcoholic, drinking is incident and not a major symptom. There are other prominent and basic neurotic or psychotic symptoms present, or even organic illness. In the reactive alcoholic it is possible to uncover a precipitating event which initiated the drinking. The drinking in this type is often sporadic, being a reaction to reality stress. The attitudes of the reactive alcoholic toward treatment are different from those of the essential alcoholic and they achieve more or are able to sustain their effort to a greater degree than the last group.

The essential alcoholic can be defined as one in whom there is manifest evidence of oral fixation and passive feminine wishes conflicting with masculine strivings. This problem is solved, upon its recognition at adolescence, through alcohol. These people are noted for their inability to carry on sustained effort in work or school. Their personality is characterized by excessive demands for indulgence. These excessive demands lead to frustration in the adult world. They experience in-
tolerable disappointment and rage, leading to hostile acts and wishes against those who caused the disappointment. This is followed by guilt and masochism. For reassurance against the guilt feelings and the fears of the dangerously destructive masochism and the reality consequence of his behavior, the individual feels an excessive need for affection and for indulgence as proof of this affection. Alcohol becomes a pacifier of this rage and disappointment. It also becomes a potent means of carrying out hostile impulses to spite parents, family and friends, and as a symbolic gratification of the need for affection. In this latter aspect it now interweaves itself in a neurotic vicious cycle.

The reactive alcoholic on the other hand is able to sustain more frustration and is able to be more productive, even in spite of the vicissitudes of our cultural pattern. He usually has attitudes toward treatment which are different from and better than those of the essential alcoholic. The essential alcoholic is really suffering from a chronic disorder; he is an oral character in whom the pleasure of the pathological state is greater than its hardships. He is therefore a poorer treatment prospect. Only after the essential alcoholic has suffered greatly or as the alcoholic says, "hit bottom", does he become amenable to any type of treatment. In the symptomatic alcoholic the alcoholism itself is of minor significance, with the solution of underlying psychotic, organic or neurotic problems, it disappears.

In all of these types it must be recognized that alcoholism is a symptom. It is a symptom pointing to something deeper, some disturbance in the character structure or the personality or the body of the individual. Therapeutic efforts must be directed toward the total man in his total environment, taking into account not only what he has to work with, in the form of personality attributes and deficiencies, but also what he has to work in and what he is working for. It is necessary to consider the total man, his goals and his environment.15

Dr. Robert Fleming, director of the Alcoholism Clinic

at the Peter Bent Brigham Hospital, Boston, in speaking of
the alcoholic, differentiates chronic drinking of excessive
amounts of alcoholic beverages into two general types or
stages: symptomatic drinking and true addictive drinking.\textsuperscript{16}

The symptomatic drinker is described as an individual
who takes alcohol in an attempt to obtain relief from the
symptoms of some underlying physical, psychological or social
condition, or any combination of these. The symptomatic
drinker stops drinking if the underlying condition can be
removed or relieved by non-alcoholic methods.\textsuperscript{17}

The individual may drink moderately upon a symptomatic
basis for many years without the appearance of serious diffi-
culties. However, if the drinking is heavy enough, there
appears sooner or later, new pathology and new symptoms as
a result of the drinking. The new pathology leads to
symptoms of a physical, psychological or social nature. In
time, the individual learns to seek relief through the re-
course to more alcohol.\textsuperscript{18}

It is when the vicious circle of drinking to relieve
the symptoms which have been caused by previous drinking has
been fixed that the condition known as true addictive drink-

\textsuperscript{16} Robert Fleming M.D., "Medical Treatment of the
Inebriate," \textit{Alcohol, Science and Society}, 1948 p. 387

\textsuperscript{17} Ibid., p. 387

\textsuperscript{18} Ibid., p. 388
The treatment of the addictive drinker is enormously complicated compared to the treatment of simple symptomatic drinking. The addictive drinking is complicated by the complex, social and personality problems that have resulted from or have been caused by the drinking. Treatment of true addictive drinking invokes the disruption of the vicious circle that is at the center of the problem. After that has been accomplished, the original basis for the early symptomatic drinking can be dealt with.\textsuperscript{19}

For symptomatic drinking based on a psychological disturbance . . . the commonest single cause is . . . the anxiety neurosis or, at any rate, an anxiety state, because alcohol is so helpful in relieving anxiety and other tensions.

Any normal human being, . . . if he drinks enough and over a long enough period of time so that symptoms arise from his drinking, may attempt to relieve them by more drinking--addictive drinking. Some individuals are much more susceptible to the action of alcohol than others; but any normal human being can get caught if he drinks enough and long enough.

The only objective of treatment which stands any chance of success is total abstinence. Theoretically what one tries to do is to relieve all the symptoms, thereby relieving the cause for drinking.\textsuperscript{20}

Dr. Robert Seliger has written numerous books on the treatment and understanding of alcoholism as a disease. He has listed among the personality motivations often found in the alcoholic, the following significant observations:

\begin{itemize}
\item \textsuperscript{19} Ibid., p. 388
\item \textsuperscript{20} Ibid., pp. 389-391
\end{itemize}
1. A self-pampering tendency, which reveals itself in a refusal to tolerate even briefly, any unpleasant state of mind, boredom, sorrow, anger, disappointment, worry, depression, dissatisfaction, and feelings of inferiority or inadequacy. A childish demand for "I want what I want when I want it because I want it", perhaps expresses the attitude of many alcoholics toward life.*

2. An instinctive urge for self-expression without the determination or staying powers to organize this urge into creative action.

3. A more than usual craving for emotional experience which calls for the removal of intellectual restraint.

4. Powerful hidden ambitions without the necessary resolve to take practical steps to obtain them, with resultant discontent, irritability, depression, disgruntledness and general restlessness.

5. A tendency to flinch from the worries and responsibilities of life, and to seek escape from reality by the easiest means available.

6. An unreasoning demand for constant happiness or excitement.

7. An insistent need for the feeling of self-confidence, self-importance, calm and poise that some obtain, temporarily, from alcohol.21

Excluding the psychotic, feeble minded, schizophrenic, and the out-and-out psychopaths, individuals who use alcohol to "excess" appear to be attempting to flee from life situations they cannot handle or be in harmony with, and to relieve various emotional conditions and features of anxiety, depression, restlessness and so on.22

* All words italicized by author Dr. Seliger.


22 Ibid., p. 85
Clinic Treatment of the Alcoholic

Treatment of the alcoholic on an outpatient clinic basis involves certain limitations that would not be encountered in a closely supervised inpatient treatment regime. The clinic lacks facilities for detoxicating the patient and to provide a protective environment until therapy can begin. Likewise, such therapy as the conditioned-reflex treatment cannot be administered in the clinic setting. In the light of these limitations it is only natural to expect the therapy employed to have a different emphasis or different immediate goal. The primary objective of clinic treatment is to interrupt the vicious circle of drinking, to relieve symptoms that have been caused by drinking.

Since this is a study of cases treated in an outpatient clinic, the discussion will be limited to those treatment methods employed at the Quincy City Hospital's Alcoholism Clinic. There is no implication intended by the writer that any one or group of treatment methods are more effective than others. Since the treatment methods discussed herein are employed at the Quincy City Hospital's Alcoholism Clinic, it is assumed that those methods are more readily adaptable to the clinic setting and the limitations of staff and facilities available.

Psychotherapy

The clinic psychiatrist attempts through the technique
of psychotherapy to strengthen the patient's ego, enabling him better to meet frustrations, depression, inferiority feelings, etc. Although this method of therapy does not relieve the basic cause for these feelings, the aim of such therapy is to strengthen the patient's tolerance for his personality liabilities. In this manner the patient first begins feebly to cope with life's situations, avoiding the pitfalls of ego weakness and later becomes more confident with the reward of success. In other words, in psychotherapy the patient "borrows" the therapist's ego and is supported through this initial period of treatment until he has gained sufficient ego strengths to face the disappointments, and the feelings of inferiority, without alcohol.

The ideal treatment for the alcoholic character disorders would be to help him remodel his character structure and become a well integrated adult personality, able to use alcohol as an adjunct to graceful living or leave it alone if he so wishes. This is rarely possible by any method of psychotherapy available today. Fortunately, it has been learned through clinical experience that if an alcoholic can permanently abstain from alcohol then the liabilities of his personality are not released and he is able, with help, to become a reasonably well adjusted and contented person again.23

Psychotherapy attempts to support the patient's personality "weak spots" as clearly described by Dr. Fleming.

The feeling of inadequacy and inferiority, which I think is often a secondary result rather than original cause of drinking, is something that the doctor can attack at

the very beginning of treatment. It is reassuring to a patient to have you point out how these feelings of inadequacy and inferiority have come about as a result of the way he has been handled. He vaguely realizes that his drinking is not all his fault, and that in some way which he cannot understand he has been caught in an entangling situation. But he has not a single defense. His friends, his wife, or his parents will point at him and say, "He did this or that." And it is true that he did and he cannot justify his behavior. After years and years of being absolutely defenseless in this situation, he is finally brought in contact with somebody who explains the situation in a way that shows it is not wholly his fault. When he understands that his feeling of being always in the wrong is really something that his associates have produced in him, although they haven't meant to do so, it cheers him up. He thinks, "Here, at last, is somebody who understands me." So, as I say, I like to start off with what you might call the psychotherapy of alcoholism, by talking about the feelings of inferiority and inadequacy that I know the patient has. One can gain his confidence in that way.

Patience is, perhaps, the most important single attribute that the therapist must have in treating the alcoholic. There are no miracles in this therapy. He should be prepared to spend days, months, and years. I am suspicious of a quick cure, for it often turns out to be just a disillusioning experience after a few weeks of abstinence.

Psychoanalysis has been rather disappointing as a means of treating the ordinary alcoholic. In cases where an original, pre-existing, underlying neurosis has been the cause of the individual's symptomatic drinking, the psychotherapeutic approach, including psychoanalysis, may be successful, or at least it is the rational approach. But psychoanalysis as a specific therapeutic approach has not turned out to be wholly satisfactory.24

Merrill Moore in a concise statement outlines the steps followed in the psychotherapy of alcoholics.

1. Getting the patient's story; finding out (if possible) why he drinks the way he does and why he started to

24 op. cit., p. 393, 395
drink when he did;

2. Gaining the patient's confidence and encouraging him to want to get well. This is often difficult because the alcoholic is usually so discouraged that he does not trust anyone, not even himself; and in some instances it means actually stimulating his will to live—making him want to go on at all.

3. Continuing to suggest to the patient that he can get well; that it is worthwhile; that he can be useful or happy in some way in the world, that he has good qualities which can be utilized or developed; helping him to get over his feelings of inferiority and inadequacy which are often the core of his neurosis.

4. Helping the patient to re-educate himself emotionally; to learn to relax without liquor; to face his basic problems and try out other solutions to them than the alcoholic escape. The physician helps him to spend his energy in constructive rather than destructive ways. The alcoholic often has social assets that serve him in good stead when he needs them. These should be cultivated. This may lead to social rehabilitation on a more adequate and non-alcoholic level. All games, sports, interests and hobbies are valuable to the alcoholic, if you can get him to accept them.25

Dr. Robert Fleming established the first outpatient clinic treatment for alcoholics in the Commonwealth and his Boston Clinic has served as a prototype for the Quincy City Hospital's Alcoholism Clinic. Dr. Fleming explains the clinic method of treating patients as follows:

Each new patient is given a half hour interview, during which an attempt is made to size up the situation, usually fairly acute, and plans are formulated. As a rule the patient is urged to be totally abstinent immediately, is given prescriptions for whatever medication seems appropriate and, as a more or less routine procedure a

25 Merrill Moore, "Toward a Better Understanding of Alcoholism," Alcohol Hygiene, Vol II No. 1 January-February 1946, p. 11
physical examination is arranged for the patient in the general outpatient clinic.

At subsequent follow-up interviews the past history and drinking history are explored and an attempt is made to reconstruct with the patient the development of his alcoholism and to help him deal more adequately with whatever personal or environmental factors might tend to resumption of drinking.

Full utilization is made of community resources such as Alcoholics Anonymous, which has been extremely co-operative, and it has been found easy to build up mutually effective relationships with the clergy, the church and various social agencies.

A number of interesting impressions stand out as a result of our experience so far. For one thing, it is surprising that successful ambulatory handling is possible in so many chronic alcoholic cases. Certainly in the vast majority of instances no questions of institutionalization or hospitalization for sobering up purposes ever arises.

It is my impression that the necessity for hospital beds in treatment of chronic alcoholism has been somewhat over-emphasized. It is true of course, that in an occasional case of acute alcoholism or of an alcoholic psychosis, hospitalization is a matter of urgent necessity, but such cases are the exception rather than the rule.

I am convinced that it is unwise as well as unnecessary to organize for the treatment of a large number of alcoholics around an inpatient setup, although it is desirable to have such facilities available for the occasional case where they are needed.

Another point is how ideal and ready made a location the conventional outpatient department of the general hospital is for treating chronic alcoholism. From the patient's standpoint, the emphasis is on the medical aspects of the problem, which is as it should be with no psychiatric stigma involved.

From the doctor's standpoint, it is easy to focus upon the ambulatory patient all the great resources in diagnosis and specialized treatment which a modern general hospital affords. These include laboratory technique; x-ray; special clinics such as gynecology, allergy, derma-
ology, endocrinology; the social service department; a record system, and the appointment office.

All the elaborate machinery for handling sick people is set up and functioning and absorbs an alcoholic clinic like a sponge. Within such framework it is possible to deal easily and effectively with most of the problems which come up in the course of treating an individual alcoholic.

Furthermore, it would seem to be educationally desirable for the medical personnel of the hospital, especially the house officers and medical students, to have contact in an organized way with the clinical material of chronic alcoholism. Alcoholic cases present many interesting and legitimate problems for medical investigation and research. One subsidiary function of an alcoholic clinic in a general hospital is to provide a framework for making alcoholic cases easily and routinely available for research purposes.

Another important aspect of the organization of an alcoholic clinic in the outpatient department of a general hospital is that such a clinic pays its own way. By using existing facilities exclusively and without any special modification, and by utilizing the work of one volunteer physician and one volunteer lay assistant three hours a week, it has been possible to operate the clinic without any budget at all.

The plan admits of almost unlimited expansion. Given adequate volunteer personnel, and utilizing outpatient facilities already existing in the general hospitals of Boston today, it should be possible to treat adequately many hundreds of chronic alcoholic men and women without the expenditure of a single cent of the hospital's money.26

Antabuse Therapy

The "wonder-drug" of alcoholism has been found in a specifically purified tetraethylthiuram disulphide, trade named "Antabuse". This drug was discovered and developed as a

treatment agent in alcoholism in Denmark and has been recently introduced and tested in the United States. This drug has been carefully tested in Denmark and has been found to be quite effective in helping the alcoholic to shun drinking. It is not claimed to cure or replace the more established methods of treating alcoholism, but it is merely another "support" in interrupting the alcoholic's vicious circle of drinking.

Experience in Denmark indicates that there should be two phases of treatment: 1) the administration of Antabuse which induces the patient to shun drinking; and 2) psychotherapy, which supports the patient in his desire to continue treatment, to readjust socially and finally to make basic changes in his habits. In addition to psychotherapy on an individual basis, group therapy is felt to be equally important.²⁷

The procedure followed in Denmark in the use of Antabuse in the treatment of alcoholism has been followed as somewhat of a pattern for its use in the United States. The treatment process in Denmark begins with a clear view of the patient's drinking habits, background, personal history and details of family history obtained through interview with the patient. This is followed by a careful physical and neurological

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examination.\textsuperscript{28}

If physical and laboratory examinations show that the patient is in good physical condition, Antabuse therapy is begun immediately or as soon thereafter as is thought advisable. The drug alone is harmless but combined with alcohol, symptoms of marked flushing, perspiration, redness of the eyeballs, difficulty in breathing, odor of acetone in the breath, palpitations, vomiting and low pressure will be marked.\textsuperscript{29}

After the above investigation has been made, the patient is informed about the method of giving the treatment and the reaction he will experience if he drinks alcohol after taking Antabuse. Effort is made to see that the patient is clear about effects of Antabuse with alcohol and he is cautioned about the future use of drugs containing alcohol such as tonics and cough mixtures. The importance of taking the medication and keeping clinic appointments is stressed.\textsuperscript{30}

The patient is encouraged to believe that his excessive use of alcohol is a disease for which treatment is indicated. An analogy is drawn between alcoholism and other conditions, such as diabetes, in which sugar must be avoided. The

\begin{itemize}
  \item \textsuperscript{28} Ibid., p. 186
  \item \textsuperscript{29} Ibid., p. 186
  \item \textsuperscript{30} Ibid., p. 186-187
\end{itemize}
patient is told that the taking of Antabuse may be as neces-
sary to alcohol-intolerant patients as insulin is to dia-
betics. The patient is given to understand that alcohol is
a poison to them. The word "alcohol-intolerant" replaces
the words "drunkard" and "alcoholic".31

It has been found that usually six or eight trials with
alcohol are carried out during the first two months of
Antabuse treatment. There are several reasons for this. 1)
to show the patient how he reacts to alcohol, 2) to adjust
the maintenance dosage of Antabuse, and 3) to develop some
aversion to alcohol. The reaction due to Antabuse plus
alcohol occurs normally after a half hour and lasts for one
to two hours. When it is over, the patient falls into a
sound sleep and awakens refreshed.32

It should be noted that the study of treating alcoholism
with Antabuse in Denmark was conducted either in sanitariums
or in the patient's own home. It can be readily seen that
the use of Antabuse in the clinic setting as described in
this study would necessitate some modifications. Since
clinic facilities are not available for a short period of
inpatient care, where trial with drinking alcohol can be
carried out, the trial portion of the treatment routine has

31 Ibid., p. 187
32 Ibid., p. 187
to be eliminated. To supplement this, the patient is encouraged repeatedly to continue in the taking of Antabuse as a safeguard against relapses.

The importance of group activities or group therapy for the patient who is in treatment with Antabuse has been found in Denmark. From the beginning, the patient is encouraged to join a Danish organization called "Ring in Ring" that has been formed on the pattern of Alcoholics Anonymous in the United States. It is an opportunity to fill the gaps in the patient’s life which has developed in connection with abstinence. Mutual support is paramount in the group associations.33

Group Therapy

The importance of assisting the alcoholic in making new acquaintances and associates has been recognized by therapists as a necessary part of the rehabilitative program. The very fact that Alcoholics Anonymous, purely a group of persons with a common understanding and purpose, abstinence, has achieved the high degree of success in relieving alcoholics from debauchery, is a clear indication of the importance of group action or group therapy in the treatment of alcoholics.

In a discussion of the therapeutic values of Alcoholics

33 Ibid., p. 168
Anonymous in the approach to the drinking problem Dr. Tiebout states:

... it is my belief that the therapeutic value of the Alcoholics Anonymous approach arises from its use of a religious or spiritual force to attack the fundamental narcissism of the alcoholic. With the uprooting of that component, the individual experiences a whole new series of thoughts and feelings which are of a positive nature, and which impede him in the direction of growth and maturity. In other words, this group relies upon an emotional force, religion, to achieve an emotional result, namely the overthrowing of the negative, hostile set of emotions and supplanting them with a positive set in which the individual no longer need maintain his defiant individuality, but instead can live in peace and harmony with and in his world, sharing and participating freely.34

It is interesting to note that the Quincy City Hospital's Alcoholism Clinic utilizes the values to be attained from the group feeling and group solidarity of the Alcoholics Anonymous with every patient that can be encouraged to attend the organization's meetings. The clinic psychiatrist feels that in no way does the work of Alcoholics Anonymous or the clinic conflict, but only aids in the treatment of the patient who can profit from the Alcoholics Anonymous experience.

The simple, sincere, religiously motivated, philosophy of Alcoholics Anonymous is clearly stated in the following paragraph:

Basically, the Alcoholics Anonymous program, which is

34 Harry M. Tiebout, M.D., "Therapeutic Mechanism of Alcoholics Anonymous," Medicine Looks at Alcoholics Anonymous, p. 18
spiritual but non-sectarian, incorporates a shift in thinking and feeling about oneself—from the destructive patterns of the past which were associated with drinking to redirected ways of thinking and feeling which inspire sobriety and peace of mind. It is substituting wholesome new attitudes for old ones which have proved faulty. Assistance in learning new ways of living is gained from the example and guidance of members who have been successful in remolding their own lives, and through weekly group meetings. Many of the groups maintain quarters which are open to members day and night. New associates and associations and assistance in finding jobs and in reestablishing family relations, are offered by the members without charge. Alcoholics who request help are accepted at face value. This attitude of acceptance without condemnation is so strikingly in contrast with the attitude of the public at large that the alcoholic experiences an emotional shift which frequently brings him into the group. By comparison with the resistance the alcoholic exhibits to suggestions about treatment offered by members of his family, friends, clergymen, and others, the acceptance of the Alcoholics Anonymous approach is remarkable. It supports the viewpoint that many alcoholics not only need assistance but will accept it when it is extended under suitable conditions—conditions of which the public to the present time, has had little or no understanding.35

In 1935, Alcoholics Anonymous was begun by two habitual "drunks", one a doctor, the other a broker, both of some distinction before alcohol addiction began to ruin their careers and threaten to break up their homes. This took place in Akron, Ohio. They decided one drunk might help another. Today the organization has some 85,000 members in 2,400 chapters throughout the country. The membership has as its

goal; to help each other stay away from alcohol.36

It has generally been conceded by authorities studying and treating the alcoholic that the Alcoholics Anonymous movement represents the most widely successful attempt at alcoholic rehabilitation in this country's history. Alcoholics Anonymous maintains that 75 per cent of its members have achieved sobriety. Even with the relative success of Alcoholics Anonymous as a group fellowship program, it does not answer the needs of all alcoholics.37 Some individuals require intensive medical and psychiatric treatment which members of Alcoholics Anonymous do not pretend to offer.38

Social Service Treatment

Social services for the alcoholic and his family are recognized as an important part of the total treatment approach to the problem of alcoholism. It can be said with relative certainty, that most alcoholics have other problems of a social, financial, marital or employment nature in addition to their problem drinking. This area of treatment for which the social service worker has developed specific skills and resources in the handling of such problems, has been recognized as contributing immeasurably to the treatment


37 Ibid., p. 204

38 McCarthy and Douglass, op. cit. p. 129
of alcoholism.

It has been noted that only patients who were seen in the Alcoholism Clinic of the Quincy City Hospital and who had pressing social problems were referred for social service treatment. The regular Social Service Department of the hospital has given social services to the patients referred from the Alcoholism Clinic. Referrals are made, in the main, by the Clinic's neuro-psychiatrist. Because of the volunteer status of the Alcoholism Clinic, referrals for social services were kept to a minimum. However, since the Alcoholism Clinic became a part of a state program for treating alcoholism in November, 1949, the Clinic has envisaged the addition in the near future of a psychiatric social worker to the Clinic's staff. This Clinic social worker will give services specifically to the alcoholic and his family that will parallel the services currently given by the regular Social Service Department of the hospital. By the addition of this worker to the Clinic staff, a greater number of patients will be receiving social service study, diagnosis and treatment. The alcoholic and/or his family who receives social services, experiences understanding, support, and assistance with the general social problems that are presented as obstacles to an adequate and rewarding adjustment. The Quincy Clinic's psychiatrist recognizes the fuller treatment of the alcoholic problem by the free use of social
Case work with the alcoholic does not deviate from the basic concept of an accepting, non-judgmental, non-condemning, non-punitive approach to the individual with a problem needing assistance. The alcoholic is a hypersensitive individual, depressed with feelings of guilt and inferiority. He wants help with these feelings, but is resistant and fearful of expressing them because of the condemning attitude shown him in the past. The alcoholic seeks and needs understanding. The social worker should, therefore,

... 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, and who respects him as a person even though not approving of all his behavior; who can be counted on to back him up when he needs it but not to take over his burdens for him.\(^39\)

Dr. Joseph Thimann, Medical Director of the Washingtonian Hospital, Boston, recognizes social services as one of the treatment methods employed in dealing with the alcoholic problem. He explains this as follows:

The third element of our therapeutic plan concerns the patient's environment. To handle this adequately is often difficult, and not so much in respect to interpreting the patient's problem to his relatives but because it may be necessary to keep a wife or mother from gratifying her neurotic needs at the expense of the patient. More often than not the nearest relatives of our patients are

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emotionally immature, insecure, demanding, possessive neurotics. In the case of a wife, disappointment in her marriage—especially if the patient's stunted psychosexual development entails a son-mother pattern of relationship—may lead to violent hostility, conscious or unconscious. The neurotic possessive wife may enjoy her sick husband's dependence. The prospect of his rehabilitation may be a threat to her. Modification of this situation calls for an experienced and skillful case worker.

Manipulating the patient's environment involves also his working environment, and sometimes vocational guidance. The patient's emotional and social under-development often manifests itself in his inadequate schooling and training. This forces him into a low social and economic stratum and certainly does not contribute to feelings of importance and accomplishment on the part of the patient or to his acceptance on the part of his wife. Guidance and encouragement may contribute substantially toward the patient's gaining self-assurance as well as economic and social security.

It is our experience that a well chosen, gainful occupation, with subsequent feelings of accomplishment, importance and security, is a relevant stabilizing factor in rehabilitation. This task of handling the patient's environment is in most cases the domain of the Social Service Department.40

Through the availability of psychotherapy, Antabuse therapy, and group therapy by the local Alcoholics Anonymous group, and social service treatment, the Alcoholism Clinic at the Quincy City Hospital offers to the community, modern treatment for its alcoholics. The increasing number of referrals from the Court and social agencies indicates the value an Alcoholism Clinic has in making more effective the social services given to families in which alcoholism is a factor.

CHAPTER IV
CASE PRESENTATIONS

The thirteen cases comprising this study are the total number of cases treated concurrently in the Quincy City Hospital's Alcoholism Clinic and Social Service Department from April, 1948 to December 1, 1949. Since this is a qualitative study involving a small number of cases, the writer abstracted case material and supplemented this with follow-up study, for the purpose of measuring the effectiveness of concurrent clinic and social service treatment of the problems resulting from alcoholism as well as the etiological factors contributing to the addicted drinking and those social factors that responded best to social service treatment.

The cases studied were those of eleven male and two female alcoholics. Their ages ranged from twenty-eight to fifty-five years with a mean age of 38.8 years and a median age of thirty-six years. This is shown in Table VII.

Eighty-five per cent of the cases studied were married at the time the agency's social studies were made. This is shown in Table VIII.

The social problems that surround the married alcoholic are many and complex. These are often centered in marital disharmony and are aggravated by financial and/or employment problems. The pattern of escape through alcohol as demonstrated by the alcoholic becomes well established as the
### TABLE VII

**AGE RANGE OF CASES STUDIED**

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<th>Age Range</th>
<th>Number of Persons</th>
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<tr>
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<td>46-48</td>
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<tr>
<td>Over 48</td>
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<tr>
<td><strong>Total</strong></td>
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</table>

### TABLE VIII

**MARITAL STATUS OF CASES STUDIED**

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<th>Marital Status</th>
<th>Number of Persons</th>
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<td>85.5</td>
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<td>Single</td>
<td>1</td>
<td>7.5</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>7.5</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>100</strong></td>
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</tbody>
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social problems increase in amount and intensity. Alcohol is his "solution" to problems resulting from drinking. It is interesting to note that those cases referred for social services and herein studied were predominately persons married or who had been married.

Cases 1, 2, and 3 of the cases presented were slight service cases, where the individual presented a social problem that required but a minimum of social service treatment. The material available in these cases was limited.

The material available in the case records studied has been summarized and interpreted herein to ascertain the etiological factors inherent in the alcoholic behavior pattern and to determine the effectiveness of the treatment given.

It should be noted that in order for the writer to present concise case abstractions from the thirteen case records studied, the more subtle aspects of the caseworkers role has been, in some instances, implied. For the purpose of ready clarity, the more tangible manipulation of the patient's environment has been presented. It should therefore be understood that each case presented herein involved the subtle therapeutic values of understanding, sympathy, empathy and in general, ego support similar to the ego support given by the clinic psychiatrist. This can be attested to by the length of time the alcoholic was known to Social
Service. Much of therapeutic value is derived from the relationship that is established between alcoholic and social worker and through interpretation and the casework skills, the patient is better able to view his problem realistically.

The following cases are grouped into two categories. Those cases that were able to utilize the concurrent clinic and social service treatment offered them were grouped under the heading of "Responded to Treatment", and the cases that were unable to utilize the concurrent treatment offered them were grouped under the heading of "Unresponsive to Treatment". In one case, Case #13, information was not available to justify grouping it under one of the above headings.

**Responded to Treatment**

**Case #1**

John E., age thirty-six, was referred to Social Service by the Clinic's neuro-psychiatrist for help in securing employment. He had been referred to the Alcoholism Clinic by the Court.

John was an unmarried army veteran who supported and made his home with his elderly mother. Job possibilities were discussed with him and he later found a construction job. He showed resourcefulness by having other job possibilities in mind.

For the brief period (ten days) John was known to Social Service, he was attending the Clinic regularly and was doing well.

**Follow-up**

John felt the Clinic had helped him in reducing the amount of drinking he did. He had felt clinic attendance
a stipulation of his probation from the Court. He was at the time unemployed.

Case #2

Clarence G., age thirty-three, was referred to Social Service by the Clinic's neuro-psychiatrist for assistance in arranging medical care. Clarence had been referred to the Alcoholism Clinic by a friend.

Examination and hospital admission were arranged for Clarence. Following his discharge, he continued with treatment in the Alcoholism Clinic. He was known to Social Service fifteen days.

Follow-up

Clarence had abstained for two years and felt proud of his achievement. He continued to attend the Clinic and Alcoholics Anonymous meetings regularly and felt that both had been of great help to him. He enjoyed financial and emotional security for the first time in years, after he gave up drinking. His family and social relationships had become more enjoyable and harmonious.

Clarence and his wife had no children and were both employed. Clarence worked as an unskilled laborer. He had always worked steadily except for a brief period preceding his treatment in the Clinic.

Case #3

Larry O., age thirty-four, was referred to the Alcoholism Clinic by the Committee for Education on Alcohol. At the time Larry was known to Social Service, he was unemployed and gave a history of losing jobs because of alcoholism. He had a history of drinking for fifteen years.
Larry was married and the father of two children aged five and three. He had an indebtedness of around $300.

Upon the request from Mrs. O. to the Social Service Department, arrangements were made under the guidance of the clinic psychiatrist for Larry's referral to the Washingtonian Hospital with a diagnosis of acute phase of chronic periodic alcoholism for a period of seven days.

Following his discharge from the Washingtonian Hospital, the patient continued with his treatment in the Alcoholism Clinic. Larry was very co-operative and for a time came to the Clinic with his wife. The case was known to the Social Service Department for one and one-half months.

Follow-up

At the request of the clinic neuro-psychiatrist follow-up study was not made on Larry. The clinic's neuro-psychiatrist felt that such a contact would arouse too much anxiety. Larry was, however, continuing with his treatment and was making progress.

Case #4

Allen N., age forty-four, was referred to Social Service by the clinic's neuro-psychiatrist for aid in arranging dental care. Allen had been referred to the Alcoholism Clinic by the Court.

Allen was a piper by occupation, but was unemployed at the time of his referral. His family consisted of his wife, aged forty-four, and three children. Daughter Alice, aged twenty-five, was married but was separated from her husband. She and her six year old son were living in the N. home.

The family was slightly in debt but Allen showed resourcefulness in finding what odd jobs he could. He attended the Clinic regularly and showed great improvement. He soon found that his neighbors were more kind to him since he showed intentions of stopping his drinking and he felt better physically. His wife was sympathetic and encouraged him to continue treatment.
A job was arranged for Allen and dental facilities were pointed out to him. During the three months that he was known to Social Service, he was getting along well and continued to attend the Clinic regularly.

Comment

Allen presented no significant personality or social problems that may have precipitated his alcoholism. Apparently he was an habitual drinker whose drinking was at a point of becoming a problem in his personal relationships.

Follow-up

Allen had abstained for a year and during that time had experienced much happier family and social relationships. He was steadily employed. He felt his new acquaintances through the Alcoholics Anonymous had been of great help to him and he enjoyed the weekly meetings for their never-ending fight against alcoholism. He felt the Clinic and Social Service had helped him to overcome his drinking and lead him to Alcoholics Anonymous.

Case #5

Ernest C., age thirty-six, was referred to Social Service by the clinic neuro-psychiatrist for financial assistance. Ernest had been referred to the Alcoholism Clinic by the Court.

The C. family was without food and fuel and was in arrears on rent. They faced eviction. They had an indebtedness of $1100 to $1200.

Ernest was at the time unemployed, but had worked as a salesman. He was a navy veteran and had had a high school education, plus one year of prep school.
The C's had been married nine years. They had three children ranging in age from seven to two years. Mrs. C. was also an alcoholic.

Financial help was obtained for the C's and soon thereafter Ernest was able to return to work. Although he had several relapses of drinking and failed to keep his clinic appointments, he was on the whole, quite regular in his clinic attendance. He was able to recognize his drinking as a problem and felt the Clinic was helping him. Ernest and his wife attended Alcohols Anonymous meetings and in this way he conscientiously tackled his drinking and responded well to treatment.

Effort was directed at Mrs. C's drinking through Ernest and Social Service contacts with her. It was soon realized that clinic treatment was needed for Mrs. C. The case was known to Social Service fifteen and one-half months and was still active.

Comment

Ernest and Mrs. C. both appeared to be immature people. As a result of their escape through alcohol, they encountered financial difficulties and marital disharmony. Through concurrent treatment in the Clinic and Social Service Department, the family was able to improve their financial situation and to develop a sense of confidence in their ability to cope with their problems.

Follow-up

Ernest was working steadily. He had abstained for over a year and in that time had become more responsible and dependable. The financial and marital difficulties had improved considerably but further improvement was blocked by Mrs. C's slow response to treatment for her drinking. She continued to drink, but felt that she had improved since
clinical treatment was begun.

Case #6

James D., age forty, was referred to Social Service by the clinic neuro-psychiatrist for assistance in solving problems related to real estate. James had been referred to the Alcoholism Clinic by the Court.

James was married and the father of five children ranging in age from ten months to six years. His wife had been a school teacher prior to their marriage. James had not completed high school.

The D. family had accumulated debts of about $1000. They were attempting to sell their home in order to make enough profit to pay their creditors and buy another home.

James felt inferior to his wife and accused her of having relations with other men. He claimed that his wife did not discuss anything about the home with him. He felt that she showed no affection for him and that she would like to see him drinking again. He blamed her for managing their finances poorly.

The patient was interested in clinical treatment and was quite regular in clinic attendance and attendance at Alcoholics Anonymous meetings. Since beginning treatment, he had abstained for a period of nine months and felt he would never drink again.

In the twelve months the D. family was known to Social Service, much pressure was brought to bear by their many creditors. Foreclosure on their home, attachment of wages and discontinuance of utilities were threatened. Leniency and deferred payment were difficult to obtain. Mrs. D. feared that action by creditors would result in James' drinking again, but through the efforts of various agencies and community resources, this was narrowly avoided.

Comment

James' feelings of inferiority and inadequacy were relieved by alcohol. Indebtedness and pressure from his
creditors resulting from his drinking only led to more drinking. Through clinic treatment, James was given reassurance and was supported by Social Service, to abstain from drinking and again face his responsibilities.

Follow-up

James was continuing with clinic treatment and Alcoholics Anonymous meetings. He had abstained for a year and in that time had become more responsible in family and financial matters. Although still pressed by creditors, the family felt they had the strength to face these responsibilities.

Case #7

Clyde M., age thirty-five, was referred to Social Service by the clinic neuro-psychiatrist for aid in social planning for Clyde and his family. He had been referred to the Alcoholism Clinic by the Court. He was diagnosed as acutely intoxicated and question of delirium tremens, and was admitted to the Washingtonian Hospital for a period of eight months where he stayed at the hospital in a living-in arrangement and received psychiatric interviews. During this time, the Quincy City Hospital Social Service was following Clyde's progress in order to give adequate interpretation to the family. Mrs. M. had threatened legal separation and this was avoided upon the recommendation of the clinic psychiatrist.

Clyde was born of Finnish, Protestant parents. His mother was strict, but both parents were kind. Mrs. M. felt that Clyde and his brother were spoiled by his parents who indulged them.

Clyde began to drink "home brew" at the age of fifteen. At twenty-three he began drinking heavily with friends. His drinking had been a problem for the past five years, even though he had two periods of abstinence, one of eight and another of nine months duration.

Clyde, a high school graduate, had married at the age of
twenty-one, having known Mrs. M. three years prior to their marriage. They had six children, ranging in age from three to twelve years. After the birth of the third child, Clyde began to drink heavily and became abusive. He seemed to resent his wife's pregnancies.

Clyde had intermittent employment and Mrs. M. felt his drinking was a factor in his losing jobs. The family's finances were in a precarious state, although there was no indebtedness.

Mrs. M. thought Clyde drank because he did not want responsibility; that he wanted everything for himself. He would request special food and was selfish.

Clyde had had one admission to the Medfield State Hospital with alcoholic psychosis and delirium tremens.

After leaving the Washingtonian Hospital, Clyde was seen in the Alcoholism Clinic irregularly. He had contact with Alcoholics Anonymous.

After another period of heavy drinking, Clyde was helped to accept private sanatorium care. Treatment at the sanatorium was very successful, where the patient was again in an atmosphere of protection.

Clyde and Mrs. M. were evaluated by the clinic neuro-psychiatrist as immature people.

Comment

Clyde was an immature man who satisfied his dependency needs through alcohol. Mrs. M's lack of understanding complicated the treatment objective. Although Clyde and Mrs. M. were of different religious faiths, it did not appear to be a complicating factor.

Follow-up

Clyde and Mrs. M. were separated. He was working steadily and living at the City Home, which is a home maintained by the City of Quincy for the indigent and the home-
less. Mrs. M. was receiving financial assistance from the Department of Public Welfare.

Clyde had abstained for a period of three months.

Unresponsive to Treatment

Case #6

Edna H., age forty-five, was referred to the Alcoholism Clinic by a friend. She had a history of mild drinking for sixteen years prior to 1945. From 1945 to 1947 she drank heavily. She had been arrested many times for drunkenness and was known to many social agencies. She had had one sentence to the Women's Reformatory, but her husband had requested her release after she had served four months of the one year sentence.

Edna H. was born in Finland and had lived in the United States and Quincy, thirty years. Her husband was a common laborer approximately ten to fifteen years her senior. Both Edna and her husband had been married previously and had children. These children were grown and out of the home. Edna's former husband was deceased.

The present marriage was suggested by Edna's daughter after Mr. H. had befriended Edna on one occasion by taking her off the streets intoxicated, buying her clothes and renting her a room. They had been married three years and had financial security, at the time known to Social Service.

Edna's early history revealed that she had been an unwanted child. Her parents had turned her over to another family. These people raised her until she was fourteen. When Edna came to the United States to join her mother, she found her mother remarried. To this union was born a child each year and Edna was like a servant in the household. She received no love from her mother. She had two brothers who were alcoholics. However, Edna learned to drink from her first husband who liked to have a good time.

Edna was an immaculate housekeeper and excellent cook, when sober. When she drank, her husband preached to her extensively, demanding to know her excuses for drinking. This resulted in Edna's drinking more, setting up a vicious circle.
Although there was undoubtedly considerable marital disharmony, neither Edna nor her husband wanted separation or divorce.

Edna was known to Social Service for three and one-half months in 1948. From an earlier Social Service record, it was learned that Edna had been known to Social Service in 1947. She had been referred by the Alcoholism Clinic's neuro-psychiatrist for assistance in finding a job that would enable her to live away from home for a time, proving herself to the husband and facilitating treatment. A job was found for Edna as a cook in a summer camp. She proved herself to be quite proficient at this and abstained from drinking for four months. She was quite co-operative in treatment. She recognized that her marital disharmony was due mainly to her drinking. Effort was made again to treat Edna in the Clinic and to assist her in repeating the satisfactory work experience of the previous summer. Resistance was encountered because Edna's family had come to think of her alcoholism as a mental condition and thought she should be committed. Likewise, Mr. H. had stated that neither he nor Edna had any confidence in the Clinic. Even in the face of this resistance Edna was helped to strengthen herself physically in preparation for accepting the job she had held the previous summer. Edna stayed with the job but a short time. She was irregular and unco-operative in her clinic treatment and finally discontinued treatment entirely.

Comment

Edna presented a picture of insecurity in her love relationships. She had been an unwanted child and carried through her feeling of being unwanted. When despondent she drank, and thereby aroused the criticism and condemnation of her husband. This increased her feelings of rejection, resulting in more drinking.

Edna's first contact with the Clinic and Social Service was supportive and rewarding to her. Since her employment was not permanent, she returned to her earlier pattern of
drinking. She lacked confidence to try again the method that had given only a brief reward.

**Follow-up**

Edna recently served four months at the Women's Reformatory in Framingham. Prior to her sentence to Framingham, Edna had not found help in the Clinic or Alcoholics Anonymous. However, while in the Reformatory she had worked in the hospital unit, where women were admitted who were sentenced for drunkenness. This experience had meaning for her and made her aware to what ends alcohol could lead.

Edna was proud that she had abstained for a total of seven months. She claimed that she had no longer a desire to drink. She had discovered a "new life" in better home relationships and in her return to the Lutheran Church. She felt confident she could continue to abstain.

**Case #9**

Doris M., age twenty-nine, was referred to Social Service by the clinic neuro-psychiatrist, to insure Doris' safe return home and to secure social data from her mother. Doris had spent the night in jail and had been brought by the probation officer to the Alcoholism Clinic. Doris was known to Boston and Quincy courts.

Doris was a divorcee with one child. Her mother stated that the child was conceived out of wedlock, but this was denied by Doris. The marriage was to a man who drank heavily the entirety of their marriage and introduced Doris to drinking. Doris had thought she could reform her husband's drinking.

Doris, an only child, claimed she had married to get away from her mother who was very strict. Her husband was disliked by her mother, who claimed he had a criminal
record. Doris had converted to Catholicism to please her husband, having been reared an Episcopalian.

Doris was irregular in her clinic attendance. She expressed getting into trouble because of drinking, but did not recognize the need for clinic help. Her mother seemed willing for her to receive treatment but did not accept responsibility for helping to bring this about.

The Clinic's neuro-psychiatrist gave a poor prognosis for treatment because of Doris' limited mental capacity.

**Comment**

Doris showed no improvement from the Clinic and Social Service contacts during the time known to Social Service. Her inability to recognize and use the treatment offered her was possibly due to her limited mentality.

**Follow-up**

It was learned from Doris' mother that Doris had recently married. It was thought her drinking had improved. Doris was not continuing with clinic treatment.

**Case #10**

Leonard T., age forty-six, was known to Social Service through Mrs. T. She had been referred to Social Service by the clinic neuro-psychiatrist for help with her problems. Mrs. T. had had a non-clinic contact with the psychiatrist at which time she presented certain social problems. Leonard was considered and later accepted for clinic treatment.

Leonard was an only son. An older sister, a religious fanatic, dominated him. His mother was deceased. His father drank and was a heavy smoker.

Leonard was a union carpenter and had been steadily employed. He drank progressively more, since marriage to Mrs. T. He drank mostly over week-ends.

He had been known to the East Norfolk County Court and
had received some treatment at the Alcoholism Clinic of the Peter Bent Brigham Hospital, Boston. He had attended Alcoholics Anonymous meetings intermittently for two or three years.

The family received financial help occasionally from relatives. There was disharmony in the home. Leonard had, on one occasion, threatened Mrs. T's life with a hatchet and threatened to burn down the house. On another occasion he had turned on the gas in the stove. Leonard was physically in poor condition and had periods of depression.

Leonard refused to accept the fact that his drinking was a problem. He attended the Clinic irregularly and finally discontinued treatment entirely.

Mrs. T. was discouraged, and although she found solace for a time in Social Service, she completed her threats by filing for a divorce. Mrs. T. was referred to a family agency for help in working through her plans. The case was closed after ten and one-half months.

Comment

Leonard was an immature person who found release for his repressed hostility through alcohol. The family's dependence upon occasional financial help from relatives further indicates immaturity as well as his acceptance of an older sister's dominance.

Follow-up

It was learned that the T's had been divorced and Leonard had moved to New Jersey. It was assumed that Leonard was unimproved in his drinking.

Case #11

Joseph X., age forty-four, was referred to Social Service by the clinic neuro-psychiatrist for social review and to interpret Joseph's condition to his wife. Joseph had been referred to the Alcoholism Clinic by the Court.
Joseph was the younger in a family of two sons. His mother died when he was fifteen. Joseph had little formal education, having completed the second grade only.

Joseph was married to a woman twenty-nine years of age, who had completed grammar school. They had been married six years at the time they were known to Social Service. They had two children, aged two and four years. Mrs. X. had an illegitimate son, Forrest, age ten, who was born prior to her marriage to Joseph. Whenever Joseph drank, he became quite abusive but would never touch Forrest.

Joseph had been married and divorced previously. His children by this marriage were under the care of the State of Maine.

Joseph did little drinking prior to July, 1948. Since that time, he had drunk every weekend and spent most of his wages on liquor. When he drank he was difficult and would beat Mrs. X. and their children. He had threatened to kill her and on one occasion had run after her with a screwdriver. Mrs. X. questioned his sanity and felt that a head injury he had received while at work might have been the cause. He was in a stupor most of the time, whereas formerly he was bright.

Mrs. X. complained that Joseph wanted sexual relations all the time. She had fears of pregnancy but implied that this was not the basis for the sexual maladjustment.

Joseph did not enjoy his work. He was employed in a foundry as an unskilled laborer. Because Joseph drank and used up his wages, the family was in debt.

During treatment Joseph showed some improvement and his behavior, while drinking, was no longer abusive. He later became irregular in his attendance to the Clinic and finally discontinued entirely.

Joseph had many social problems that complicated the picture. The family faced eviction and during the seventeen months the family was known to Social Service, they had illness and financial difficulties. The Social Service Department was able to help them with these problems either directly or through other community resources.

Contact with the family was terminated by their moving from Quincy. Referral to other social agencies was suggested.
Comment

Joseph was a near illiterate person without skills or a trade. His inability to face the competition of his fellow workmen and associates and a feeling of inferiority to Mrs. X., led him to escape through alcohol. The social problems that resulted from his drinking produced the vicious circle of alcoholism.

Follow-up

Joseph was again drinking at his pre-clinic rate. Although Mrs. X. encouraged his continuing treatment, he refused to listen. The family was at times without food and other essentials, after Joseph had spent all his wages on liquor. He was again abusive and threatening to Mrs. X. and their family. He made excessive sexual demands upon Mrs. X.

Mrs. X. was pregnant. Because of this, she felt she could not fulfill her wishes to leave. Joseph was uninterested in her pregnancy and was unconcerned about her medical care.

Case #12

Ralph G., age fifty-five, was referred to Social Service by the clinic neuro-psychiatrist for help in providing housekeeping services in the home. Ralph's wife was ill. In addition, assistance was needed to obtain a stay of eviction. Ralph was referred to the Alcoholism Clinic from the Quincy City Hospital's medical clinic.

Ralph was a very intelligent man having graduated from the New England Conservatory of Music and received his Ph.D. in music from Oxford. He had been born in Canada but had lived most of his life in the United States. He
had worked as a musician in various theaters and radio studios as well as being a teacher of music. He told of having jobs that paid $500 to $600 per week salary.

Ralph had been married three times and fathered twelve children, all of whom were living. The first marriage ended in divorce. Six children were born to this union. The second marriage lasted nineteen months. The wife died in childbirth and left one child. The third and current marriage has been in effect twelve years. Five children have been born. The six children from the second and third marriage were in the home.

The G. family was facing eviction and Ralph was without employment. They were receiving assistance from the Department of Public Welfare. Several months later, the family was able to find a flimsy built summer cottage, in which they planned to spend the winter.

Ralph attended the Clinic and showed remarkable improvement in his physical complaints of nervous exhaustion, neuritis and cirrhosis of the liver. His clinic attendance was fairly regular for a time, but soon he discontinued treatment entirely.

Ralph had had one commitment to Medfield State Hospital for acute alcoholic psychosis and delirium tremens. He refused at the time, to accept voluntary commitment to undergo treatment.

Comment

If the history were known of Ralph's drinking, one would likely find he had a pattern of long time use of liquor. Drinking to "solve" the problems created by drinking was already a familiar routine.

Ralph's inability to find a position for which he was trained has done much to activate the vicious circle of drinking.

Follow-up

Ralph continued his pattern of drinking and although
efforts to help him accept Clinic and Social Service treat-
ment had been made, he was still unwilling or not ready to
accept this. The family was continuing to receive assistance
from the Department of Public Welfare.

Case #13

Edward N., age twenty-eight, was referred to the Alco-
holism Clinic by the Social Service Department when the
problem of his drinking became known during his wife's
hospitalization for miscarriage.

The N's had been married four months at the time they
were known to Social Service. Edward was an honorably
discharged veteran who had completed one and one-half
years in a School of Business Administration prior to his
marriage.

Both Edward and Mrs. N. were unemployed. They claimed
to have sufficient savings to care for their needs until
employment could be found. In accepting clinic treatment,
Edward insisted upon paying a fee which was not routinely
expected.

Edward gave a history of drinking since the age of
twenty-one. He drank mostly when depressed and de-
spondent. He had received outpatient treatment at the
Washingtonian Hospital during the summer of 1947 and had
received psychiatric treatment in Boston prior to this.

Report from the Washingtonian Hospital revealed that
Edward had been resistant about accepting outpatient
treatment. His chief problem was that of masturbation.
He would masturbate several hours every night until he
fell asleep. He had had a great deal of guilt in con-
nection with this and would drink in order to forget his
habit.

He had had several girl friends, but was unable to have
sexual relations with them until drunk. He was lonely
and discouraged. He was living at the time with an aunt who gave him good care but no affection. Edward had two younger brothers and a step-brother. He was raised by his step-mother. As a child, Edward had temper tantrums.

During his treatment at the Washingtonian Hospital, Edward's masturbation stopped. Effort was made to relieve his guilt associated with masturbation. He was given reassurance and other ways of relaxation were suggested.

During treatment, he had only one relapse. This was in connection with a girl who expected sex-relations and he drank. After spending the night with the girl, he went to a policeman and asked to be arrested. He felt badly following this. Contacts with the Washingtonian Hospital were voluntarily discontinued.

Edward's attendance to the Clinic was regular for a time, but later, he repeatedly broke or postponed appointments. Mrs. N. seemed to lack full understanding of Edward's condition and was not too co-operative. The N's were known to Social Service nine and one-half months.

Edward was diagnosed as anxiety neurosis; secondary, alcoholism.

Comment

Edward was a symptomatic drinker whose drinking was the "solution" of a deeper psychological problem. His basic problem was on a psycho-sexual level. His feeling of inadequacy was temporarily relieved while drinking. With psychiatric treatment, he was able to gain sufficient ego strength to lay aside masturbation and drinking.

Follow-up

The N's had moved from the address known to Social Service. The follow-up data was not obtainable.
The writer considers it significant to note that seven of the thirteen cases studied were able to utilize the clinic and social service treatment in meeting their problem of drinking. Another five of the thirteen cases were unable to utilize effectively for any length of time, the treatment offered them. In one out of the thirteen cases studied, information was not available that would enable an evaluation.

The above statements are general evaluations that were based upon the follow-up data obtained from the patient, his family or the clinic psychiatrist. The writer does not consider the above evaluation as representative in view of the small number of cases studied, but is suggestive of the possible effectiveness of concurrent clinic and social service treatment.
CHAPTER V
SUMMARY AND CONCLUSIONS

This thesis was undertaken to make a qualitative study of thirteen alcoholic patients treated concurrently in the Quincy City Hospital's Alcoholism Clinic and Social Service Department. These thirteen cases comprised the total number of patients that received concurrent treatment from April, 1948, to December 1, 1949. This study was undertaken in order to determine: 1) the etiological factors producing alcoholism that were seen in the cases studied; 2) in what way the clinic and social service treatment affected the alcoholic's adjustment; and 3) the social factors that responded best to social service treatment.

In order that a better understanding could be had of Quincy, Massachusetts as a community in which its inhabitants live and work and where the need for an Alcoholism Clinic was seen and developed, a descriptive picture was presented to give the setting.

The Clinic's development was summarized, from its beginning as a volunteer and personal project of the Clinic's neuro-psychiatrist and later as a treatment unit of a state sponsored plan for the treatment of alcoholism, as recommended by the Committee on Alcoholism of the Greater Boston Community Council to the Legislature.
In order to provide a framework of understanding for the treatment of the alcoholic on an outpatient clinic basis, the writer presented from the literature, the etiology of alcoholism as seen by the various therapists in the field. Even though the different authorities varied in their area of emphasis, they generally agreed that the individual, with his immaturity and inability to face reality, found through alcohol a "solution" to his feelings of inferiority and inadequacy that later developed into an uncontrolled behavior pattern.

Since all therapies now in use for the treatment of alcoholism are not readily applicable for use in a clinic setting, the writer has limited the material presented herein to those therapies in use at the Quincy City Hospital's Alcoholism Clinic. These included psychotherapy, Antabuse therapy, group therapy, and social service treatment. Although group therapy was not given directly within the Clinic, Alcoholics Anonymous membership was encouraged or prescribed as an important part of the treatment process. It was pointed out that the treatment methods employed at the Quincy Clinic were not presented as being the most effective of modern treatment methods but were assumed to be the most adaptable to a clinic setting.

The writer presented some of the general aspects of casework with the alcoholic and his family as an important
part of the total treatment approach to the problem of alcoholism. It was pointed out that casework with the alcoholic does not differ in approach or technique from the basic casework skills. The social worker with his understanding and support of the alcoholic and his knowledge of community resources and skill in the handling of social problems, is recognized as contributing immeasurably to the total treatment of the alcoholic.

The cases studied were presented in a brief summarized form to facilitate a clearer view of the social situation as presented and treated in Social Service. A brief comment was made by the writer following each case presentation (except cases #1, #2, and #3 that received slight social service) as a focus upon some of the etiological factors that were seen present in each case. A follow-up study was made on all cases, except case #3 and #13 as a measure of the effectiveness of concurrent clinic and social service treatment upon the patient's adjustment.

The study indicated that those social factors of the patient's early life in which he met with rejection, insecurities and feelings of inadequacy, contributed to the addicted drinking. Not all cases studied had information of the patient's early developmental history that would enable a more critical evaluation of contributory factors in the addicted drinking.
A basic emotional immaturity centered around a narcissistic core appeared and characterized the personalities of the cases studied. The alcoholic's feelings were directed inward in self-pity, feelings of inferiority and inadequacy. Feelings of hostility were repressed and gained expression through alcohol.

The Clinic's treatment directed its attention upon the basic immaturity, attempting to strengthen the ego and to relieve the strong feeling of guilt. Through this approach, the patient could again gain self-respect and a feeling of adequacy. The social problems directly affected by the patient's drinking responded best to treatment. These included marital and family disharmony, financial and employment difficulties.

The cases that were grouped under the heading of "Responded to Treatment", were able to accept their drinking as a problem. Through understanding and ego support in treatment, the patient was able to gain sufficient strength to accept life's responsibilities rather than escaping through alcohol. Those cases grouped under the heading of "Unresponsive to Treatment", found the problems associated with their drinking as less painful than the treatment process. These individuals did not recognize their drinking as a problem and felt that they could stop drinking at will. Their drinking solved for them the responsibilities, insec-
curities, and feelings of inadequacy, which they were unable to face realistically.

In those cases in which concurrent clinic and social service treatment resulted in abstinence, the patient's adjustment has become more wholesome, meaningful and enjoyable for him and his family.

This study bears out the complexity of social and personality problems involved in the treatment of the alcoholic and indicates some facets of case work attempted with the alcoholic.

This study clearly indicates that the alcoholic can attain a more wholesome and satisfactory adjustment through the concurrent treatment of an Alcoholism Clinic and Social Service Department. As is suggested by this study, close integration of clinic and social service treatment is of paramount importance to assure the best possible treatment to the alcoholic and his family. This involves skilled social service personnel in dealing with the complex problems presented as well as careful and detailed data by both psychiatrist and social worker to best tackle the problem from all directions.

Approved,

Richard K. Conant
Dean
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