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The psychotherapy of alcohol addiction

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THE PSYCHOTHERAPY OF ALCOHOL ADDICTION

by

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"The sincere scientific study of recent years makes evident that successful therapy for the ordinary alcoholic demands a catholicity of approach quite beyond the average psychiatrist's interests and a complexity of treatment not available in the typical institution."

- Dr. Robert S. Carroll in *What Price Alcohol?*
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FOREWORD

This dissertation is a direct result of my own personal struggle against alcohol addiction. After submitting to some half dozen different methods of treatment at the hands of some dozen psychiatrists and psychologists, I was given up as "hopeless" or as incapable of further improvement at their hands. Thus by a process of elimination I was more or less forced to undertake a study of this insidious disease myself and to attempt to dig out the principles which would contribute to my own rehabilitation. In the course of this study and research I became more and more impressed with the terrific toll which the disease of alcohol addiction exacts year in and year out in nearly every portion of this planet, and I decided to devote the remainder of my life to doing my share toward its elimination from the face of the globe.

Needless to say, my own rehabilitation and the completion of this dissertation could never have been accomplished without the long decade of sympathy, understanding, and help of my mother, Mrs. Lena B. Cropley, and my grandmother, Mrs. Emma F. Bronson. Others who have made considerable contributions toward the completion of the dissertation are Dr. Wayland F. Vaughan and Dean Howard M.
LeSourd of the Boston University Graduate School, the former Phyllis M. Wicker of Richmond, Virginia, Isabella Bencivenga of Chicago, Dr. George Stevens of Manchester, New Hampshire, Wilson Mackay and Courtenay Baylor of Boston, Samuel Crocker and W. W. Wister of New York City, Count Alfred Korzybski of Chicago, Mr. and Mrs. Herbert Crosman of Eureka College, Illinois, Frederick Gorgone of Watertown, Massachusetts, Thomas Stefan, Harriet Babson, and David Isenberg of Boston, Fred Squires, Bertha Palmer, Father Gibson and Father Higgins of Chicago, and several officers of The National Forum of that city. I have also received valuable assistance and criticism from Drs. Nathaniel W. Portman, Richard Heller, William Sadler, William Parrilli, and Ben Reitman, all of Chicago. Valuable criticism has also been given by the editorial board of The Quarterly Journal of Studies on Alcohol. I am greatly indebted to Drs. Karl M. Bowman and E. Morton Jellinek for their comprehensive review of the literature on "Alcohol Addiction and Its Treatment" which appeared in the June, 1941, issue of the same Journal. This article enabled me to round out the dissertation more adequately and also served to corroborate many points which I had dug out independently. Many other items of indebtedness will be apparent from my footnotes and bibliographies.
The extremely up-to-date and comprehensive alcohol libraries of The Scientific Temperance Federation of Boston and of the National Woman's Christian Temperance Union of Evanston, Illinois were put at my complete disposal time and time again by their able and conscientious secretaries, Mrs. Grace Howard and Miss Eamons. I also owe a considerable debt to the following libraries and their librarians: The Boston Public Library, The Boston Medical Library, The Harvard Widener Library, The Chicago Public Library, The John Crerar Library of Chicago, and The Northwestern University Medical Library. Indebtedness to particular authors can be judged by the extent of quotations from them in the body of the dissertation.

V. B. T.
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A. The Importance of the Problem

It is only comparatively recently in the history of mankind that alcohol addiction has been recognized as the disease, or "symptom of disease" which it really is. It was not until the beginning of the present century that mental disease in general was attacked on a realistic basis and not until the last decade that a series of popular books and articles on alcoholism made it clear that here, too, was an affliction which had been grossly misunderstood and the sufferers from which had been unjustly despised and condemned without any widespread attempt being made to understand the reasons back of this degrading habit. To be sure, there had been in the 19th century a few far-sighted individuals who recognized alcohol addiction as a disease, which in many cases could be cured by various types of treatment. On the whole, however, it may fairly be said that the scientific attack on the problem of alcohol addiction had to wait upon the work of Freud, Jung,
Adler, and their followers, and upon the psychiatric lessons learned from the First World War before much significant progress could be made.

In view of the large number of published books and periodical articles dealing with this long neglected subject which have been published in the last ten years, the advice that some otherwise intelligent individuals still offer their friends on the treatment of alcohol addiction is indication of almost criminal negligence. I hope, in this paper, to clear up most of these misconceptions and to describe the more successful methods of treating alcohol addiction at the present time.

Early in 1940 Neil Dayton released his "New Facts on Mental Disorders,"1 an analysis of the causes behind the 756,000 first admissions to mental institutions in the Commonwealth of Massachusetts between 1917 and 1933. Chapters Four and Five of this important work were devoted to the relationship between alcohol, alcohol addiction, and mental

disease. A few quotations from this report will convey some idea of the tremendous importance of alcohol addiction in the national life of the United States.

Chronic alcoholism appears as a prominent etiological factor in one-fifth of all admissions to mental hospitals in Massachusetts. This applies to 32% of all male first admissions and 6% of female. Between the ages of thirty and sixty over 40% of male first admissions are intemperate users of alcohol.\(^2\) In some ages and in certain years, fifty and sixty per cent of patients presented alcoholism as a major etiological factor.\(^3\) The intemperate use of alcohol has long been considered one of the major factors in the creation of that ever lengthening line of patients coming to the doors of our mental hospitals.\(^4\) For years nearly one in every ten first admissions to our mental hospitals has been diagnosed as an alcoholic psychosis. In addition to the alcoholic psychoses, another ten per cent of mental disorders over chronic alcoholism as a prominent etiological factor. One-fifth of all admissions reveal alcoholism as a major causative factor. The Commonwealth spends about ten millions of dollars every year on mental hospitals. Thus, the cost to the taxpayer of alcoholic mental disorders becomes fairly obvious.\(^5\) Fully a third (of the inquiries to the Massachusetts Statistical Division of Mental Disorders) have concerned alcohol and its influence on mental disease. The public has a deep and abiding interest in alcohol as a problem having a powerful influence on the public health.\(^6\)

\(^2\) Dayton, _op. cit._, pp. 144-5.

\(^3\) _Ibid._, p. 184.

\(^4\) _Ibid._, p. 149.

\(^5\) _Ibid._, p. 150.

\(^6\) _Ibid._, p. 184.
The unexpected indifference of the psychiatrist to the place of alcoholism in mental disorders has not passed unnoticed by the general public. Many have expressed amazement at the non-existent research in a major problem like the alcoholic psychoses. The public itself has a very keen interest in the subject. 7 Dr. Herbert L. Nossen states that in 1936 more than forty per cent of the 25,000 admissions to Bellevue Hospital in New York City for all causes, were for alcohol addiction, and that roughly the same percentage has endured since that year. (TWELVE AGAINST ALCOHOL)8

Since the publication of Dr. Dayton's book, and perhaps partly because of his startling findings, there has been formed by a group of the country's distinguished scientists, The Research Council On Problems Of Alcohol, whose official publication is The Quarterly Journal of Studies on Alcohol, published by The Yale University Press. In order to convey the impression of the deadly seriousness with which these scientists view the problem of alcohol addiction, I can do no better than to quote one page from their recently released folder: (1940)

THE NATION'S

GREATEST DISEASE ENEMY

WHICH IS NOT BEING SYSTEMATICALLY ATTACKED

This enemy is alcoholism - a disease about which most people have only a vague or inadequate understanding. It is socially desirable that business men, pub-

7 Dayton, op. cit., p. 150.

lic spirited women, family doctors, and other leading citizens, especially relatives and friends of alcoholics, be accurately informed regarding its nature.

Alcoholism is a disease, due to the excessive and continued use of alcohol, so serious as to require thorough and systematic treatment.

An alcoholic is a person who cannot or will not control his drinking, and needs thorough and systematic treatment.

Alcoholism manifests itself in characteristic mental and physical disorders. It is accompanied by social maladjustment in one or more of many realms of human activity. Alcohol has gained such a strong, habitual and enduring hold on the alcoholic, that he finds himself unable, without assistance, to discontinue its use.

An alcoholic should be regarded as a sick person, just as is one who is suffering from tuberculosis, cancer, heart disease, or any other serious chronic disorder. He should be looked upon as a person needing medical care instead of one who is guilty of a moral or criminal offense ....

If medical science is to deal with alcoholism as it is dealing with the problems of tuberculosis, cancer, heart disease, syphilis, infantile paralysis, mental disease and other major disorders, it must develop research in three fields - (1) Fundamental Causes, (2) Methods of Treatment, and (3) Preventive Measures...

The conquest of alcoholism in the United States lags because the people of the United States have not yet come together for an effective attack on the problem. The scientist has been working laboriously in laboratory and hospital; other professional groups are ready. An encouraging beginning has been made. If, now, business men and public spirited women will help, as they have done so nobly in the fight against tuberculosis and other major diseases, the movement for the cure and prevention of alcoholism will soon be established.

9 For the physiological effects of alcohol see Appendix I.
Each and every citizen can aid in the new, scientific program of combating alcoholism - the nation's greatest disease enemy not being systematically attacked. Thus, in a very real sense, he can have a part in the conservation of national health and vigor and in the building up of our human resources for national defense.

The following statistics gathered by Robert V. Seliger, M.D., Psychiatrist at Johns Hopkins University and Hospital, serve to give additional weight, if any is needed, to the foregoing quotations. First admissions to Maryland public and private hospitals for some form of alcoholism increased from 8.2% from 1914-18 to 14.0% in 1934-38. In the ten years between 1928 and 1938 the percentage of women among all alcoholics admitted for the first time approximately doubled — the percentage rose from 8.4% in 1928 to 17.3% in 1938. Again, females arrested for drunkenness in the District of Columbia increased from 104 in 1932 to 160 in 1935 and to 1465 in 1938. In the city of Washington, intoxication is the cause of nearly 42% of commitments of women to prison, and the cause of nearly 56% of male commitments.

In view of the foregoing facts, I am sure that all who read this discussion will agree that the problem of alcohol addiction is a serious one and one which is rapidly becoming more pressing. Statistics such as these are ample

10 Seliger, Robert V., "The Psychiatrist’s View of the Alcohol Problem," The Union Signal, May 4, 1940.
justification for the writing of a work on the treatment of alcohol addiction at this time.

B. Definition of "Alcohol Addiction"

About a year after I had chosen the subject of Alcohol Addiction for my dissertation, the Research Council on Problems of Alcohol was formed. This Council, consisting of many of the leading scientists of the country, publishes the Quarterly Journal of Studies on Alcohol. In the June, 1941 issue of this Journal appeared an extremely comprehensive review of the literature on "Alcohol Addiction and Its Treatment"11 by two well known doctors, Karl M. Bowman of New York University and Bellevue Hospital, and E. Morton Jellinek of Yale, in which they propose several relevant definitions:

Chronic alcoholism: "Physical and psychological changes following the prolonged use of alcoholic beverages."

Alcohol addiction: "An uncontrollable craving for alcohol. The outstanding criterion is the inability to break with the habit. In primary addiction, this craving serves the purpose of artificial social adjustment. In secondary addiction, the purpose is

that of counteracting the physical effects of a preceeding bout. ... 

Chronic alcoholism may exist with or without addiction and addiction may exist without chronic alcoholism."12

Abnormal Drinking: "Habitual indulgence in alcoholic beverages beyond the limits of merely satisfying thirst, or using the alcoholic beverages in the sense in which a condiment is used, or in its formal social use, or as an occasional stimulant."13

In other words abnormal drinking is simply habitual over-indulgence. The drinker could stop altogether if he felt like it. Alcohol addiction, however, is involved when the drinker can't stop even if he wants to; chronic alcoholism, when permanent physical or psychological deterioration has already resulted from the abuse of alcohol.

Since the chronic alcoholics are more or less hopeless as thus defined, and the abnormal drinkers don't need any other treatment than simply to make up their minds to quit, this thesis will limit its treatment to the alcohol addicts, that is, to persons who cannot stop drinking even if they want to do so.

12 Bowman and Jellinek, loc. cit., pp. 104-5.
13 Ibid., p. 104.
C. The Plan of Our Approach

We shall first discuss some of the reasons why people become alcohol addicts, with a short case history of one addict. Then we shall discuss the three outstanding attitudes toward alcoholism - the moralistic, the medical, and the psychological-psychiatric. Following this will come a historical presentation of how the treatment of alcohol addiction has developed and progressed during the last hundred years. We shall then evaluate the success of these various methods, abstract their common points, and propose a well rounded eclectic approach. Finally, we shall consider what needs to be done to educate the public concerning the problems of alcohol addiction.
CHAPTER II

DEVELOPMENTAL ASPECTS OF THE PROBLEM OF ALCOHOL ADDICTION

One of the best brief analyses of the reasons why alcoholics drink (as opposed to actual methods of treatment) was published in Coronet for February, 1939. The information in the article was given to Doree Smedley in conversation with a well-known psychiatrist in charge of the alcoholic ward of a New York City Hospital. I shall give several quotations from this article, "There Is No Drink Problem", because, in addition to summarizing concisely the reasons for abnormal drinking, it also emphasizes two extremely important facts:

First, that the relatives and friends of alcoholics frequently are a severe hindrance rather than a help in dealing with the alcoholics, and

Second, that our present hospital facilities are decidedly not doing a good job of dealing with alcoholic cases.

The superstitions that the relatives of drinking men cherish about alcoholism are the cause of a third of our difficulties in treating alcoholics. You can't tell them anything. They are serenely confident that George drinks because he is the victim of some strange, insidious craving for alcohol, or that he inherited a taste for liquor from his great-grandfather, or that he has a weak character and can't control himself.
By acting and preaching at the alcoholic on the basis of these and other false-to-fact assumptions the relatives only upset the patients and make them feel and behave worse than ever.

In answering the question, "Isn't there a disease of some kind that causes a craving for alcohol?" the doctor replies:

"... No drinker has any special craving for alcohol. What he craves is a partial or complete unconsciousness. Alcohol is only one means of inducing it. Morphine, chloroform or ether would be just as effective. Obviously, no man craves unconsciousness unless he is in pain. The question with every drinker is, 'What kind of a mental or physical pain has he that makes him crave unconsciousness?' There is no point whatever in curing him of drinking (without getting at the underlying difficulty). He may use drugs instead."

"Every hard drinker has some painful mental or physical disease that has become so difficult to endure that he longs for an anesthesia of any kind. Even social drinkers and men who go on periodic sprees are known to have fairly serious personal problems. They seek relief in alcohol chiefly because it is socially acceptable and easier to obtain than drugs. Excessive drinking is always a danger signal, a warning that the individual is in some intolerable situation from which he feels impelled to escape. One might as well curse a cancer victim for craving morphine as to hurl epithets or inspirational advice at a drinker for using alcohol. The cause of his suffering is the problem, not his method of relieving it.

"The largest percentage of drinkers are ... mentally or emotionally maladjusted. Go to any bar in the city after five in the afternoon and you will find that out of twenty men who are regular patrons, there are ten cases of infantilism, six neurotics, two borderline psychotics, and two who have some physical disease or deformity. That's the ratio. You won't find psychotics among the regular patrons because proprietors throw them out. They are apt to become unmanageable when they get drunk. There is a borderline psychotic, however, that you will find at every bar. That's the manic-depressive type. He's popularly known as the 'periodic drinker'."
"During periods of elation he enthusiastically swears off liquor for life, announces that he is 'cured' and stays sober as long as the cycle lasts. Then his friends and relatives say, 'Thank God, George has turned over a new leaf!' A few weeks or months later, his period of depression returns and he gets gloriously drunk again and usually stays drunk for the remainder of the depressed period. These cycles are sometimes two or three weeks apart, sometimes months or even a year or so apart. It depends on the stage of the disease. He has these cycles of elation and depression whether he drinks or not. Of course, indulgence makes the conditions worse, but if you can imagine having a mental toothache for weeks or months without let-up, you will appreciate what these periods of depression mean for the psychotic. Sheer misery.

"Every neurosis is based upon submerged emotional conflicts of a painful nature which keep the neurotic in a chronic state of anxiety, indecision and self-consciousness. He feels habitually glum and uneasy and his nerves are always on edge. Certain types of neurotics are apt to drink excessively. Especially, men who have what we call the sin-sex-guilt complex. This particular emotional problem appears among drinkers more often than in any other type. The amount and the frequency of their use of alcohol merely indicates how mild or how deep-seated the conflict has become. Incidentally, the sin-sex-guilt complex is common among women who drink to excess, too. In fact, we seldom find a feminine drunkard without it. It is perhaps the most painful of all emotional conflicts.

"Infantilism is an arrested emotional development. An infantile adult is a person who has grown up mentally and physically but whose emotional machinery corresponds with that of a five-year-old child. Infantilism is the basis of all mental disorders but marked symptoms do not always transpire. Most infantile adults seem quite normal. But these people always feel inadequate. Life seems too much for them. Earning a living gives them the same feeling of bewilderment and anxiety that it would a small child. They can't adjust themselves to an adult relationship in marriage. Nor to the job of being a parent. They react in a childish way to any adult situation -- and they can't help it. This baffles and humiliates them quite as much as it does anyone else.
"Tirades of abuse about his drinking only serve to make him feel more inadequate than ever, and hence, more in need of alcohol than ever. His emotional problems can best be corrected by a prolonged period of re-education, preferably at the hands of a competent psychologist. Infantilism is caused by excessive discipline or neglect during early childhood, or by excessive pampering during the teens and twenties. Sympathy rather than condemnation would be more to the point."

In answer to the question, "Why do you consider inspirational advice harmful for an alcoholic?" the psychiatrist replies: "Because it distracts his attention from the real issue: why he is in need of an anesthesia. Alcohol is only a means to an end. Also, every drinker has a sense of guilt about drinking, and inspirational arguments only intensify it. Most reformers mistakenly believe that if they can only make a man sufficiently ashamed and remorseful about drinking he will surely stop. Actually, you can't cure an alcoholic of drinking until you can cure him of a sense of guilt about it. The goal of treatment is not penitence but indifference. The more humiliated he feels about drinking the longer it will take to cure him. Many normal drinkers are developed into incurable alcoholics by the preaching of some close relative or friend, because a feeling of humiliation has been ground so deeply into them that they could never feel indifferent about it again. The sad but slightly humorous truth of the matter is that it is no more immoral to crave alcohol to anesthetize a mental pain than it is immoral to crave bicarbonate of soda to cure a stomach-ache. The motive in each instance is the same -- relief.

"We are sorely in need of clinics for alcoholics in this country where the proper treatment could be given at a minimum of expense to the individual. Alcoholics require both medical and psychiatric treatment for weeks or months, as a rule. Most of our hospitals lack the funds, personnel and equipment necessary to undertake this. They simply house the alcoholic overnight, give him a shot of paraldehyde or a sedative to quiet him so he can sleep it off, force liquids on him when he wakes up, and then dismiss him the next day or the following. A week later he may be brought in dead drunk again."
This may go on for years. Hence at no point do our present hospital services provide treatment of permanent value. The individual must go to a private sanatorium or go without treatment.

There are any number of ways of classifying alcoholics. The article quoted above states that out of every ten alcoholics you will find five cases of infantilism, three neurotics, one manic-depressive, and one suffering from some physical disease or infirmity. Another classification is as follows: 14

1. The individual who wants to abstain but who cannot; he has good intelligence and emotional maturity.

2. The individual who desires to abstain and cannot; he has poor habits and poor contacts, but good intelligence and emotional maturity.

3. The individual with good intelligence and some emotional maturity who should abstain, but who does not desire to abstain.

4. The individual who has become deteriorated mentally through drink.

5. Feeble-minded individuals who are continually picked up by the police for excessive drinking.

Further on in the body of this thesis we shall consider the classifications of Drs. Wingfield, Strocker, and

14 Murphy, Thomas E., "What's Your Alibi For Drinking?", Your Health, Summer Quarter, 1940.
others in regard to this disease.

In order that there may be as little misunderstanding as possible as to what we mean when we say that a certain person has "alcoholic" tendencies, I list here a number of indications that alcohol is taking psychological hold on the individual, although his alcoholism may not as yet have become obvious or fully developed:15

1. Requiring a drink the next morning.
2. Preferring to drink alone.
3. Losing time from work due to drinking.
4. Family being harmed in some way, the result of drinking.
5. Needing a drink at a definite time daily.
6. Getting the inner shakes unless drinking is continued.
7. Irritability - present since drinking.
8. Being careless of family's welfare since drinking.
9. Becoming jealous of husband or wife since drinking.
10. Changing of personality since drinking.
11. Developing body complaints since drinking (headaches, palpitations, etc.).
12. Becoming restless since drinking.
13. Difficulty in sleeping since drinking.
14. Becoming more impulsive since drinking.
15. Having less self-control since drinking.

15 Quoted from Dr. Robert V. Seliger in Your Life, December, 1939, "Do You Dare Take This Liquor Test?"
16. Decrease of initiative since drinking.
17. Decrease of ambition since drinking.
18. Lacking perseverance in pursuing a goal since drinking.
19. Drinking to obtain social ease (in shy, timid, self-conscious individuals).
20. Drinking to relieve marked feelings of inadequacy.
21. Changes in sexual potency since drinking.
22. Evidence of marked dislikes and hatreds since drinking.
23. Increasing of jealousy in general since drinking.
24. Marked moodiness as a result of drinking.
25. Decrease of efficiency since drinking.
26. More sensitiveness to what people say and think since drinking.
27. Becoming harder to get along with since drinking.
28. Turning to an inferior environment while drinking.
29. Health becoming endangered in some way while drinking.
30. Peace of mind becoming affected since drinking.
31. Home life being made unhappy since drinking.
32. Business being jeopardized since drinking.
33. Clouding of reputation since drinking.
34. Harmony of life being disturbed since drinking.
35. Being obliged to consume more and more liquor to get that "grand feeling".
36. Drinking because one is vaguely unhappy, or discouraged, or because one has to face an unpleasant situation.
37. Looking forward to a party for the sake of the liquor rather than the people.
38. Relying on liquor for pep or energy to do a particular job.
39. Feeling that you can't get along without liquor - that you need it to keep going.
40. Frequently promising yourself that you're going to quit for a while - and then never doing it.
41. Secretly believing that you're drinking too much.
42. Making liquor an end in itself - rather than as a means to fun and sociability.

In order that those unfamiliar with alcohol addiction may gain a better idea of what it is and what it may lead to, I have included as Appendix II a brief description of a typical spree such as might be indulged in by a periodic drinker.

To clarify the way in which an alcoholic may develop from an ordinary drinker, let me cite "The Seven Ages of the Steady Drinker": 16

1. The Stripling. The other boys drink, and he doesn't want them to think he isn't a regular guy. He hates the taste of the stuff. Age 20.
2. Sociable fellow. Sure, glad to have a cocktail! He's 24.

16. Murphy, loc. cit.
3. Regular fellow. Once in a while he will drink too much and he'll tell the boys at the office what a head he has! He's 28, and it would be easy to quit now.

4. Booze Artist. He can handle his liquor! Can drink anybody under the table. Does a little practicing on the side by himself. Pretty hard to quit, now that he's 33.

5. Rummy. He hates the stuff. Doesn't get the kick out of it now that he used to - still he needs it to keep going. Beginning to show the false affability and unreliability that is characteristic of the rummy. At 38 his prospects aren't very good.

6. Soak. His system is thoroughly soaked in alcohol and it shows in his face, his eyes, and his bearing. He'll never quit, now that he's reached 40.

7. Just another bum, with no morals to speak of, no self-respect left -- and with a body that is just about kept going by the food which it has adapted itself to - liquor! He's 45, and he can't quit now - at least not without professional assistance.
CHAPTER III

ATTITUDES TOWARD ALCOHOL ADDICTION

There are, of course, any number of individual attitudes toward alcohol addiction and any classification of these attitudes will be subject to considerable overlapping. However, for the sake of convenience, we can group these attitudes under three main headings: Moralistic, Medical, and Psychological.

A. Moralistic

Many laymen and even many physicians untrained in Psychiatry still look on alcohol addiction as a moral problem. The alcoholic is considered to be what he is because he chooses to be and therefore he deserves the results of his folly and "cussedness". He is thought to be a spineless creature with no will of his own and no consideration for his family, friends, and relatives. It is supposed that he deliberately chooses to go out and get drunk in the full realization that his drinking will in time lose him his family, friends, home, and job, and eventually land him in the gutter. Of course, nothing could be further from the truth. Most real alcoholics are poignantly conscious of their misdemeanors and during the long drawn out hang-
overs literally suffer the physical and mental tortures of hell; they are, however, unable to understand why they cannot drink moderately as their friends do and a long period of reeducation is necessary to make them realize that they are "allergic" to alcohol in any form. It is commonly supposed that by preaching, lecturing, and exhorting, the alcoholic can be shamed into sobriety, whereas in reality such criticism only drives the patient deeper and deeper into drunkenness.

B. Medical

I do not know of anyone who is qualified to make a disinterested appraisal of the attitude of the typical non-psychiatric physician toward the problem of alcohol addiction. During the past five years I have talked and corresponded with hundreds of physicians east of the Mississippi and I have not gained the impression that the typical practitioner has a very complete understanding of this complicated problem. The usual procedure in alcoholic cases is to hospitalize the patient for a few days either in a regular hospital or in an alcoholic home, and then to forget about the problem. This treatment does sober a man off but it contributes nothing toward the lasting solution of his difficulty.
C. **Psychological-Psychiatric**

Psychiatrists, of course, recognize the existence of a psychological problem back of most abnormal drinking but relatively few of them have worked out any comprehensive plan of treatment. Dr. Neil Dayton and Dr. Robert S. Carroll, both of whom stand high in psychiatric circles, admit that most psychiatrists have neglected this vital problem. Dr. Carroll states that most psychiatrists are not trained to handle alcoholics nor are most mental hospitals equipped to handle them as they should be handled. This unhappy situation is recognized by leading psychiatrists and steps are now being taken to spread the known facts about alcohol addiction as widely as possible. In the last ten years several excellent books have been published dealing with the problem of alcohol addiction which can be understood by doctors and laymen alike. In 1940 The Research Council on Problems of Alcohol was formed and the publication of its Quarterly begun. It can be assumed that the present ignorance on this vital national disease will be dispelled in the near future.

Much of the pioneer work in this field was done by laymen with an interest in but no formal training in psychology; many of them had previously suffered from alcohol addiction themselves. Most of the individuals specializing exclusively in alcoholic rehabilitation in
this country are neither physicians nor [formally trained] psychologists. For every psychiatrist interested in alcoholic problems, such as Carroll, Seliger, Nossen, Strecker, etc., others can be cited who practice without a medical background: Chambers, Crocker, Mackay, Baylor, Worcester, Schnorrenberg, Durfee, and Wister.

The psychological approach does not by any means neglect the body. Psychologists recognize the necessity for building up bodily health and strength, the elimination of poisonous chemicals from the blood stream and so on. This is regarded as basic but not as the whole story. It is realized that because of heredity and environment the alcoholic's education for life in the world of actuality has at some point been inadequate and that a long period of re-education must ensue before his self-destructive habit, which is but a symptom of his maladjustment, can be permanently overcome.

Although for the sake of simplicity in presentation most of the therapeutical approaches will be given largely in the order of their historical development, there will be no doubt as to which of the above categories they belong.
CHAPTER IV

METHODS OF TREATMENT FOR ALCOHOL ADDICTION

In this section, which comprises the bulk of the dissertation, we shall examine in considerable detail some twenty methods of dealing with those suffering from alcohol addiction. Treatment for this disease began to include psychotherapy and to be placed on a scientific basis about one hundred years ago (1840). Therefore we shall begin with that date and take up examples of all methods of treatment developed since then which have proved at all scientific or efficacious.

Four British (Kerr, Clum, Wingfield, Bramwell) and four continental (Freud, Jung, Adler, Korzybski) systems of therapy will be discussed and analyzed. Three of the British works analyzed were concerned solely with alcohol. None of the continental works gave alcoholic therapy any particular emphasis. At the present time (January 1942) the United States is far in advance of any other country in this rather esoteric field, and accordingly these most recent contemporary methods are given considerable space in the latter part of this section.

I have surveyed a considerable amount of continental European literature on the alcohol problem, but have not re-
ferred to most of it in this paper because I am inclined to agree with the conclusions of Dr. Robert Fleming, who made an extensive survey of European methods of alcoholic therapy in 1936. He found that:

... in no place [in Europe] is the problem of the treatment of chronic alcoholism being attacked in an objective, dispassionate, and experimental manner ... In fact, the whole field of alcoholic work is characterized by a lack of effective cooperation and intellectual direction.

The following discussion of the more effective alcoholic therapies will provide us with a background from which we will extract the soundest therapeutical principles as a basis for our own eclectic compilation.

A. The Nineteenth Century American Therapies

1. The Washingtonian Movement

Exactly one hundred years ago The Washington Temperance Society was founded in Baltimore, Maryland, by six reformed heavy drinkers, and during the next few years it literally swept the country. Thousands of drunkards and heavy drinkers were reformed - at least temporarily - by listening to the accounts of the personal experiences of other former sufferers. They were taught that it is the "just one glass" which does all the damage and gets the

17. Taken from The Washington Temperance Society, (written by a member), John D. Toy, 1842.
drinker started on a spree. To join the society or its affiliated branches, all a man had to do was to take a pledge of personal abstinence. Drunkenness was looked on as a disease and the sufferer from it as unfortunate and weak rather than wicked and immoral as previously. There were no religious strings attached as in the other temperance societies; a man could be Protestant, Catholic or infidel, if he so chose, and still be a member in good standing as long as he abstained from liquor, wine and beer.

It was found that while drunkards and heavy drinkers tended to remain untouched by speeches on the evils of drink by mere observers of drunkenness, they were extremely susceptible to the relation of actual personal experiences by men who had themselves suffered from liquor and had finally succeeded in conquering the temptation. The members were imbued with the missionary spirit and the movement soon spread to New York, Ohio and elsewhere, with the huge meeting halls everywhere packed to overflowing.

Wherever societies were founded experience meetings were held every week to which new converts were attracted. Later on Washingtonian Homes were founded in various cities, where a man could go to sober off from a drunk. After its initial spurt, this movement gradually died out, but not before contributing several important new principles to the rehabilitation of alcoholics.
2. The Pioneer Work of Dr. J. Edward Turner

Dr. Turner was one of the first to recognize alcohol addiction as a disease requiring medical and sanitarium treatment. In 1857 more than a thousand physicians petitioned the New York legislature for the establishment of a state institution to save the rich and poor alike from a drunkard's death and grave. In September 1858, at Binghamton, New York, the cornerstone was laid for the first alcoholic sanitarium in the world, to be directed by Dr. Turner. Three years later, however, political manipulation turned this institution to other purposes. This was a serious set-back for the movement of the scientific treatment of alcoholism and a great disappointment to Dr. Turner, the objective of whose life was to teach mankind that alcohol addiction is a disease and a curable one.

3. The Keeley Cure

With the publication of his book on The Non-Heredity of Inebriety by Dr. Leslie E. Keeley, in 1896, the famous "cure" which bears his name was given national publicity. This treatment consists principally of the hypodermic injection of chloride of gold and sodium into the patient together with a month's rest, good food, and general physical upbuilding. Let Dr. Keeley give a brief description of

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his remedy in his own words:

A single remedy can cure inebriety in a few weeks, without a hospital or asylum and without restraint. 19

The mind has no control over inebriety. The consciousness and will do not affect it. 20

In his summary statement of general principles, Dr. Keeley states: 21

1. That the only cause of alcoholic inebriety is alcohol.

2. That inebriety is a variation in type and conduct of the nerve centers and cells, which variation results in an automatism requiring a periodic poisoning by alcohol.

3. His remedies, he says, "antagonize this effect of alcohol upon the nerve cells and break up the rhythmical automatic craving for liquor. Automatism is the foundation of alcoholic inebriety, and the rhythm of the automatism is the key to its existence."

Dr. Keeley's treatment achieved great popularity over a considerable period of time and over the entire United States. Some of his institutions are still in operation today. In this, as in other treatments, it is almost impossible to get any accurate and objective figures for the percentage of permanent cures achieved. If you deal with a large enough number of patients, almost any method of treat-

19 Keeley, op. cit., p. 288.

20 Ibid., p. 297.

21 Ibid., pp. 348-9.
ment will result in some cures. Such institutions as well as most private practitioners seldom have any business-like system of follow-up on the cases which they treat and if they never hear from a patient again, they assume that he is "cured." This is, of course, an unscientific assumption; in case of another relapse, the patient would naturally not be sent back to a place which had been unsuccessful in its curative efforts. The usual tendency would be to send him to a different institution, if such were available, or perhaps just to give the whole thing up as a bad job. However, from my personal conversation with several former inmates of the Keeley institutions, I have learned that because of a dearth of similar "rest homes" specializing in alcoholics, there are great numbers of repeaters who make anywhere from two to two dozen return trips in all to get sobered up and in good physical shape after an extended spree.

B. The Nineteenth Century British Therapies

1. The Treatment of Dr. Norman Kerr

During the latter half of the nineteenth century, a British doctor named Norman Kerr did a considerable amount of work with English alcoholics. In his book, *Inebriety or Norcomania - Its Etiology, Pathology, Treatment and Juris-
prudence, he stated that this condition was a problem in nearly every family in England but that it was rarely recognized as a disease. Dr. Kerr considered inebriety to be a disease allied to temporary insanity, comparable to the temporary manias, kleptomania, pyromania, erotomania, etc.

Dr. Kerr advances narcomania as a "mania for narcotism of any kind, and an inexpressibly intense involuntary morbid craving for the temporary anesthetic relief promised by every form of narcotic." He found in many cases, a prior melancholic depression or nervous insufficiency, which would be followed by a state of morbid exaltation or a superabundance of nerve force resulting in an excessive discharge of nervous energy. He describes this condition as an expulsion or liberation of nerve force as in epileptic seizures. A man or woman feels buoyed up and unusually elated, more than ordinary [sic] talkative, playful, demonstrative and excited, in short, displaying symptoms of undue exaltation.

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22 Kerr, Norman, Inebriety or Narcomania -- Its Etiology, Pathology, Treatment and Jurisprudence, New York, J. Selwin Tait & Sons, 1888.
23 Ibid., pp. 1-3.
24 Ibid., p. 15.
25 Ibid., p. 32.
26 Ibid., p. 221.
27 Ibid., p. 222.
28 Ibid., p. 177.
If he drinks in this state of hyper-exaltation, he drinks to excess. He cannot help it. He is carried away, body and soul, by the neurotic whirlwind that has unexpectedly arisen within him.\footnote{Kerr, \textit{op. cit.}, p. 222.}

This analysis would appear to have much in common with that of Dr. Abraham Myerson, who, in his recent article in the \textit{Quarterly Journal of Studies on Alcohol}\footnote{June, 1940, p. 19.} takes issue with the usual explanation of drinking to escape from reality, and contends that people frequently drink out of feelings of exuberance, abandon, and revolt against the decorum of a too orderly existence.

Dr. Kerr found innumerable precipitating, predisposing and exciting causes. He concluded that generally the beginning of inebriety in women was the taking of gin, wine, etc., during their menstrual periods to relieve the pains.\footnote{Kerr, \textit{op. cit.}, p. 177.}

He also found that inebriety was sometimes caused by the nervous prostration induced by excessive intercourse, and that alcoholism so induced was amenable to treatment by a simple moderation of the exercise of conjugal rights.\footnote{Ibid., p. 177.}

Dr. Kerr found that many inebriates suffered from a periodicity of nerve explosions and that any number of pre-paroxysmal pathological antecedents might be the immediate basis of the attack\footnote{Ibid., p. 181.} (examples of these given are alteration

\footnote{Ibid., p. 222.}
of cerebral substance, impairment of brain nutrition by the abnormal action of any organ or tissue on the circulatory fluid). He found that those susceptible to alcoholism have a deficient tonicity of the cerebral and central nervous systems with an accompanying defective inhibition in relation to alcohol, which latter might be either hereditary or acquired. 34

Dr. Kerr lists a number of antidotes for alcoholism including the Turkish bath, cocoa, alcoholic extract of frog, raw beef, vegetarianism, strychnine injections, the bark "cure", kola nut, etc., and adds that these sometimes help temporarily. 35 Kerr found that cinchona bark was a useful auxiliary to moral instruction. This bark acted as a tonic because of its nerve stimulating and anti-periodic qualities. Often two grains of quinine with orange would allay the craving as with strychnine and belladonna. He did not consider the "liquor cure" — cooking all food in alcohol 36 — to be of value, but found that hypnosis and suggestion was sometimes helpful. 37 Dr. Kerr recognized the necessity of the highly individualized approach in his statement that "What blunts the crave in one will have no effect on another." 38

34 Kerr, op. cit., p. 227.
36 Ibid.
37 Ibid., p. 260.
38 Ibid., p. 247.
He found that certain types of inebriates in certain recep­
tive conditions had been cured by hypnosis, chemicals, faith
healing and moral and religio-psychical methods. In his
opinion a real cure should be five years anyway and he con­
cluded that there was no nostrum or royal road to cure.

Dr. Kerr, writing in 1888, stated that the treatment
of alcoholics was becoming more successful even with female
inebriates "whose treatment is very much more difficult
than is the treatment of males." He stated that he had
recently been curing about one-third of the male patients
and one-fifth of the females. Dr. Kerr includes in his
principles of sound treatment (1) The immediate withdrawal
of alcohol (2) The use of various stomach and sleep
medicines (3) Turkish baths and wet packs (4) The repair
of the physical injury to tissues, etc. by individualized
diets of good sound food (largely vegetarian), plenty of
fresh air, exercise, cleanliness, activity, amusement and
recreation (5) The rehabilitation of nerve-tissues by nerve
food (6) Strengthening of the inhibitory power and the em­
ployment of moral control by (a) reasoning (b) religious in­
fluences (c) rational therapeutics, that is, individualized
treatment according to the predisposing cause. He strongly
favors keeping the mind engaged in the performance of regular

39 Kerr, op. cit., p. 262.
40 Ibid.
41 Ibid.
duties (both vocational and avocational) realizing that the 
more leisure the patient had the more would be his tempta-
tion. 42

In discussing the best means for placing a patient 
in an environment favorable to recovery, Dr. Kerr refers to 
several methods then in use: 43 (1) The home cure - treating 
the patient while he remains in his own home - was found 
satisfactory during the early stages of treatment, (2) The 
change of country cure. The theory behind this so-called 
cure was that by sending drunken sons away from England and 
into one of the dominions to either work or starve, their 
inmate sense of independence would be aroused and it would 
make men out of them. The results of this theory were not 
very successful. Most of these sons, when placed on their 
own, suddenly and in disgrace went down and stayed down, 
(3) Voyage in a teetotal ship, (4) Having an abstaining 
companion, either at home or traveling, (5) Residence with a 
teetotal medical man or family, (6) Residence in a Home or 
Retreat for Inebriates. (Residence in a regular insane 
asylum was found to be bad for alcoholics).

Dr. Kerr found that the best answer to the problem of 
environment and treatment was the Inebriate Home, 44 the ad-
vantages of which far outweighed the objections to it. In

42 Kerr, op. cit., p. 262.
43 Ibid., pp. 298-303.
44 Ibid., p. 304.
the first place, the necessary discipline could be provided for; secondly, an esprit de corps was built up by association with a homogeneous group who were seriously endeavoring to free themselves from slavery to liquor; third, in such a place it would be absolutely impossible for them to get any liquor whatsoever, so that the alcoholic poisons could be entirely eliminated from their systems in a few months. As to the length of time required for such treatment, Dr. Kerr found that this kind of treatment required from 12 to 24 months.

The patient should be left alone for a considerable period of time after being placed in such a retreat, and then visited frequently after he had been there for two or three months. Otherwise, if he is allowed visitors during the first few weeks of his confinement, he will invent all kinds of complaints and play on the known weaknesses of his friends and relatives to regain his freedom. In Dr. Kerr's words:

The truth is that as soon as the patient recovers from the immediate effects of drink, his appetite revives, he feels strong and vigorous, and thinks he is all right now and quite fit to go anywhere in the midst of temptation. Of course, he is not. This is a most perilous period, this period of reaction from inebriate depression ... This interregnum of restlessness is the very time when he should be seen only by cool-headed, experienced, and judicious experts, or by disinterested, intelligent persons who understand the nature of the crisis through which he is passing. 45

45 Kerr, op. cit., p. 306.
Psychologists and psychiatrists will readily recognize from this and other quotations from Dr. Kerr that as long as fifty years ago here was a man who had considerable insight into the difficult problem of alcoholic diagnosis and treatment. From a perusal of the post-war literature on the subject of alcohol addiction, it will, I think, be apparent that Dr. Kerr a great many years ago anticipated many of the recent "discoveries" in this field. Over a period of eleven years, out of a total of fifteen hundred alcoholic patients treated, Dr. Kerr found only two who were ever able to become "moderate drinkers" again, and it is, of course, possible that in the light of contemporary knowledge these cases might be classified as "heavy drinkers" rather than true alcoholics.

Dr. Kerr thus recognized the following principles, which are accepted by most specialists in this field today:

1. Once a man has become an alcoholic, he will continue to be one unless he is willing to give up drinking entirely.

2. Contrary to popular opinion, many periodic alcoholics begin drinking during a manic period of hyper-exaltation.

3. One of the most dangerous periods in the treatment is the two months period immediately following his recovery from his alcoholic melancholia.

4. In certain types of cases, it is sometimes necessary to have the patient shut up for a few months.

5. A certain amount of discipline is necessary.

6. Association with other men fighting the same battle is helpful.
7. The mind must be kept engaged in regular duties to avoid too much leisure.

8. A highly individualized approach is necessary.

9. The nerve tissues must be rehabilitated.

10. There must be plenty of exercise, activity and recreation.

2. The Treatment of Dr. Franklin D. Clum

In that same year, 1888, Dr. Franklin D. Clum published a book entitled *Inebriety: Its Causes, Its Results, Its Remedy.*  

Dr. Clum agreed with Dr. Joseph Parrish, then president of the American Society for the Cure of Inebriates, that inebriety was a disease and that the peculiar type of nervous system predisposed to seeking alcoholic indulgence could be inherited. Dr. Clum came to the conclusion that "Dipsomaniacs drink because compelled by an irresistible impulse," and believed that an understanding of the reasons for excessive drinking is a long step in the direction of its cure. He wrote, "We are half dead before we understand our disorder and half cured when we do."  

He found that many alcoholics would have intervals of perfect health alternating with intervals of nerve exhaustion. His words have an almost contemporary ring when he refers to the

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47 Ibid., p. 121.

48 Ibid.
alcoholic's continued attempts to drink moderately and his persistent delusion of his ability to stop drinking whenever he so desired.

Another well-known present day principle which Dr. Clum stressed was that the personal consent of the patient to assist in his own reformation was a prerequisite of a successful attempt at cure. Before undertaking the treatment the doctor would reason the entire problem out with the patient until the latter was honestly convinced that his situation was serious and that he must work earnestly for a solution of his problem. The doctor should neither curse or pity the patients but treat them matter of factly as men. Dr. Clum taught his patients to avoid the thoughts, the persons, and the places that lead to temptation, and to think about and frequent the opposite types of places. He insisted that they keep busy at something that would occupy their close attention. He taught them that they should not become discouraged and give up the struggle even though they should break their resolutions time after time. He found that most patients would listen to plain unvarnished truth, but that they despised trickery and hypocrisy. He refers to the method of Dr. Vedder of Saugerties, New York, who had been in practice there over fifty years, from 1835-88. Dr. Vedder attacked the alcoholic problem primarily from the moral stand-

49 Clum, op. cit., p. 161.
point and attempted to develop the highest manhood of his patients by friendship, Christian kindness, patience, charity, mutual counsel, and skillful manipulation of the mind.

Dr. Clum believes that alcoholism is also a question of nerves, a neurosis, but that the most scientific, skillful, and ingenious treatment would fail without kindness and sympathy. He brought the bodies of the patients to a state of health and advised them to arrange for a change in occupation and residence if necessary. He treated them with Turkish baths but avoided the use of drugs unless absolutely necessary. He found it helpful to remove city drunkards to the country or to the seashore where they could obtain plenty of fresh air and exercise as well as a change of scenery.

Dr. Clum taught his patients to cultivate self-knowledge of their own peculiar temptations - that is, what social circumstances were most conducive to their drinking. He taught them to analyze the types of company which tempted them to drink and the types of beverages which were especially attractive to them. He advised "moderate drinkers" that inebriates cannot be cured by punishment or scorn. (Compare Coronet, Feb. 1939) He gives as the two principal causes of inebriety (1) Nervous exhaustion (cf. Janet - "Psychological Healing"), and (2) The habit of using intoxicants to relieve this exhaustion. He recognized that different types of inebriates required different methods of
treatment. Some men might need "something to live for" (cf. Jung's "Meaninglessness of Life") especially if they were penniless, in poor health, or without friends. Once a man has something to live for, it is important that he look forward and not backward, thus wasting time on useless self-recriminations for his past follies. Dr. Clum agreed with Dr. Day of the Washingtonian Home that alcoholics can never touch one drop of any liquor containing alcohol even after they are "cured"; if they do try to drink any intoxicants they will become drunk again unless they are imprisoned before that state is reached. Dr. Day found that the prognosis for alcoholic cure was favorable when:

a. The patient was in good health,
b. was the offspring of intelligent, moral and cultivated parents,
c. had been subjected to mental discipline,
d. his passions had been kept in check as a youth,
e. had had early religious training,
f. had not suffered shocks, concussions of the brain and spinal cord, and were free from inherited disease.

He found the prognosis unfavorable when:

a. There was injury to the brain,
b. the patient had no regular business or occupation,
c. he had a weak or untrained will or a very limited education,
d. he had no family connections and was homeless,
e. he had nervous or cerebral disorder or hereditary
predisposition to inebriety or insanity in any of its various forms,

f. he was a habitual user of opium, chloral, or any form of narcotic for sleep.

C. The Omnibus Treatment of Dr. Hugh Wingfield

The relatively new science of psychiatry and psychotherapy made extremely rapid strides during World War I. The unpleasant situations in which soldiers of the various warring nations found themselves forced them into many unconscious forms of escape from their unhappy surroundings. In 1919 Dr. Hugh Wingfield published The Forms of Alcoholism and Their Treatment. He made an analytical separation of alcoholics into four principal groups requiring different techniques of treatment.

(1) Pseudo-Dipsomania

This is a sort of imitation of true dipsomania where the alcoholic does not usually experience any craving for alcoholic beverages until after he has taken his first drink. Once having taken the first drink, however, the craving for additional drinks becomes irresistible and forces him to continue his excessive drinking until he is physically unable to take any more alcohol. These attacks seize the sufferer periodically and the intervals between the attacks vary in different cases from one week to several months.


51 Ibid., pp. 11-12.
Once the drinker has somewhat recovered from the physical and psychological ill effects of his spree, he is inclined to think that, despite his past history, he can now take enough drinks to get "feeling good" without getting started on a drunk. Ordinarily it takes several years of periodical drinking before a man or woman is/willing to admit to himself that finally that he cannot fool with liquor at all.

(2) Chronic Sober Alcoholism

This is the type of case where a patient drinks every day to excess but very rarely becomes intoxicated. No craving is noticeable unless the alcoholic drinks are partly or completely cut off.

(3) Chronic Inebriate Alcoholism

This is similar to the above except that the patient is rarely sober. He is usually slightly or markedly intoxicated.

(4) True Dipsomania

This comparatively uncommon craving arouses spontaneously and does not require an initial alcoholic drink to excite it. The drinking takes place in periodical bouts. In treating the periodical group of drinkers, Dr. Wingfield found that there were four main factors to take into consideration, (1) they would have moods of mild or ecstatic euphoria alternating with (2) moods of mental depression or dysphoria. (3) He found variations in the natural alcoholic tolerance of patients and (4) he found a partial paralysis of
the inhibitory mental functions (the Will). He found that this type of patient would yield to all kinds of temptation even a few minutes after taking the first glass of intoxicants.52

Dr. Wingfield found that "the craving is always for the mental effects of alcohol and never for the alcohol per se."53

In the following words Dr. Wingfield disposes of those schools of psychological and medical thought which have attempted to teach abnormal drinkers to drink in moderation:

Nothing, I believe, has done more mischief to these poor creatures than this mistaken insistence on their power to drink in moderation. It is true, indeed, that their salvation does depend on the exertion of their will - to abstain entirely. Beyond this they are absolutely powerless, for, just as they cannot by will prevent the onset of convulsions if they take an overdose of strychnine, so, in the case of alcohol, are they equally powerless by will to ward off the effects of the drug. Will is a poor weapon when used as an antidote to a powerful poison.54

Wingfield found that the premonitory signs of an oncoming attack would occur three to six days before the actual craving arose.55 During these periods the patient will become irritable and restless.

In commenting on the confinement treatment of alcoholics, Dr. Wingfield says (A) that Dr. Kerr's idea of
putting the alcoholic away for a year or two offered no real treatment and was ineffective. \textsuperscript{56} (B) The moral and religious treatment given at Lady Henry Somerset's Homes at Duxford had resulted in some very real success. \textsuperscript{57} (C) The six to twelve weeks voluntary retirement plan of Dr. Hare at Norwood Sanitarium has shown some relatively good results. \textsuperscript{58} Dr. Hare's treatment consisted in part of cutting off all alcohol from the patient and in inducing him to attempt to remain a total abstainer. He is taught that whatever immunity to alcoholic poisoning he may once have had, has now been lost and that he can never again drink in moderation. \textsuperscript{59}

Wingfield found that the chief cause of an alcoholic's continuing relapses lay in his memories of previous periods of euphoria which excited in them a desire to renew these pleasant sensations. To combat this he recommended a Combination Treatment consisting of:

1. Suggestion and Moral Encouragement to strengthen the will to resist.

2. The use of drugs to induce temporary feelings of disgust and loathing for alcohol in order that the memory of this disgust may supplant that of the euphoria after the effect of the drug has passed away.

\textsuperscript{56} Wingfield, \textit{op. cit.}, p. 42.
\textsuperscript{57} Ibid., p. 43.
\textsuperscript{58} Ibid., p. 44.
\textsuperscript{59} Ibid., p. 45.
3. Special individualized treatment. The physician must seek out and combat the precipitating cause of the first drink. Some of the immediate physical causes were found to be heart affliction, asthma, disorders of digestion, insomnia, menstrual distress, and recurrent neuralgia. Common mental causes are: extreme shyness (one of the most intractable), sudden attacks of agoraphobia; depression (temperamental or otherwise), boredom, and various trifling annoyances of life.

4. The patient must be convinced of the necessity of total abstinence, not mere moderation. He must be kept free from all outside worries.

5. The patient must be treated with suggestion (light hypnosis) every day for eight consecutive days, then three times a week for two weeks, and twice a week for one or two more weeks. After this he should be treated less frequently but at least once every three months for several years.

6. The patient must be weaned away from the consumption of alcohol. In pseudo-dipsomania or true dipsomania the attack will end rapidly and spontaneously, but in the case of chronic alcoholism the alcohol should be withdrawn gradually at the rate of about three ounces a day from the inebriate's average daily intake. For example, if a man has been consuming thirty ounces of whiskey a day, let him drink thirty ounces altogether at regular intervals during his first day of confinement; twenty-seven ounces the second day; twenty-four the third day; and so on, until he can get along without any whiskey. It is important that you know his previous average consumption; it is better to err on the side of too much than too little. If his symptoms show that he is being given too little, give him more immediately. If the patient has a fatty heart, it may be necessary to reduce the daily dosage by as little as one ounce or one-half ounce per day. The patient should be kept confined for from two to four weeks.

60 Wingfield, op. cit., p. 47.

61 Ibid., p. 49.
D. Three Minor Systems of Treatment

1. The Conditioned Reflex Approach

I had thought until I came across Dr. W. L. Voegtlin's article in the American Journal of Medical Science\(^{62}\) that the emetic conditioned reflex approach had been pretty well given up in recent years; however, since Dr. Voegtlin is writing in 1940 and believes he has achieved permanent cures in nearly two-thirds of the patients treated, for the sake of the record I shall include a brief discussion of his findings in this paper.

The action of the nauseant drugs, emetine and apomorphine, is utilized to elicit the unconditioned reflex of nausea and vomiting, and the sight, smell, and taste of alcoholic beverages serve as the conditioned stimulus. These physical properties of alcoholic beverages, when utilized as the conditioned stimulus, initiate reflex activity of the centers of nausea and vomiting, thus creating a distaste amounting to a definite aversion to the sight, smell, and taste of alcoholic beverages. During the last four years 685 patients were treated by this method; the exact status of 538 of the treated patients is known. For the six months following treatment, the percentage of sobriety among the patients was 97.3; the greatest number of relapses occurred between the 6th and 12th months following treatment, so that the percentage of sobriety during this period was only 65.7. Permanent cure, it is believed, was produced in 64.3 per cent of those treated. If a relapse did not occur during the first year the subsequent danger of a relapse was slight. Psychotherapy and routine reinforcement after the 6th month following treatment would probably improve the results. Young individuals and women were less promising patients from the standpoint of ultimate cure than mature men. The percentage of continued abstinence

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among women was 57. No success was obtained with individuals under 28 years of age. The average age of the patients on admission was 45 years and the average age of those who again drank was 38 years.

2. Hypnotism

Dr. J. Milne Bramwell in his Hypnotism, Its History, Practice, and Theory records a significant percentage of recoveries from alcoholism through the use of hypnotism alone. Out of 76 cases of dipsomania and chronic alcoholism treated in London over a period of ten years, Dr. Bramwell achieved 28 recoveries, 36 improved cases and 12 failures. Taken together the recoveries and improved cases constitute a very significant percentage -- 64 out of 76.

All of these patients belonged to the educated classes. The average number of hypnotic treatments in the recoveries and improved cases was 31. The average length of time since recovery of the first group was three years. Most of the improved cases were able to engage in useful work and drank only at rare intervals, although formerly they led lives of drunkards.

This is not the place to give a description of the various methods of inducing hypnosis and the techniques followed while the patient is in the hypnotic state. Those interested in this field will find Bramwell's book extremely valuable. Hypnotism has suffered from abuse by quacks, even

more than has psycho-analysis. It is my opinion, however, that many alcoholic patients may benefit from hypnosis at the hands of a trained practitioner. In many cases hypnosis, along with nausea conditioning, may be valuable supplements to the main psychological approach, especially in recalcitrant cases.

Important points brought out by Bramwell in his hypnotic treatment are as follows: 64

1. The patient must be willing to be cured.

2. Susceptibility to hypnosis is a varying and important factor... the ill-balanced are usually difficult to influence. Time and trouble are often requisite; and frequently slight hypnosis alone can be induced. Fortunately deep hypnosis is not essential to the production of good therapeutic results.

3. In dipsomania one ought to begin treatment at the commencement of a period of quiescence and aim at preventing, or at all events retarding and weakening the next attack.

4. During the earlier part of the treatment the patient should never be left alone but should always have near him some trustworthy person, to whom he can confide his temptations and turn for aid in overcoming them. As restraint has proved useless in all the cases which came under my notice, I never employed it.

5. The operator must be persevering and not easily discouraged; many persons, who ultimately do well, relapse more than once during treatment.

6. A distaste for alcohol ought to be suggested, as well as the abolition of the craving for it. The patient must be made to understand that he can never look forward to being a moderate drinker, and that the only choice before him lies between

64 Bramwell, op. cit., pp. 228-9.
total abstinence and the gutter.

7. Even when the craving disappears quickly, the patients ought to be hypnotized regularly for a month. If they can be seen from time to time for the next six months, so much the better and safer.

8. The object of the treatment is not only to cure the diseased craving, but also to strengthen the will of the patient, and help him to combat the temptations of social life. The latter point is important. Some patients forget what they have gone through, and, although they have no diseased craving, yield to ordinary temptation. If the patient has not gained the power to control himself, the treatment has failed in its object; for self control, not artificial restraint, is its essential feature.

"In estimating my results," Dr. Bramwell says, "it must not be forgotten that the majority of my cases were extremely unfavorable ones."

One of the principal criticisms of hypnosis has been that its effects were temporary, usually lasting not more than a month or two before recurrence of the eliminated symptoms. Recently Andrew Salter, a professional psychologist of New York, claims to have removed many of these objections by his development of self-hypnosis, in which the patient is, in half a dozen interviews, shown how to continue hypnotizing himself and thus keeping the undesirable symptoms permanently in the background without the expense of continually consulting a professional. Salter's techniques are described fully in "Three Techniques of Autohypnosis" in the Journal of General Psychology for April, 1941.
Bowman and Jellinek in commenting on both hypnosis and nauseant drug therapies for alcohol addiction, state:

The therapist who relies entirely on drug treatment assumes that the problem of the alcohol addict is alcohol and nothing else; hence, he directs his treatment toward the alcoholic habit, but not toward the emotional and intellectual difficulties which are in back of that habit. If the habit is broken, there still remains a maladjusted person, and the maladjustment will manifest itself somehow, even though it takes a different form. Perhaps this new form will be less obtrusive, and therefore more acceptable to society, but, as far as the patient is concerned, it may be just as detrimental as the old one.

.... it is possible that in some patients recovery from alcohol addiction may be brought about indirectly by those psychological factors which are incidental to drug treatments, but theoretically these treatments are symptomatic and actually misjudge the main issue.

In our view, hypnosis, inasmuch as it is not used for probing but only for influencing, has no wider aims and, therefore, no deeper effect than most of the drug treatments. (Emphasis mine)

3. The Lumbar Puncture Treatment of Dr. Cowles

Dr. Cowles of the Park Avenue Hospital, New York City, discovered that in many cases the spinal fluid pressure of alcoholics was excessively high. He concluded that not only did alcohol cause a high spinal pressure but that the high

65 Quarterly Journal of Studies on Alcohol, June, 1941, pp. 152-3.
68 Medical Journal and Record, 133: 417 and 472, May 6 and 20, 1931.
spinal pressure drove a man to drink. He found many cases in which the spinal pressure, (which should normally vary between 6 and 8 Mm. of mercury), had been forced up by the excessive use of alcohol to readings of from 30 to 48 mm. Dr. Cowles found that he could reduce this abnormal pressure to something like normal by the withdrawal of from 10 - 12 cc. of the spinal fluid at ten day intervals. If the alcoholic starts drinking again, however, the spinal pressure will again rise. The spinal fluid comes in contact with the delicate cells of the brain and this excessive pressure in the nervous system makes one feel extremely restless and vaguely disturbed without knowing exactly what is the matter. This feeling can be relieved temporarily by sexual intercourse but after two or three hours the uneasiness will return and the alcoholic knows by past experience only one sure way to be rid of it - to narcotize his nervous system with alcohol.

Cowles gives lip service to the idea that the whole man must be studied and treated in all his physical, conscious, and subconscious divisions, but from his conversations with me and from the cases which I know of that he has treated, I am sure that he considers the lumbar punctures the principal part of the treatment. He finds that even one drink taken by an alcohol addict changes his whole personality and mental attitude. As long as he continues to drink he is afflicted with "meningeal irritation
and chronic edema in the brain resulting in intercranial pressure and cellular irritation in the central nervous system. Cowles states that a mild manic-depressive trend is nearly always found in his alcoholic patients. The technique of withdrawing the spinal fluid is extremely important - it must be done very slowly to prevent the formation of a vacuum in the cerebro-spinal canal, and only 10 to 12 cc. should be withdrawn at one time. If the patient is nervous and unable to sleep when first appearing for treatment, Cowles favors giving him 4 tablespoonsful of elixir of paraldehyde the first night and two the second night, also on the second day 10 grains of a chloral bromide solution.

From my own research I know that lumbar punctures greatly alleviate the suffering of a hangover, and, together with the very considerable psychological suggestion which cannot help but go along with such an elaborate procedure, they may help a man keep sober for a period of several months, besides immediately clearing his brain of its alcoholic fogginess. But I certainly cannot agree that any such primarily organic treatment will enable a man to remain permanently recovered, since it does not reach at all to the underlying psychological imbalance which led to the symptom of alcohol addiction in the first place. I do feel, however, that in cases where excessive spinal pressure
continues for some weeks after drinking has ceased, or in cases where psychotherapy alone does not seem to be producing immediate results, it may be advisable to bring the patient's pressure down to normal.

As to the psychology connected with the lumbar punctures: it is a definite, unusual and rather painful procedure which leaves the patient with the feeling that something tangible is being done to help him. I have in mind one case where after his first spinal puncture, the patient did not touch alcohol for fourteen weeks, then had three brief relapses and went another fourteen weeks without alcohol, only to burst out in a series of increasingly severe relapses at the end of that period. During the entire eight months the patient had a total of twelve spinal punctures with from 15 to 30 cc. of spinal fluid withdrawn each time.

The spinal puncture may also be used to rescue a man from Delirium Tremens or to lessen the suffering of the hangover. I have not encountered any other physicians who even recommend this procedure as an accessory to cure, to say nothing of considering it a cure in itself.

E. Alcoholics Anonymous

Frequently, if a person has enough faith, he can cure himself of almost any neurosis, and the neurosis of which alcoholism is a symptom is no exception. Many cures have
been effected by regular priests and ministers. Christian Science has reclaimed many drinkers and in recent years the Buchmanite groups have been helpful to some. The danger of the more popular religious cures is that in religious fanaticism the underlying neurosis may merely find another outlet, having given up the drinking. Another criticism of many religious "cures" is that they tend not to be permanent. They may last anywhere from three months to three years and then, when the novelty of the conversion wears off, the alcoholic may relapse into his former habits. I do not know of any trustworthy records giving either the total number of religious cures or the percentage of actual cures to attempted cures, neither do we know whether those cured would have been diagnosed as true alcoholics by a psychologist or whether they were merely heavy drinkers.

Since 1935, there has arisen a popular religious group which is, for the time being at least, sweeping the country. In judging any such movement scientifically we must bear in mind that the highly comparable Washingtonian Movement had a similar initial success a hundred years ago but that it faded very rapidly.

The principles of "Alcoholics Anonymous" are set forth in a book by the same title. The treatment of these groups are based on actual drinking experience, plus medical and psychiatric findings, plus certain spiritual principles
common to all creeds. There is no fanaticism and everybody is tolerant of everybody else's beliefs. There are no dues or fees collected by these groups. The members do their alcoholic work as an avocation. The gist of their recovery program may be outlined as follows: 69

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

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

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

4. Made a searching and fearless moral inventory of ourselves.

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

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

7. Humbly asked Him to remove our shortcomings.

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

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

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

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

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

My experience with "Alcoholics Anonymous" is not very extensive, but in the few meetings and dinners which I have attended no fanaticism was noticeable, and a spirit of earnestness, sincerity and good-fellowship prevailed. One may well be lifted up out of himself and encouraged in his own personal fight against alcohol when he feels himself one of a group of people who are literally beginning a new life, as these people are. There is little doubt but that if a man has any faith to begin with, this faith can be utilized in his rehabilitation. It is my feeling, however, that by far the greater part of the good which is done by Alcoholics Anonymous is done principally by the atmosphere of companionship and helpfulness to others. Most psychologists and psychiatrists advocate the development of new non-drinking friends for alcoholic patients. They also advocate the forgetting of one's own troubles in helping others and in the taking up of new interests and hobbies. This part of the work being done by Alcoholics Anonymous seems to me therapeutically sound and most of the members whom I have talked with have talked altogether about these aspects of the work and have hardly mentioned religion.

Theoretically at least, it would seem to me that it would be dangerous for a man or woman to admit that he was helpless to solve the problem himself and to throw it in the lap of God; because, if he then fails, where else can he
turn? He might well conclude that God himself had failed him and that the Fates were against him. The only way out, after this terrific disappointment, might well appear to be suicide or utter hopelessness, which would result in his "going on the bum" and becoming a perennial drifter. In such a state of mind, a man would be harder to treat than if he had never given up faith in himself completely and thrown his troubles into Someone Else's lap. For, a vitally important part of most psychological approaches is the rebuilding of the patient's confidence in himself. He is taught that he wants to be cured primarily for himself and only secondarily for the sake of others. Otherwise, whenever he becomes angry with others, his wife or brother or father, he has a made-to-order excuse for going on another spree and "showing" them what they have made him do.

It is helpful for some addicts to attend the Alcoholics Anonymous meetings for the group fellowship and spirit of unselfish self-sacrifice which they find there. They should be warned not to sit back and throw the whole problem into the lap of God, but to utilize whatever faith they have or can build up to the fullest extent. This social-religious method of treatment by volunteers is too young to allow any valid conclusions to be drawn as to the permanence of its "cures", which is not true of some of the methods of treatment which have been in operation for from ten to twenty-five years.
F. **The Therapies of the Analytical Schools**

1. **Psychoanalysis** (Freud)

   This is not the place to attempt to give an extensive exposition of the technique of the various psychoanalytic and allied schools of psychotherapy, but some idea of the principles and methods of procedure of these schools should be given since the psycho-analysts, Individual Psychologists, Analytical Psychologists, and others do occasionally attempt to treat alcoholics. It is only fair to state, in judging the results of such treatments, that only a very small percentage of the time of such practitioners has been concentrated upon the problem of alcoholism, and only an extremely small portion of the literature of these schools is devoted to this subject. The usual approach is to look on alcohol addiction merely as the symptom of some typical neurosis and to treat the neurosis itself without paying any special attention to the alcoholic complications. The analysts who consider alcohol addiction as worthy of specialized treatment usually consider that the patient has to be confined for a period of at least a year in a mental hospital.

   To my way of thinking both of these extremes are using the wrong approach. Confinement in an institution, even an ideal alcoholic institution (of which there are none at present) would at best be a poor preparation for future
living in the real world. It would be impossible to tell whether the analysis was being effective in the elimination of the symptom (excessive drinking) or not, as long as the patient was absolutely unable to get hold of any alcohol. I have known personally several hundreds of patients who have been confined for from one to six months at a stretch in various institutions and hardly any of them have felt any serious craving for liquor as long as they knew that it was impossible for them to get at any. Apparently, after a few weeks or months of institutional life they were perfectly contented and all craving for alcohol had disappeared. I have seen these same men, however, one, two, or three days after their release, dead drunk, or in jail, or back in the same institution from which they had gone forth — full of confidence and hope for the future. Therefore, even though there may be certain indications that a patient's underlying neurosis is being successfully attacked while in an institution, that does not and cannot prove that upon release he will not revert to his old habits.

Another difficulty with the psychoanalytic approach is that some analysts tell their alcoholic patients that when they are completely cured they will be able to drink normally or "drink like gentlemen". It has been the experience of the vast majority of alcoholic specialists that once a man or woman has become a true alcoholic, he can
NEVER drink normally again; and the futile attempt to re-capture that "first, fine, careless rapture" of their early drinking days is one of the most serious obstacles standing in the way of their recovery.

It is perfectly true that, in a sense, alcohol addiction is only a symptom of some underlying neurosis, but the effective treatment of alcohol addiction is greatly complicated by the fact that the persistence of the symptom (alcohol addiction) during treatment makes the continuance of the treatment periodically impossible and lengthens the time necessary for complete cure very considerably. For this reason initial hospitalization from one to four weeks is frequently advisable in order to free the patient's system from the accumulated poisons of long-continued drinking.

For the purpose of reducing alcoholic relapses to a minimum during treatment it is also advisable to require payment of the fee for the treatment monthly IN ADVANCE. Unless this is done the patient may unconsciously plan to use the money that would ordinarily be paid to the therapist, for liquor and a "good time". If it is clear to him, however, that the treatment fee is already paid in advance and that accordingly it is nobody's loss but his own if he misses his appointments with the analyst, there is a strong tendency for him to keep the appointments and thus receive full value for his money.
With this introduction, I will proceed to outline briefly the theories and therapies of the analytical schools. 

The Psychoanalysts (Freudians) consider alcohol addiction to be the symptom of an underlying sin-sex-guilt complex combined with an unconscious desire for chronic suicide. It is the symptom of an infantile regression indicated by (1) dependence, (2) the putting off of the disagreeable, (3) self-indulgence (no control over the appetites), (4) a childish sense of humor. The psychoanalytic therapy may be divided into two parts, (1) exploration, and (2) readjustment.

The principal techniques of exploration are:
1. Conversation
2. Free Association
3. Interpretation of Errors and Mistakes
4. Dream Analysis - the most important
5. Word Association
6. Hypnotic Suggestion

The process of readjustment consists of:
1. Catharsis
2. Transference
3. Reeducation (Reconditioning)

Psychoanalysis is much stronger on the Exploration than on the Readjustment. The whole purpose of the various techniques of exploration is self-knowledge (autognosis).

70 Much of the discussion of the three Analytical Schools is based on notes taken in the Psychology of Personality course given by Dr. Wayland F. Vaughan, Head of Department of Psychology, Boston University Graduate School.
The patient in conversation gives the analyst his own idea of his troubles, and in the free association he lies on a couch with his eyes closed and relates to the analyst "everything" that passes through his mind, no matter how trivial and unimportant the memory may appear to him at the time. Errors and mistakes, such as slips of the tongue or of the pen, forgetting, etc., by the patient are analyzed and their underlying meaning dug out. The content of dreams is analyzed and its hidden meaning in relation to past memories resolved. Various forms of resistance will be encountered in getting at the underlying causes back of the neurosis and the strength of the resistance will be some indication of the importance of the hidden data.

Catharsis or abreaction consists of the patient's going back and reviving bad experiences and purging himself emotionally and intellectually of their bitter residue in his unconscious mind. This process is somewhat comparable to the psychology of the confessional or to the mechanism of "feeling better" after we tell a person what we think of him. The process of living through a previous fearful experience in the presence of the analyst without fear tends to eliminate the fear residue.

Transference consists of prying loose the libido of the patient from its fixation on some infantile object so that it can eventually be brought to bear on the problems of
the adult environment. As a sort of "half way station" the libido is transferred to the analyst; frequently the patient falls in love with the analyst. As the final step the analyst must give the libido back to the patient. Sometimes this may not occur and when it does not the consequences may be very serious for the patient.

The goal of Reeducation is to get the patient to substitute the mature Reality Principle for the infantile Pleasure Principle and to utilize this principle for actual problem solving in the world of reality. By a process of Desensitization he must develop a tolerance for adversity. He must assume responsibility and learn to undertake disagreeable tasks requiring coordination of effort and concentration of effort. He must replace the infantile morality taken over from his parents by a morality which is of social value in the eyes of others.

Dr. Karl Menninger in The Human Mind and Man Against Himself states:

It (alcohol) is a very serviceable and psychic anaesthetic, and this utility easily leads to its excessive use by individuals whose unconscious struggles are particularly painful. This, in turn, is apt to lead to a psychopathic state of addiction, which is a deplorable kind of failure, complicated secondarily by the damage that alcohol does to the tissues of the brain.

The psychology of the addiction to alcohol is the psychology of insatiable needs and can only be understood by reference to the insatiable thirst of the little child who cannot live if he is deprived of the milk from his mother's breast and the love from her heart. The alcoholic addict is quite often a lovable, charming fellow who has never grown up, who is utterly dependent for his existence upon love administered to him in a maternal fashion (sometimes by men, however). Denied this or thwarted in it to some extent, he shows the same distress that one sees in the thwarted suckling and, just as a baby turns to its fists or toys or any other object that it can put in its mouth, so the alcoholic addict turns to liquor. In doing so, not only does he find a satisfactory substitute, but the anaesthetic effects of alcohol lull the craving for love or enable him to experience it in some other form (homosexual contact, prostitution, etc.). Moreover, it accomplishes a revenge upon the person who thwarted him — we all know how much the wives and parents of alcoholics suffer.

Theoretically, alcoholics, like other neurotics, are curable. In practice a cure is exceedingly difficult for one reason: Alcoholics rarely take their addiction seriously, and their optimism is so contagious that, frantic as relatives may be during or immediately after a spree, they are easily won over by the patient's optimism into accepting the vain illusion of the promise that he will never go on one again. Alcohol addiction is an extremely serious affection, comparable with the psychoses ("insanities"). Recently alcohol addicts have been studied and treated with psychoanalysis, and considerable understanding of their special neurotic conflict has been gained. Usually proper institutionalization must be associated with the psychoanalytic treatment. While some encouraging results have been seen, it is too early yet to evaluate the success of this form of treatment, which attempts to remold the personality make-up and resolve the neurotic conflicts that lead to addiction.73

The Freudians, on the whole, have been much more successful in their techniques of exploration (finding out the

underlying bases of the neuroses) than they have in re-adjustment and reeducation. This was one reason for the revolt of Adler and Jung against pure Freudianism, which led to the establishment of their own systems of psychotherapy.

2. **Individual Psychology (Adler)**

The therapy of Alfred Adler is based on the hypothesis that people crave power rather than love, and that to understand a person we must study their daydreams and thus find out what their Goals or "Guiding Fictions" really are. Adler defines a neurotic (under which classification comes a large proportion of alcoholics) as an individual who:

1. Is afraid of competition, is timid and afraid of failure.
2. Lacks confidence, and is jealous of others' successes.
3. Wants power
4. Is sensitive to criticism
5. Has a feeling of being unwanted
6. Has a sense of helplessness
7. Has a feeling of Inferiority
8. Lacks courage, guts, intestinal fortitude
9. Is unwilling to work and get things the hard way
10. Doesn't recognize his social responsibilities
11. Is always telling other people about his ailments and troubles.
Adler holds that most neurotics have either some actual organ inferiority or some psychological feeling of inferiority and that they compensate for this feeling by means of neurotic fictions such as Daydreaming and Bluffing. This mechanism is known as Over-compensation. Adler does not consider sex as particularly important but emphasizes the Will to Power as the driving force. He finds the Masculine Protest to be especially strong in some individuals - the desire to be a big, strong, and powerful He-man. In contrast to Freud who holds that peoples' actions are primarily motivated by the libido or a push from behind, Adler considers that they are motivated by their goal or a pull from in front. Freud explains many conflicts and complexes by the rivalry for love, while Adler explains similar situations by the rivalry for power.

3. Analytical Psychology (Jung)

Carl Jung's therapy emphasizes DOING things and his therapy is active rather than passive. He has his patients draw and paint and then give their own interpretations of the results. He criticizes Freud for having too much talking and not enough doing. By means of these drawings the patient gets down in concrete form his own phantasies and thus brings his own imagination into the world of reality.
Then he is encouraged to interpret the pictures with intellectual and emotional understanding. Jung found that many of his patients were trying to intellectualize and rationalize everything, and he emphasizes the need for placing greater emphasis on the feelings and emotions rather than on the intellect. Jung emphasizes the Synthetic against the Reductive method. That is, he doesn't believe in trying to trace everything back to childhood. Instead he tries to find out what is bothering the individual in the present and to make a readjustment. In other words, Jung places the greatest emphasis on the present maladjustment and its cure.

Jung considers that during the birth experience the individual was forced to leave a warm, comfortable, effortless existence and go out into the cold, cruel world. From this time on the individual is striving to be reborn, to start life all over again, avoiding the mistakes of the present existence. In religious conversion some individuals are, in a sense, reborn. They find a new spiritual meaning to life which makes it worth living once more.

Jung's method of therapy is Synthetic and Constructive as opposed to diagnostic. He emphasizes Reeducation. He believes that many analysts take the individual apart (diagnosis) and then don't bother to put him together again, whereas Jung himself considers the "putting together" to
be the most important part of the whole process. He considers SPIRITUAL UNREST to be the cause of most neuroses. Not many years ago he stated, "I am now convinced that I have never had a case which did not originate in Spiritual Unrest." By this he means that many people, as they become better acquainted with life, are struck by its seeming senselessness, uselessness, and meaninglessness. Middle-aged breakdowns in particular are frequently brought on by a growing realization of the lack of accomplishment of the individual.

Jung believes that the desire for Individuality is as strong as sex in motivating people. Women as well as men want to be credited with being individuals and want to have a chance of expressing their own peculiar talents. But until very recently, at least, women were bound to suffer from the lack of opportunity to express their individuality, which resulted in frustration and the creation of neurotic difficulties.

Jung found that about one-third of his cases were suffering only from the senselessness and uselessness of their lives. They had no purpose in living; they found no meaning in life. This he believed was due to an over-critical and over-intellectual attitude toward God and Faith. They did not let themselves be guided enough by Feeling, and, as a result, the world seemed to have lost its meaning.
title of one of Jung's later works, Modern Man in Search of a Soul, gives us some conception of this point of view. He secured the results that he did by explaining to his patients how and why life still had plenty of meaning spiritually, and by showing them how to express their own individualities.

To my knowledge neither the Freudians nor the Jungians claim any significant percentage of cures for alcoholism. I do not know whether the Individual Psychologists (Adlerians) do or not. Such a small portion of their cases are alcoholics and they have devoted so little time and space to the analysis of this special type of neurotic symptom, that their lack of promising results is easily understood. Certainly many of the therapeudical techniques of these schools have been heavily drawn upon by those therapists who make a specialty of alcoholic treatment.

G. Count Alfred Korzybski's System of General Semantics

The teaching of the new methods of evaluation and predictibility as set forth in General Semantics has proved helpful in the reorientation of many neurotic individuals to life's actualities. General Semantics is a theoretically difficult but practically simple system of achieving and maintaining balance and sanity in a world notorious for
having neither. This system was set forth by Count Alfred Korzybski, Director of the Institute of General Semantics, Chicago, in his great work, *Science and Sanity* \(^74\) in 1933, and since that date has had considerable influence on progressive psychiatrists, scientists, educators, psychologists, etc. Several alcoholics have been treated in accordance with this system with encouraging results. The teaching of the principles of General Semantics is carried on by the lecture method so that very few individual interviews are necessary; moreover, the length of time required for instruction is only one or two months. This means that patients who can be cured by this method alone can be brought back to normal far more rapidly than by long-drawn-out methods of regular psychotherapy which frequently take well over a year.

I shall now outline the method of Semantic instruction given to two alcoholics with psychopathic personalities in a private mental institution.

The treatment of these two patients by General Semantics was carried on by Dr. John G. Lynn \(^75\) at the McLean Hospital, Waverly, Massachusetts, during 1934. This was the first application of the new methods to alcoholics, but so

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\(^75\) Quotations from his "Preliminary Report of Two Cases of Psychopathic Personality with Chronic Alcoholism Treated by The Korzybski Method." Institute of General Semantics, Chicago, 1938.
few had been so treated at the time his paper was written, that no statistically valid conclusions could be drawn.

Both of these patients were mature intelligent individuals, so it was thought wise to incorporate in their education considerable theoretical material. Assignments in Science and Sanity were given for daily study and a one-hour conference with each patient was held six evenings a week. In these interviews the subject matter was clarified and its applications in reorienting and re-evaluating their own personal life situations and problems was pointed out.

After some introductory observations in which the patients were taught the distinguishing characteristics of vegetable, animal (locomotion), and human beings (time-binding), they were taught that

... they must through a direct neurological training of a special type develop their temporal coordinating Semantic mechanism; that it was to be expected, as they improve through Semantic training the efficiency and integrated activity of their time-binding mechanism, that automatically they would develop more cortical dominance and control over their total behavior patterns and so improve their adjustment and personality efficiency.

It was further explained that their chief troubles in adjustment to this date were due precisely to the fact that literally they copied animals in their impulsive signal reactions, which, while of survival value to animals in an animal special environment, were definitely of non-survival value to them as humans in a human environment. As a consequence they were sent to this hospital for shelter and re-education as well
as to protect society. They were told further that neurologically speaking they had simply never learned to delay their reactions long enough to permit higher cortical time-coordinating mechanisms to interfere in their behavior. As a result almost invariably all their impulsive emotional reactions might serve to give a momentary satisfaction in spacial adjustment but invariably as signal reactions failed to have adaptive value over any period of time. They, as physical athletes, could not be expected to make adequate spacial adjustments in complex athletic activities without complex training in proper use of their spacial coordinating neuro-muscular mechanisms. Similarly they could not be expected to be able to coordinate their activities to survive over any great period of time in this complex society of today unless their temporal, coordinating, neuro-semantic mechanisms were trained and trained adequately so that as an adaptive mechanism specific and unique for man it could successfully dominate and condition the manner of response of all of their levels of integration. Such a Semantic training would give to them the ability to live a well-adjusted, happy, consistent life with a greater ease of social adjustment and greater ability to do constructive and creative work in any field of endeavor they should choose.

After this introductory explanation the following eight point program was carried through with both patients:

1. A thorough-going and persistent non-Aristotelian training using the method outlined by Korzybski in *Science and Sanity*.

2. Daily assignments for study in *Science and Sanity*.

3. An hour's conference with each patient separately six evenings a week over a period of from two to three months.

4. Silence on the objective level was persistently taught, and thus they were taught more and more to avoid identifying words with things.

5. The Structural Differential was brought into the picture as early as possible and its significance as an instrument for non-Aristotelian training explained and demonstrated.
6. The patients were drilled in the use of the Differential to develop habits of delaying reactions and to acquire a feeling of non-allness and non-identity, and so to become conscious of different levels of abstraction.

7. The subject matter of Science and Sanity was discussed and elucidated for them and they were constantly encouraged to apply the new knowledge, new insight and new non-Aristotelian habits to the clarification and solution of their own problems.

8. Finally, after two or three months of such training, they were encouraged to take up study and work in a field of endeavor which they might hope to make their own and continue in after discharge from the hospital.

In his summary of the discussion of these cases, Dr. Lynn states that his objective was to improve the patients' adjustment to life and thus eliminate the habit of chronic alcoholism of many years' standing.

The method used was persistent, daily, direct, neurolinguistic extensional training in delaying their reactions; in drill with the Structural Differential; in eliminating false-to-fact intensional orientations; and in establishing extensional true-to-fact orientations, etc. The empirical work was supplemented by study and discussion of Science and Sanity, with the constant application of the new extensional method and non-Aristotelian points of view to the solution of their own problems.

Results After Four Months

1. They showed marked decrease in impulsive, erratic reactions and corresponding increase in stability, self-control and consistent behavior, productive of:

2. An increase in honesty and dependability, with a manifest desire to live up to their parole and other obligations, and success in so doing;
3. A marked improvement in the harmony of their relations with nurses and other patients;

4. A definite development of greater ability by both patients to extensionally analyze, discuss, and solve their own adjustment problems with less and less assistance from the instructor.

5. With the exception of several drinks taken by Patient A as a personal experiment one month ago and done with the writer's (Dr. Lynn's) knowledge, there has been no return to date (March, 1935) in either patient of drinking habits. During the last three months both have had ample opportunity to indulge if they so desired.

6. Patient A, on his own initiative secured, and has successfully held with much commendation, a responsible position with a large concern during the last two months. He has lived outside of the hospital and has reported his progress to the physician weekly.

7. Patient B, within the last two weeks has taken up and applied himself diligently and effectively to a course of study in Aerial Photography mapping and surveying, in which he plans later to enter professionally.

8. Both patients report a peace of mind, feeling of security and self-confidence, with a new interest and purpose in life, never experienced before.

Conclusions

1. "The Korzybski method of direct, neuro-linguistic, extensional non-Aristotelian training, using the Structural Differential, has proved definitely successful during the last four months, in developing greater cortical, inhibitory control, in restoring nervous balance and in the elimination of tendency to inebriation, etc., in two men of unstable psychopathic personalities."
2. "In view of the success of the method in so markedly improving the adaptation of these two patients suffering with maladjustment difficulties of a type hitherto notoriously refractory to any prevailing form of therapy, it is felt that the Korzybski technique should be tried on a series of such cases in order to ascertain its value as a possible standard procedure in the treatment of alcoholics and psychopaths.

3. "Furthermore, in contrast to the older and more specific remedies, the method, in its essential features, is so general as to suggest at once that it should be seriously considered and tried as a possible form of group therapy, badly needed in psychiatry today."

Since General Semantics is still a rather esoteric discipline, I shall here give a brief outline of some of its outstanding principles as I understand them from Korzybsky's seminar in General Semantics, from Science and Sanity, and from his 1940 address before the American Psychiatric Association.

Sanity is considered as the ability to evaluate facts and experiences realistically and correctly. Mis-evaluation leads to every variety of mental illness and maladjustment. If we react to stimuli immediately we necessarily make an animalistic, thalamic, or signal reaction. By training ourselves to delay our reactions momentarily we give the cortex an opportunity to function and accomplish
a symbol reaction appropriate for humans.

General Semantics makes us realize that the word which we have agreed to use in describing an object IS NOT the object itself and that we necessarily ABSTRACT from the totality of qualities inherent in the original object, those qualities which on the basis of our experience we are interested in at a particular time. Korzybski makes us conscious that our word refers to only a part of the reality and that therefore in our conversation we are referring only to parts and rarely to wholes. This brings our tacit assumptions and folklore to our conscious attention and aids greatly in eliminating false-to-fact knowledge. We no longer act as if our false-to-fact assumptions were 'all there is to be known.'

Korzybski uses five "extension devices" to assist in straight thinking:

1. Indexes or sub-numbers are used to emphasize the fact that each individual of a given class is different. For example, Dog₁ may be a friendly cocker spaniel and Dog₂ a vicious and ugly chow. It will easily be seen that it is important for the unknown visitor to the dog's owner to differentiate and evaluate properly in this case.

2. Dates are also used as sub-indexes. For example, F. D. Roosevelt 1910 was presumably a considerably different individual from F. D. Roosevelt 1942. Yet this per-
sonality development is frequently overlooked when we accuse people of inconsistencies.

3. The addition of the word 'ETC.' to sentences to emphasize the fact that they do not cover the entire subject under discussion.

4. Quotes are used freely to show that the writer realizes the dangers inherent in misevaluating a given word. For example, Freud's teachings would have taken hold much more rapidly if he had made it clear that his SEX age 2 was a very different thing from his SEX age 22 and that his 'libido' was in fact not libidinous, but a general term denoting psycho-physico-sexual craving-energy.

5. He also uses hyphens to help clarify the meanings of words: "neuro-linguistic", "psycho-logical".

Korzybski feels that our present educational techniques teach us a reversed order of evaluation. We first learn the WORD and then apply it to the object, whereas in the natural order the real object or fact preceded the label. Thus, by simply reversing our present reversed way of looking at things, we arrive at a correct method of evaluation and predictability which is essential to the maintenance of complete sanity.

If we evaluate experience correctly, we are enabled to predict coming events accurately which makes for sanity and mental health. Misevaluation means lack of predictability
leading to insanity and mental disease. Korzybski applies this to international affairs and nations as well as to individuals.

Present day psychotherapy attempts to bring mental patients into closer contact with reality; it is necessarily individual and dependent in large degree on the personality, insight, and ingenuity of the therapist. Korzybski feels that by getting at scientific rules of procedure group psychotherapy can be performed by almost any intelligent person, and that it can be used on large groups as preventive therapy before the development of mental disease. Moreover, General Semantic-therapy is frequently effective in one month or less in contrast to the 12 to 24 months necessary in psychoanalysis and other therapies.

I have taken Korzybski's regular course in General Semantics and found it helpful in working with alcoholics and other types of maladjusted personalities. It is extremely difficult, however, to isolate its results from the totality of methods used on each patient. Dr. Lynn wrote me in 1940 that his cases were still doing very well, but of course he tried it on only three patients. I feel that we must withhold judgment as to the effectiveness of General Semantics in cases of alcohol addiction until a considerably larger amount of statistical evidence is available.
H. The Psychobiologic Approach to Treatment

1. Dr. Oskar Diethelm

One of the best summaries of the psychobiologic approach to the treatment of alcoholics is given by Dr. Oskar Diethelm in his book, Treatment in Psychiatry, 76 (pages 441 to 451). Diethelm states:

A patient should be considered a chronic alcoholic when he harms himself or his family through the use of alcohol and cannot be made to realize it, or when he no longer has the will or strength to overcome his habits. 77

Diethelm finds that marked personality disintegration is common resulting in

- impulsiveness
- lack of self-control
- with increased irritability, especially when accused of neglect of their duties
- euphoric mood
- lessened perseverance in interests and actions
- diminished initiative and ambitions
- in not too far advanced alcoholism and especially when well-groomed, the patient is charming to his friends, talks glibly about ambitions and impending successes and finds plausible excuses for his failures.
- In his own family the same person may be rude or threatening, even to the point of striking members of his family, showing uncontrolled behavior on the least provocation and developed marked dislikes and hatred. According to the personality, definite pathologic traits appear, such as jealousy, paranoid tendencies, marked moodiness, and even fantastic-mystical tendencies. 78

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76 New York, Macmillan, 1936.
77 Ibid., p. 441.
78 Ibid., p. 442.
Diethelm finds several different ways in which the alcohol habit is formed. Some drink to pull themselves out of moods of depression and discouragement.

Shy and self-conscious people drink to attain social ease. People with marked feelings of inadequacy drink for self-encouragement, especially when confronted with situations that demand too much from them. The lonely self-maladjusted person tries in this way to forget his longing or understanding which he cannot achieve. ... latent homo-sexuality may be a dynamic factor.\textsuperscript{79}

Some drinkers seek relaxation from tension, others get encouragement and push from alcohol. Anxiety frequently leads to drink. Social drinking habits frequently have a detrimental influence in the case of suggestible persons such as adolescents and emotionally immature adults.

The treatment of chronic alcoholism has usually been directed along three lines: That of personality analysis, in an endeavor to find strivings which drove the patient into alcoholism; re-education under enforced abstinence; and the use of drugs to change hypothetical chemical processes in the body or to produce a lasting disgust to alcohol through chemical alterations. The attempt to treat with drugs can hardly be called scientific and is, therefore, usually administered by non-physicians. The large number of persons who seek help in such institutions is an indication of the failure of medical science to outline well-planned treatment.

The only treatment which can be effective in all cases and which can be adjusted to the patient's individual needs is treatment which combines personality analysis and adjustment with training of

\textsuperscript{79} Diethelm, \textit{op. cit.}, p. 443.
healthier habits over a long period of time and under strict abstinence. 80

Dr. Diethelm finds that the insight which the patient shows soon after the beginning of treatment lasts only a week or two.

It is not based on real understanding of the danger of his alcoholism, but on alcoholic euphoric optimism. It is followed by a grouchy revolt of two to four weeks, in which the patient insists upon less restriction because he is well and will be able to handle the alcoholic problem in the future or because he does not care for the treatment. 81

This is a very dangerous period because frequently the patient will persuade the members of his family to allow him to discontinue the treatment at this point. It is not until this negative reaction has passed that real insight develops which makes the patient willing to cooperate and anxious to see how he can develop self-dependence and self-reliance without the help of alcohol. 82

Dr. Diethelm believes that the patient ought to have two months of close supervision preferably in a closed psychiatric institution, with definite restriction of his personal freedom.

During this period the psychiatrist makes a thorough investigation of the patient's personality, shortcomings, resources, and interests.

After real insight has been gained a constructive analysis will show him how his assets can be used to overcome his difficulties. 83

80 Diethelm, op. cit., p. 444.
81 Ibid., p. 445.
82 Ibid., p. 445.
83 Ibid.
During the second phase of the treatment an individualized reeducational approach is used. This should be carried out in an open institution in which the patient can lead a healthy life with a well balanced routine which includes work and suitable recreation and a healthy physical regime.84

Weekly consultations are considered sufficient from this point on.

Dr. Diethelm agrees with most workers in this field that "treatment should always lead to total abstaining" and that "a physician who is a total abstainer will achieve better results than a physician who has one attitude for himself and another for his patients."85 He considers that "the totally abstaining physician carries much more conviction in his advice and exerts a strong suggestive influence."86

He believes it essential that upon his return home the patient's family be willing to abstain also and to provide a home environment where no alcoholic beverages are served.

Dr. Diethelm believes that on the average the entire hospital stay should last about a year. He finds that the

84 Diethelm, op. cit., p. 445.
85 Ibid., p. 446.
86 Ibid.
first two months of the treatment can be carried out in an up-to-date psychiatric hospital in which the physicians have sufficient time to study the patient carefully. He is not satisfied with most existing special institutions which attempt to carry out the second or reeducational phase of treatment. He admits that some good work is being done by means outside of hospitals but that if such treatment fails to produce the desired results, hospital treatment is necessary. 87

Dr. Diethelm realizes that it is sometimes difficult for a former alcoholic to resist the temptation to drink so long as he travels in social groups who persist in a certain amount of drinking. To counteract such undesirable influences the patient needs the whole-hearted backing of his family and friends and it is suggested that he join social or religious groups who cultivate total abstinence. Such groups may be formed among the patients and former patients of alcoholic specialists. 88

In 1933 Dr. Diethelm suggested the establishment of self-supporting farms for carrying out the reeducational second phase of alcoholic treatment. 89 There is small doubt but that some such broad social attack on this wide-

87 Diethelm, op. cit., p. 447.
88 Ibid., p. 449.
89 Ibid., p. 450.
spread problem is necessary before we can successfully reach the large number of alcoholics whom alcohol has made unable to support themselves or to pay for psychological treatment.

2. **Dr. Robert S. Carroll**

One of the most comprehensive treatments of the problem of alcohol is to be found in Dr. Robert S. Carroll's excellent book, *What Price Alcohol?* published in February, 1941. Dr. Carroll believes in "a healthy person in and through a healthy body."

A drunkard, alcoholic, or alcohol addict is defined as one who "turns to alcohol as a necessity when facing the physically or mentally disagreeable, or uses it as an escape from any unpleasant reality." Ultimate responsibility for recovery rests in the patient's own hands and an apparent confusion of personalities and symptoms are condensed into three practical groups: "those who can help themselves; those who don't help; and those whom we class as incurable, the unfortunate who can't help."  

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90 New York, Macmillan, 1941.
91 Ibid., p. 155.
92 Ibid., p. 163.
Dr. Carroll classes as benign

the man whose physical health has not been undermined and who has a record of some definite accomplishment. He has won recognition as efficient at something. He has responded to ideals at some period. When sober he is honest and presents himself as one who has tried earnestly to stop drinking, has failed, and now seeks help.

Such a man is cooperative in whatever steps the therapist suggests; he is willing to give up habits such as cigarettes and coffee; he is willing to learn to endure monotonous work and to aim at the goal of total abstinence. The steady day-by-day drinker is more promising than the periodic, and the regular periodic more hopeful than the irregular periodic. "It requires only moderate therapeutic skill to care for the intelligent, eager, willing applicant for curative directions.

Difficult patients are those who have never been prepared in youth to meet life four-square, mothers' or fathers' darlings, sons and daughters of overindulgence, and practically all women patients. These require much longer periods of reeducation than the benign type described above. On the borderland between difficult and incurable cases are the dipsomaniacs who after long periods of sobriety and without warning go on a spree and disappear to end up days later in some gutter, jail or dive. Dipsomania is related to the manic-depressive disorders and is a function of hormone disequilibrium. Some of these cases can be
helped, "but only when they can and will consistently and persistently help themselves."

The incurable group include constitutional inferiors, psychopathic personalities, those with encephalitis, meningitis, brain injury, schizophrenia, the more severe manic-depressives, paranoids, demented, etc. "In fact, the entire list of those who are hopelessly under the dominance of alcohol are victims of some incurable central nervous disorder."

A discussion of Dr. Carroll's treatment of benign cases will suffice, for in difficult cases it is mainly a question of more of the same over longer periods, and in incurable cases custodial care is about all that can be offered. He attacks the superstitions that the alcoholic is what he is because he chooses so to be or that he is morally sick and can be saved only through religious regeneration.

The negative attitude of apathy among the members of the medical profession, however, is the outstanding influence which has so long delayed the modern approach to this far from hopeless question. Even psychiatrists have shown a definite inertia and have often expressed anti-pathy toward the alcoholic and the solution of his problem.93

Dr. Carroll admits that there is no specific for alcoholism and that there exist isolated instances of cure

93 Carroll, op. cit., p. 179.
by all sorts of emotional procedures. Sure therapy, however, must go much deeper. He would no more think of treating an alcoholic in his home environment than performing a delicate brain operation in the patient's kitchen. He must be removed from his old associations and unhappy memories. One of the first steps in the treatment is a complete physical examination including thorough examination of the central nervous system, gastrointestinal tract, cardiovascular tree, blood, urine, spinal fluid, and other significant secretions. During the early weeks from $1/500$ to $1/200$ of a grain of scopolamin is hypodermically administered night and morning to ease the patient's distress and reassure him that his needs are being attended to. Alcohol and cigarettes are taboo.

There is an unquestioned close relation between inhalation of cigarette smoke and a growing desire and need for the more powerful vasomotor sedative of strong drink.

For the neurotic we cannot possibly over-emphasize the alluring seductiveness of nicotine-inhaling. It is a major cause for return to drink. 94

Personal conferences take place daily during which the patient's mental and emotional reactions, prejudices, defenses, etc. are thoroughly analyzed. Occupational therapy, especially the outdoor variety is strongly emphasized and

94 Carroll, op. cit., p. 184.
gradually "the great need of the average alcoholic - pride in unspectacular accomplishment - develops." The patient participates in all forms of sport and there is hiking every day - an average of five miles.

Probably no single element contributes as much to the patient's change in attitude and his preparation for the mental growth and emotional reorganization as the realization of physical zest and incentive to accomplishment. The rhythm of self-indulgence is being broken.95

"One of the most reconstructive influences utilized in the modern regimen is a far-reaching revolution in diet" due to excess of proteids, overrichness of fats, and deficiency in vitamins. "When food is earned through exercise, the patient responds with an unexpected sense of physical well-being."96 Alcoholics usually have defective blood-brain-barriers and are especially susceptible to food poisoning.

The sting is taken from the inculcation of discipline by utilizing group discipline with its companionship, self-forgetfulness and camaraderie.

When the schedule of activities has attained the maximum, the patient will be spending seven to eight hours in out-of-door constructive labor and diverting sport - little time is left for daydreaming, self-pity, and resentments.97

95 Carroll, op. cit., p. 187.
96 Ibid., p. 188.
97 Ibid., p. 189.
The physical fatigue honestly earned ... is the body's finest tonic during youth and maturity, and the best of all medicines for nerves distraught. Wholesome weariness frees one from cloying apprehension and welcomes sleep-hours eagerly.

The alcoholic addict must in the future avoid all alcohol just as the sunstroke victim must avoid the sun. In addition to possessing the will to get well he must possess the capacity to maintain determination - the persistence in the will to get well.

No treatment is sound which does not teach the patient to stand and make use of monotonous. ... Only as the capacity to meet monotonous without resentment, or rebellion, or surrender to the craving for new sensation develops does the mature will-to-get-well find expression.

Dr. Carroll also favors devoting twenty minutes a day to definite mental improvement in some avocation remote from the patient's occupation and letting "the GIVE eclipse the TAKE in a daily hour of social contact at home or elsewhere."

An excellent suggestion for relieving the tensions which lead to abnormal drinking is to take an ounce of castor oil and follow it by a meatless meal; if things do not look hopeful again in six hours take a second dose. This practice "stands as a bulwark of protection for the toxic-periodic alcoholic."

I consider Dr. Carroll's book and method of attack extremely sound in theory but I am rather sceptical as to how he is carrying these principles out in actual practice.

During the summer of 1941 I had the opportunity of
observing the actual working out of these sound theories under his direction for about two months. The occupational therapy and the health-building and dietary set-up were excellent but the psychotherapy was almost non-existent. What went by the name of psychotherapy was carried out with both male and female alcoholics by an extremely brilliant and attractive middle-aged maiden lady who had never had any personal experience with drinking. The "therapy" consisted in the discussion for half an hour a day of the first ten chapters of Dr. Carroll's rather antiquated *Mastery of Nervousness*¹⁸ which was last revised in 1918, plus the discussion of some half dozen chapters in his new book *What Price Alcohol?* This "therapy" consumed from three to four weeks of the eight weeks which the typical alcoholic stays at his institution, and there the "therapy" ends. In reply to my criticism of any such procedure, I was informed that if a patient needed any additional therapy, he got it. But most alcoholic specialists agree that every alcoholic addict needs at least one year of real psychotherapy, not merely the parroting back of Dr. Carroll's opinions. And what alcoholic in his sober moments is going to lay all his confessions at the feet of an elderly spinster, however brilliant? If Dr. Carroll's already excellent outdoor and

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occupational therapy could be followed up by a year's real psychotherapy such as Diethelm, Seliger, Durfee, Nossen, Peabody, Strecker, et al. insist on, then and then only would he have a real and effective method of treatment.

I. Psychological Systems of Therapy

1. The "Common Sense" Approach of Dr. Herbert L. Nossen

Dr. Herbert Ludwig Nossen of New York gives a good brief description of the psychological approach to the treatment of alcoholism in his article in the North American Review for June, 1939, and in his book of case histories, Twelve Against Alcohol, published in 1940. He says:

His (the alcoholic's) psychological disorder must be corrected because of family and society, and not primarily because of his own well-being. What is needed is patient, tactful discussion over several months. The physician obtains the patient's confidence bit by bit which greatly simplifies treatment.

Common delusions of patients are that they drink excessively because of lack of business promotion, debts, etc. The therapist must convince them that they will be able to pay their debts and gain promotion by the simple avenue of ceasing to drink.

100 Ibid., p. 10.
The initial attitude of the typical patient is that of an infant. This must be replaced by the mature conviction that ceasing to drink will solve his difficulties.

This study is not an advocacy of one special method of cure, but proposes to show that careful medical treatment directed by the well-equipped physician, together with the cooperation of the patient and his family, can effect more recoveries than is widely regarded possible.101

It is quite inaccurate, of course, to say that every alcoholic is susceptible to successful treatment, because there are two definite categories which elude medical or psychiatric aid: one is that class of drinkers who are so mentally deficient by nature that there can be no appeal to reason; the other is that category of drinkers in whom alcohol has destroyed so much of the fabric of personality that there remains no foundation on which to base recovery. Aside from these exceptions, the percentage of alcoholics that are curable is surprisingly and hearteningly high.102

The primary task of the physician who devotes himself to treating dipsomania is to achieve the unreserved confidence of the patient. To attain this, it is compulsory for him to give the sincerest attention to the concerns of the sufferer, to the extent indeed of sharing them. Once the patient feels and is convinced of this interest, half of the battle is won. Pursued by his conscience, and usually hounded by the unflagging criticism of his family and friends, he has been constantly on the defensive. This inevitably built a fear complex, adding to the delusion that he or she could escape certain problems of life by drink. But when he perceives that the physician has a real interest in his problem, that he is not eager to blame the patient unjustly, the victim's first reaction is one of the utmost relief; this leads to a state of mental relaxation - he is safe in a friendly port after a tempestuous

101 Nossen, op. cit., p. 11.
102 Ibid.
voyage. Henceforth he develops a desire to renew this store of relaxation, and in most instances he can be depended upon to return to the physician for it with at least some degree of the faith that he once invested in alcohol.103

Parenthetically, it may be added that the problem facing both patient and doctor is immeasurably simplified when the sufferer’s family and other intimates regard him as a sick human being and not as a disgusting outcast without function in society or a nonentity beyond remedy.104

Dr. Nossen finds it inexplicable that the general attitude toward alcoholism at present is one of defeatism and resignation, if not almost of indifference, and that the subject is "still beclouded by an appalling amount of abracadabra and hypocrisy," all this in face of the uncontestable fact that "the United States is confronted with a steady increase in excessive and uncontrolled drinking, in almost all age groups from adolescence onward."

Two significant statistics that Dr. Nossen quotes are that "in 1936, the Bureau of the Census reported that more than eleven per cent of the 101,462 first admissions to public and private mental hospitals in the nation were alcoholic patients," and that "between 1920 and 1933 (the Prohibition years) hospital first admissions for alcoholism in most metropolitan districts increased by as much as 700 per cent; between 1930 and 1934, these initial admissions multiplied by 117 per cent, and the year following, 1935

103 Nossen, op. cit., pp. 11-12.
104 Ibid., p. 12.
(two years after Repeal), the first admissions were still greater."

... of the 25,000 admissions in 1936 to Bellevue Hospital in New York City for all causes, more than forty percent were for alcoholism. Roughly the same percentage has endured since that year.106

One of the prime reasons that the problem reached its present dimensions has been the nation's shortsighted insistence on viewing alcoholism as stemming from 'moral' deficiencies. In plainer words, more often than not the alcoholic in the public mind was 'weak-willed' or 'spineless'; he was without 'conscience' or 'scruples'. In the more succinct vernacular, he was a 'bum'. And as such, he was the target of much invidious humor. 107

This remains the popular conception. The inebriate is a pariah, an outcast. It is true that this attitude is changing, but it is not changing fast enough nor in the right direction. For many years past the general viewpoint toward alcoholism was that it was virtually incurable - the almost invariable end, it was hopelessly maintained, was delirium tremens, and death. 108

It is of paramount importance that the public should know that the majority opinion today among professional men who have had first hand experience with dipsomaniacs is that, given some degree of cooperation, they can be rehabilitated. It is happening every day, with sufferers from all walks of life. 109

Dr. Nossen has this to say about the commercial "cures":

Let one consider briefly the traditional 'curative' methods, many of them still in use and

105 Nossen, op. cit., p. 239.
106 Ibid., p. 240.
107 Ibid., p. 242.
108 Ibid.
109 Ibid.
almost all of them based on the belief that the
cure of dipsomania is strictly a matter of physio-
logical adjustment, not always necessarily combined
with confinement. Thus, for more than half a
century various institutions have treated al-
coholics by drastic forms of medication. Today
there are still employed countless 'gold cures',
perhaps the most important of all 'antidotes',
since once the chemical action wears away, the
alcoholic's craving is often greater than before
he began treatment. Yet such institutions con-
tinue to guarantee cures in four weeks (for such
fees, for example, as 160 dollars) - a manifest
impossibility. Then, also, there are supposed
short-cuts that only serve to intimidate the
patient, or momentarily hypnotize him into the
delusion that he is en route to teetotalism.
Again, there are innumerable purges, designed to
rid the inflamed system of alcohol in anywhere
from twenty-four to seventy-two hours, followed
sometimes by prolonged and weakening baths in
sedative solutions. Rarely if ever are these
followed by a thoughtfully prescribed regimen in
which there is special provision for a 'buffer' to
stand between the convalescent whose physical
health is slowly returning, and his distraught
nervous state that follows the complete stoppage
of all alcohol into the system. The components
of that 'buffer' are both physiological and psychol-
ogical, and they are of the utmost importance to
pull the sufferer past those shoals of profound
boredom, irritation and acute mental sensitivity
that occur as the physical machine is on the mend. 110

In the absence of such provision, frequent
medical experience is that a relapse becomes so
likely that it may almost be called inevitable. 111

It is cause for astonishment that such
'cures' were not recognized long since as generally
worthless, dangerous, and, in some instances,
fatal for the patient. They serve merely to
transfer responsibility for the sufferer's normal

110 Nossen, op. cit., pp. 243-44.
111 Ibid., p. 244.
behavior from himself, where it belongs, to various agents - sometimes religion, sometimes pills, injections, purges, baths, and even physical intimidation. In essence, they are no less an evasion of reality than, say, the alcoholic's application to the bottle to forget his wife's peccadillos. One cannot minimize the importance of rebuilding the body in the treatment of alcoholism, but to regard it as taking precedence over the patient's mental health is to use elaborate pains to put the cart before the horse. 112

The doctor must expect relapses and discouragements that sorely try his own nerves. These setbacks, however, are not necessarily dangerous or fatal if the sufferer has such confidence and trust in the physician that he tells him candidly how and why they occur. Under such circumstances, there is nothing to do but go over the arguments that before had in part convinced the patient that his life would be easier, happier and less involved in a regimen that had no room in it for alcohol. 113

... the immensely encouraging point is that it can be done. Experience in thousands of cases has proved that the percentage of failure is hearteningly small. It comes to this, even in severe cases: If the sufferer will consent to see the doctor at regular intervals over a maximum period of a year, and if he will tolerate a mild degree of discomfort, for only a few days, he can in most instances be cured. He can learn to walk again. 114

2. Courtenay Baylor

Finally we come to the continuing line of alcoholic specialists which culminates in Alcohol - One Man's Meat.

112 Nessen, op. cit., pp. 244-5.
113 Ibid., pp. 245-6.
114 Ibid., p. 246.
by Strecker and Chambers of The Pennsylvania Hospital. This tradition began with the work of Dr. Elwood Worcester of Boston and was carried on through Courtenay Baylor and later through Richard Peabody, both of Boston. Other men whom I know to be working along the same line are Wilson Mackay of Boston and Samuel Crocker, W. W. Wister, and Rudolph Schmorrenberg of New York City.

Dr. Elwood Worcester returned from studying abroad in the latter part of the 19th century with a doctorate in psychology from one of the best German universities. He wrote several books, among which was Religion and Medicine, in which he tied together the older psychology, religion, and the new psychoanalytic psychology of Freud and his associates. Dr. Worcester founded the Emanuel religious movement in Boston and put his knowledge of psychology to practical use by relieving many of his parishioners and others who suffered from functional neurotic ailments.

Just before World War I, he successfully treated for alcohol addiction a forty year old insurance executive named Courtenay Baylor. Mr. Baylor became so interested in the idea of helping others to find themselves as he had found himself that he gave up his insurance position and became

associated with Dr. Worcester in carrying on this much needed work. In the fullness of time, Courtenay Baylor helped Richard Peabody find himself and to recover from the same affliction. Mr. Peabody also became an alcoholic specialist and among others was successful in curing Wilson Mackay, Samuel Crocker, and Francis Chambers.

In the course of their work, both Courtenay Baylor and Richard Peabody wrote a book. Baylor's book was called *Remaking a Man* and Peabody's book was called *The Common Sense of Drinking*. Several years later Mr. Chambers associated himself with E. A. Strecker, one of the country's leading psychiatrists and they pooled their knowledge of the alcoholic problem to write *Alcohol - One Man's Meat*. Since these books are more or less in a continuing tradition, it would be redundant for me to attempt to isolate here the contribution of each individual. The more so, because as we have seen in the earlier portions of this paper, many of our most "modern" findings on the alcohol problem were anticipated by some of the British pioneers over fifty years ago. Therefore, I will devote the greater part of my attention to summarizing the latest of these books and will only attempt in passing to point out a few of the more important

117 Boston, Little, Brown, 1931.
ideas which were first emphasized by the earlier writers.

Dr. Worcester did not devote much space to the problem of alcohol addiction as such. His approach was general and alcohol addiction was merely one of the neuroses. I talked with Dr. Worcester in 1939 when he was all of 83 years of age, and his mind was still actively interested in the most recent advances in psychotherapy.

Courtenay Baylor is some fifteen years younger and is still actively engaged in remaking men. In my several conversations with him I have been helped greatly not only by his explanations but by the strong confident and yet humble character of the man himself. My contact with Wilson Mackay extended over a longer period of time and was extremely beneficial to me. I received several new ideas from my eight or ten talks with Samuel Crocker and W. W. Wister of New York.

Courtenay Baylor has a powerful religious belief, not in any sanctimonious sense, but as a vital living force. He is confident of his destiny and of the destiny of the human race. This has been a powerful factor in the shaping of his character. One of the points which Baylor emphasizes is relaxation and suggestion. He has developed two or three extremely effective techniques of relaxation, by which he can take a patient whose mind is "racing" and reduce him to a state of complete relaxation in five or ten minutes. His
demonstration of this technique to me was very convincing. Much the same sort of result has been worked out in more scientific terminology by Dr. Edmund Jacobson of the University of Chicago.

Baylor believes that every case of alcohol addiction has behind it a neurotic atmosphere and that this environment must in its turn be cured. He finds similar neurotic symptoms in families that do not use alcohol. The mental states are similar and yield to similar treatment. Baylor divided alcoholics into three classes: 119

1. The alcoholic neurosis
2. Definite psychosis (insanity)

Baylor found that "the taking of the tabooed drink was the physical expression of a certain temporary but recurring mental condition,"120 and that this was due to the combination of wrong impulses and a wholly false though plausible philosophy.

These strange periods were due to a condition of the brain which seemed akin to physical tension and which set up in the mental process a peculiar shifting and distorting and imagining of values: and I have found that with the release of this 'tenseness' a normal coordination does come about, bringing proper impulses and rational thinking.

119 Baylor, op. cit., pp. 3-4.
120 Ibid., p. 6.
This same dual condition is found in the non-alcoholic neuroses of this type. There is a conflict of impulses, an instability of thought, a kaleidoscopic change of values, and with these the lack of power in the sick person to truly analyze his attitude and actions. He rarely realizes that his business, family, friends, and politics seem all wrong largely because of his own fear, depression, irritability, or distorted imagination. He consciously believes that he is fearful, depressed, or irritable entirely because of the attitude of other people. 121

... the impulse to fear or depression or irritability which is itself the result of a neurotic condition, arouses in him an attitude of mind which, as soon as it becomes apparent in his conduct - and it is inevitably translated into conduct - creates in reality the condition which he first imagined in his fear. This new and real condition now gives him a logical reason to continue and increase his fear tendency; and so he goes around the circle again and again with ever increasing momentum - fear creating conditions, and conditions creating new fears. 122

These are only a very few of the many worthwhile quotations and ideas in Courtenay Baylor's Remaking a Man, but since many of them have been incorporated into Peabody's book and later into Alcohol - One Man's Meat, I will stop with these, which are enough to indicate the very real importance of Baylor's work in the development of the psychotherapy of alcohol addiction.

3. Richard Peabody

Since so many of the ideas expressed by Richard Peabody in The Common Sense of Drinking are dealt with and

121 Baylor, op. cit., p. 10.
122 Ibid., p. 12.
elaborated in the more recent Alcohol - One Man's Meat, in this section on Peabody I will confine myself to a few of the ideas expressed in the series of seventy notes which he found especially helpful in treating his patients.

Peabody emphasized the idea that the alcoholic must always keep in mind the fact that he is giving up his drinking for his own sake, and not for the sake of his wife or mother. To be sure, other people will greatly appreciate and benefit from his ceasing to drink, but even if this were not so, it would still be the expedient thing for the patient to do. The secondary reasons are important but the primary reason of self-interest must be constantly emphasized; otherwise, if one thinks he is staying sober on his wife's account, he may use any little disagreement with her as an excuse for "showing" her that he can get even - and so getting drunk all over again.

In his treatment Peabody emphasized a many-angled attack on the problem of drinking. Among the points of approach were (1) Exercise, (2) Relaxation, (3) Reading, (4) Thought Control, and (5) The construction of a Daily Schedule. He pointed out that people have a tendency to avoid doing the one thing from which they will derive the most benefit, and that if any one of these was neglected this only resulted in placing an additional burden on the other four.
He stressed the importance of organizing one's time by means of a daily schedule to be made out the evening before:

A daily schedule prevents idleness, fixes the attention on the fact that a definite effort at re-organization is being made, and, what is more important, forms the habit of making people execute their self-imposed directions, and in this manner develop a disciplined personality.

If you cannot train yourself to act as your judgment dictates where the small things of daily life are concerned, then you have not much chance of permanently saying 'No' to liquor. You cannot make headway against such a tricky antagonist with unorganized resources. 123

Peabody states that many acts cause us displeasure because through nervousness we try to do them in a hurry.

While undue hurry is the result of tension it is also a cause of tension. A man who is fatigued by unnecessary hurry is apt to turn to alcohol to break up the resulting contracted condition.

One method of avoiding hurry is to think of what you are doing while you are doing it - and not of the next thing that you are going to do. Another is to make yourself do something with exaggerated precision once you discover yourself to be 'racing.'

In advising concerning the danger of sudden changes

123 This and the following quotations are taken directly from the notes which Peabody compiled for use with patients and which are being used effectively today by Strocker and Chambers, MacKay, Crocker, Wister, and Schnorrrenberg, among others. Since they are not available except to alcoholic patients, no good purpose would be served by listing the numbers of the notes quoted in this paper.
Peabody says:

Relapses on the part of those who are sincerely trying not to drink generally occur at some period of change, particularly when the change involves an emotion . . . Such changes are from good times to bad, from excitement to dullness, AND THEIR OPPOSITES. Changes of location as well as of occupation, even though they may be momentary, also require an extra amount of defensive preparation.

Peabody emphasizes the point that, while wise planning is a necessary preliminary, this is comparatively easy for most people.

The sustained execution of a plan is much more difficult, and so it is in this direction that willpower plays its most important part. Once a course of action has been determined upon, execute it, unless you have a very honest reason for changing your mind.

The overcoming of the alcoholic habit calls for SUSTAINED ACTION. Words and theories which do not produce this essential element in the reorganization of personality are useless.

Peabody points out that one must be doubly on his guard immediately after he has won a victory over his temptation. It is fairly common for a man to refuse several drinks at a party and then stop in at a roadhouse on his way home and get drunk. He also shows that the freedom which comes from being able to drink when one so desires is only an imaginary freedom for an alcoholic, and that real freedom consists in his throwing off the shackles of his bondage to liquor.

The discontent and restlessness which often come immediately after a man has given up liquor are turned by Peabody into an asset:
Discontent Is The First Stage of Achievement

The early stages of permanent sobriety are often accompanied by feelings of discontent and irritability. This should cause you no surprise or discouragement. On the contrary, it is the first step in the direction of accomplishing something. Every worthwhile step in the advancement of the human race was initiated by men who were dissatisfied with things as they were. Nothing has ever yet been achieved by men who were complacently satisfied with life and with themselves.

In your drinking days, whenever discontent appeared you promptly drugged it with alcohol, creating a momentary illusion of well-being, power, good nature and achievement, which was immediately followed by an increased discontent and depression. In other words, your creative instinct was smothered by means of a narcotic the moment it showed any signs of asserting itself. Now if the drug is no longer used, discontent eventually turns it into ambition. If a man is discontented long enough he will proceed to do something about it, and in this process of doing something which legitimately satisfies the desire for self-expression, real action takes the place of alcoholic phantasy.

Peabody also points out that practically every excessive drinker has been through a stage of normal drinking earlier in his life and that it is this type of drinking that he is continually hoping vainly to recapture. The patient must be made to realize that alcohol has now become a physiological and psychological poison to him and that he will never be able to drink normally again.

Since the mind is never completely blank, old thoughts can be removed only by substituting new ones which are constructive. An alcoholic should try to forget himself in other interests, use his imagination, cultivate a hobby, etc.
With regard to emotional stimulation, Peabody writes:

It is common knowledge that the unpleasant emotions - anger, worry, and sorrow - serve as good excuses for drinking. It is not so well recognized but equally true that the pleasant emotions, particularly if they are accompanied by excitement, have a similar relationship. Strangely enough men have to learn to withstand success and happiness just as surely as they do unhappiness and failure.

Intellectual conceptions are only a starting point. Ideas as purely theoretical conceptions have little or no value except as starting points for action ... a passive theorizing which does not lead to action is useless.

Peabody taught his patients that they were learning something far more important than merely how to stop drinking.

Sobriety is an essential preliminary but only a preliminary to a contented life, and it is the contented life that you are in search of. When the inner personality, which you were so unsuccessfully trying to escape from in drink, is so changed that you no longer want to escape from it, you will be living enjoyably rather than merely existing in a nervous and depressed state of mind.

The alcoholic has already exhausted the pleasures of drinking. He may have had some glorious parties in the past, but now all he gets from his drinking is unhappiness. "The good old daze" can never be recaptured, but far better days can be created if the patient is willing to work toward the objective of giving up liquor for good and all. Associations of ideas relating to the "good times" had on former alcoholic occasions must be broken up and redirected so that the ex-
ceedingly bitter end consequences are emphasized rather than the ideal parties of long ago.

The Creative Urge

All men have in them a definite urge to create, though they may not always be aware of it. Whether they paint pictures, build bridges, sell bonds, cultivate a garden, or run for public office, they are in each case satisfying the instinctive desire for self-expression. Where this normal desire is frustrated, its force is not extinguished but turned inward, causing a morbid pre-occupation with the frustrated ego, and returning to consciousness in the form of worry, dissatisfaction, and at best boredom.

To put it the other way round, these unpleasant attitudes toward life are symbolic expressions of the repressed urge to express ourselves in creative action - a most unsatisfactory solution of a problem that must be logically solved, and which can never be made anything but worse by resorting to alcohol. Becoming intoxicated is most assuredly not a creative act, though the state of mind that goes with it in the early stages seems to be one of self-satisfaction that is unfortunately somewhat similar to that resulting from actual achievement. It is the desire for this feeling, without the willingness to do anything to produce it legitimately, that is the cause of much intoxication. The drinking of alcohol is an attempted short-cut to happiness, but the nervous tension and feelings of inferiority which follow prove it to be a most deceptive form of relaxation and ego-satisfaction.

These quotations will give some idea of the tremendous amount of energy which Peabody devoted to the study of alcoholism. He carried on and brought up to date Baylor's earlier work, and, especially since Remaking a Man was out of print, Peabody's The Common Sense of Drinking filled a long felt need for a book which would appeal to alcoholics
in a language they could understand. Peabody did considerable research on this problem at Harvard and around Boston and his work has had great influence on one of the foremost present-day schools of alcoholic treatment.

Bowman and Jellinek state\(^{124}\) that:

In this country, Peabody has probably exerted more influence than anyone else on the psychotherapy of alcohol addiction. His reeducational program proceeded in nine steps as follows:

1. A mental analysis and removal of doubts, fears, conflicts created in the past.

2. Permanent removal of tension, which is only temporarily released by alcohol, by formal relaxation and suggestion.

3. Influencing the unconscious mind by suggestion 'so that it cooperates with the conscious to bring about a consistent intelligent course of action.'

4. Control of thoughts and actions.

5. Hygiene.

6. Daily routine of self-imposed schedule to keep the patient occupied, to train his will-power and efficiency, and to give him the feeling that he is doing something about his problem.

7. Warning the patient against unexpected pitfalls.

8. Providing the patient with some means of self-expression.

9. Realization that the same force which drove the patient to disintegration will, under conditions of sobriety, carry him beyond the level of average attainment.

\(^{124}\) In Quarterly Journal of Studies on Alcohol, June, 1941, pp. 159-160.
A more detailed outline of Peabody's line of attack on the problem of alcohol addiction will be found on pages 125-30 where Dr. Seliger's thirty-five points are listed, all of which are taken directly from the works of the late Richard Peabody.

4. Strecker and Chambers

We now come to the latest and culminating book written in the tradition which was begun by Dr. Worcester and Courtenay Baylor more than a quarter of a century ago - Alcohol - One Man's Meat, by Dr. Edward A. Strecker and Francis T. Chambers. This is the book which I have thus far found most helpful in my work with alcoholics and, therefore, I will give a fairly substantial summary of its main methods of attack on the problem of alcoholism.

Francis T. Chambers himself suffered from alcohol addiction some years ago and was enabled to find himself again largely by means of Peabody's method of psychotherapy. After his own cure Chambers, remembering his own sufferings, remained greatly interested in helping others out of similar difficulties. He felt the need of putting the work on a sound scientific basis and so enlisted the aid of one of the

country's foremost psychiatrists, Dr. Edward A. Strecker of the University of Pennsylvania School of Medicine and the Pennsylvania Hospital. These two men have been associated in work with alcoholics now for several years with a considerable amount of success. The facilities have been available to them to keep medical and psychological case records of numerous patients, and in 1938 they embodied their more significant findings in a book. The material which I herewith present is taken from its pages.

In the first place, Strecker and Chambers point out that there are certain types of individuals who occasionally use alcohol to excess, who are not fundamentally alcoholic at all. These are (1) the mentally sick, (2) the mentally defective, and (3) the psychopathic inferiors. As a rule, morons, manic-depressives, and constitutional psychopathic inferiors do not respond to the usual forms of treatment, or indeed to any treatment. The attempt of doctors to deal with such individuals has been the cause of much of the defeatism surrounding the whole question of alcoholic rehabilitation. Concerning these types Strecker and Chambers say:

They are not fit subjects for psychological re-education and often exert a destructive influence on sincere men who are earnestly endeavoring to overcome alcoholic addiction. This type must be separated in diagnosis from the abnormal drinker who can be helped. They are crippled personalities in which a capacity for even a fractional response
to treatment has been destroyed or never existed, and it is as futile to expect from them a sincere application to a reeducational program as it would be to expect a one-legged man to run a race.126

Strecker also singles out as unfavorable for treatment (4) the aggressive type—temperamentally antisocial and inconsiderate, (5) the unstable type—by nature impulsive, impatient, restless, and impetuous, (6) the adynamic or dull type—made up of those who have little or no ambition or drive and are usually at a low economic level, and (7) a primitive type—made up of individuals also living at a very low economic level, whose behavior is largely instinctive and whose reactions appear in extremely simple patterns.127

Outside of these groups, however, there remains a very large segment quite favorable for treatment—consisting mostly of "potential psychoneurotics". The alcoholism in practically all of these cases is simply a symptom of some hidden emotional-mental difficulties and the mere fact that a man drinks to excess is no more an indication of his basic trouble than is a headache or a fever an indication of underlying bodily illness.

Strecker and Chambers view alcoholics in three dimensions:

1. They have a strong tendency to shut out or escape from reality,

127 Ibid., pp. 27-8.
2. They usually have an ingrowing or introverted personality, and

3. There is usually a definite neurotic nucleus. 128

One might almost regard emotional immaturity as the seed, introversion as the soil, and the psychoneurosis, alcoholism, as the growth that is produced. 129

At least ninety percent of the patients treated by Strecker and Chambers have been introverted - that is, their self-critical faculties have caused them to be painfully conscious of their position in real life. They tend to be sensitive and self-analytical and to shrink from the ugliness and squalor, and the sordid competition of reality. Alcohol brings such individuals into free and easy human contact such as they very rarely are able to achieve without its help. It helps them to compensate for the distressed feelings of abnormal introversion by temporarily extroverting or socializing themselves with alcohol. Such individuals are likely to have set their life standards and goals too high (cf. Adler) and to feel inferior because they sense that they will not be able to attain these ideals. Drink produces stuporous phantasies in which they attain for the time being in their imaginations the ideals for which they strive. 130 When a man is drunk, he is "King for a day."

128 Strecker and Chambers, op. cit., pp. 41-42.
129 Ibid.
130 Ibid., p. 42.
These authors found that seventy percent of their patients had an unfavorable home life and that eighty-five percent of them had a constitutional predisposition to alcohol addiction. They agree with most authorities that the tendency to excessive drinking is not inherited and endorse the following statement of Richard Peabody:

What unquestionably is inherited is a nervous system which proves to be non-resistant to alcohol, though this same nervous system is more often acquired from neurotic parents who have expressed their nervousness in some other manner than that of chronic intoxication. Just as a disposition to weak lungs is inherited and not tuberculosis itself, so I believe is a nervous system transmitted which is highly susceptible to alcohol and which may manifest itself in a variety of symptoms regardless of the original manner of expression. An investigation of the inheritance of alcoholics indicates in almost every case a neurotic history at least on one side of the family, and often to an extreme degree.131

One interesting point brought out by these authors (and which I have frequently noticed in patients) is the tendency of drunkards to search out drinking places where he can mingle with an intellectually inferior and less morally-conscious group than he finds at his usual social level. It seems to us that often this merely represents a compensation for self-nagging inferiority. He escapes the pity and censure of his own social group, and purchases a bit of approbation and ego-maximization. One may note the

131 Quoted from Richard Peabody, op. cit., p. 15.
same reaction in non-alcoholic inferiority. 132

It is pointed out that the psychologist must use a great deal of tact and patience not only in dealing with the patient but also in dealing with his family. All too frequently the family is deceived by the post-spree alcoholic optimism of the drinker and permit themselves to be convinced that "it will never happen again." Their "hush hush" attitude about the whole situation complicates matters, and often they are unwilling to accept the true seriousness of the drinker's condition after the spree is over and he looks "in the pink" again. Frequently the family do not respond to the psychologist's constructive suggestions as to how the patient should be handled. 133

To many alcoholics the attainment of normality means learning how to drink normally or moderately as they were able to do during the first years of their experience with liquor. Most psychologists, among whom are Strecker and Chambers, agree that this cannot be done. If the patient still thinks it can be, he is advised to go out and try it. One or two trials will usually convince him that the psychologist was correct, and then he will be more willing to listen to reason and work toward the goal of complete abstinence - for life. Once the patient makes this surrender

132 Strecker and Chambers, op. cit., p. 112.
133 Ibid., p. 119.
and the idea has had time to sink into his unconscious mind
the terrific alcoholic conflict which torments him even
during his periods "on the wagon" will disappear and leave
him with a new and extremely pleasant tranquility of mind. 134

The following quotation gives a good brief outline
of just what these therapists are trying to do for the
alcoholic:

In a period of treatment lasting a year, or
sometimes longer, we hope to accomplish a gradual
maturing process, the treatment terminating, not
in a rebellion, but in a feeling of justifiable
independence, mutually accepted by the patient
and the therapist. What has happened in effect
is that the patient, having failed during child­
hood and adolescence to make his own emotional
adjustment, retraces with us his life course, and
re-makes, or makes anew, an emotional adjustment
that will fit into a reality that demands such
adjustment. 135

Some patients have one or several relapses after
undertaking the treatment; others never take another drink
after their first interview with the psychologist. Relapses
are by no means necessary and they are rather distressing
ordeals because of a temporary breakdown in the newly re­
constructed psyche. The reasons behind the relapse should
be discussed with the therapist as soon as possible after
it occurs. There is no preaching by the psychologist. He
knows that the patient has already suffered his own little

134 Strecker and Chambers, op. cit., p. 135.
135 Ibid., p. 145.
private hell of mental anguish. No great damage is necessarily done by these relapses except that they lengthen the time necessary for treatment and are thus doubly costly in cash to the patient; he not only spends a lot of money on the spree, but he must also pay extra money for additional interviews. Incidentally, this is one reason why alcoholic psychologists usually insist on collecting at least one month's fees in advance. Otherwise, the patient may figure (unconsciously) that he could use a week's treatment money to drink on. For example, if a man is paying twenty-five dollars a week for three to five hourly interviews, he might unconsciously plan to take this twenty-five dollars and spend it on half a case of good whiskey. But if he knows that these interviews are already paid for and that the money is not returnable, he is more likely to make sure of getting his money's worth and continuing with the treatment.

In giving a summary of their treatment, Strecker and Chambers divide it into four main categories: Rules, Psychological, Reeducational, and Physical, as follows: 136

I. Rules

1. An understanding on the part of the patient of the seriousness of the condition, and the development of a desire to take the treatment.

2. There must be abstinence from alcohol during the period of the treatment.

3. The patient must be entirely frank and honest in all his dealings with the therapist.

4. In the event of a relapse, the patient must notify the therapist, or see that he is notified as soon as possible.

II. Psychological Phase of Treatment

This consists of about one hundred hours spent in conference with the therapist.

1. There is considerable psychological value in the therapist's impersonal, unemotional, and objective attitude toward alcoholism; also in the thought that the therapist accepts only those cases which he thinks will recover.

2. A satisfactory rapport must be arrived at and by catharsis or confession the therapist digs out the underlying causes of the alcoholism.

3. A conditioned reflex with respect to alcohol is established. The patient is taught that whenever any alcoholic thought enters his mind, he must not repress it but must relive all the unhappiness and misery which alcohol has caused him and contrast this with the happiness of a non-alcoholic future.

4. The patient's rationalizations, dreams, and relapses, if any, are exhaustively analyzed and their significance and real meaning uncovered.

5. It is reiterated that the patient is getting well primarily for his own good and that the only way to recover is to renounce alcohol forever. The ultimate goal is not abstinence but emotional maturity from which abstinence will naturally follow.

6. The patient is taught how to achieve complete relaxation.
III. Reeducational Phase of Treatment

1. Bibliotherapy - notes on selected outside reading.
2. Following a schedule of daily activities.
3. The development of hobbies.
4. The consideration of a change of vocation.
5. Copying and meditating on some seventy notes which represent the crystallization of many years of experience with alcoholics.
6. The development of a better attitude toward family and friends.

IV. Physical Phase of Treatment

1. Deciding whether preliminary hospital or sanitorium care is necessary.
2. Getting the patient into good physical condition.
3. Exercise and diversion.
4. Caution against letting over-fatigue occur.
5. Particular attention to nutrition and metabolism, especially in relation to blood sugar and Vitamin B1.

Strecker and Chambers have a special chapter at the end of their book on "Physiological and Nutritional Factors". This phase of the treatment of course falls within the province of the physician rather than the psychologist. The findings of this chapter, corroborated by other similar findings, are that in the rebuilding of the body to better resist alcohol the use of Vitamin B Complex and Dextrose is extremely important. The continued use of alcohol causes
the individual to neglect the proper diet leading to vitamin deficiency which must be repaired. Also various tests have shown that when the peculiar alcoholic nervousness comes over a person just prior to his taking a drink, the blood sugar content of his body is dangerously low. At such times the eating of dextrose-rich substances is very helpful in warding off the temptation to take a drink.

5. Charles H. Durfee

In his recent book, To Drink or Not To Drink, Dr. Charles H. Durfee gives a clear and readable analysis of the underlying causes behind abnormal drinking and outlines the methods which he has found effective in treating "problem-drinkers". Dr. Durfee prefers the term "problem-drinker" to "alcoholic" because of the disagreeable connotations of the latter word, and also because many individuals are definitely "problem-drinkers" as he defines the term, who have not as yet arrived as clearly defined "alcoholics". Durfee defines a problem-drinker as one who feels an imperative urge to drink at certain times or on certain occasions, as well as one who by his drinking endangers his health, his peace of mind, his home life, his

137 Durfee, Charles H., To Drink or Not To Drink, Longmans, Green, 1937.
business, or his reputation. In the Preface, Durfee pays tribute to the previous works of Arthur H. Ruggles, M. D., Elwood Worcester, D.D., Courtenay Baylor, and Richard Peabody, alcoholic pioneers all.

Dr. Durfee has established a farm in Rhode Island where he re-educates his alcoholic patients over a period of several months so that they will be able to reassume their rightful places in society. He agrees with most of the other alcoholic specialists that alcohol addiction is merely a symptom of some underlying maladjustment of the patient's personality and he aims his therapy at the underlying difficulties rather than superficially at the alcohol addiction itself. Other maladjusted individuals with different backgrounds find their escape in eating too much, smoking too much, or in a restless search for pleasure in speeding, movies, bridge, sex experiences, domination of others, an abnormal passion for neatness, greed, miserliness, nagging, or other emotional outbursts.138

Dr. Durfee's approach to the problem-drinker's rehabilitation follows the Gestalt or Configurational outlook as expounded in this country by Kurt Lewin. The entire drinking situation is considered, including the patient's family, environment, the limitations imposed on him by his

work and recreation, and his general social background, in other words his total situation. He envisages the whole man as a dynamic entity functioning in the social environment. The symptom, alcohol addiction, is noted only very incidentally as probably the most conspicuous but certainly not the most significant aspect of him. In order to remove the symptom he must first search out the patient's unconscious ambitions and innermost yearnings.139

Dr. Durfee favors a temporary change of environment for the patient, an environment in which he will have greater freedom for self-expression - not less, where he will have more variety and interest - not monotonous institutional routine. He must learn how to relax and how to work and play in association with normal people. He lets the patient be useful and even important; he lets him win success; in short, he shows him a more satisfying way of life which eliminates the necessity of depending on alcohol to put him temporarily in a dream-world of his own. He lets the patient lead a normal life in a protected environment which provides the special help which his individual needs require. Dr. Durfee finds ideal for this purpose a fairly good sized farm near a village so that the patients can play an active role in the life of the community around them. The patients

"get a kick" out of getting back close to mother earth. The occupational therapy of farm work and the close association of patients and psychologist in working, swimming, and riding together is very provocative of odd moment recollections and confessions of important experiences in the patient's past life which may not be recalled during formal periods of psychotherapy. Group digging seems to have an excellent therapeutical effect.\(^{140}\)

Psychoanalysis is not usually found necessary for a patient's recovery. Durfee feels that the Adlerian concepts of feelings of inferiority, the inability to face reality, and the leading of "a wrong style of life" constitute a more logical interpretation of the problem-drinker's difficulties than the "pleasure principle" of Freud. The problem-drinker is apt to be socially unsure and unadapted, and to have an infantile need for self-assertion. It is the therapist's task to help him achieve a sense of satisfaction and importance by more wholesome means than that of alcohol. "Perhaps we all suffer to some degree from what Jung calls 'the general neurosis of our time ... the senselessness and emptiness of our lives.'\(^{141}\)

An understanding of the problem alone, although an essential foundation, does not usually effect a cure. The

\(^{140}\) Durfee, \textit{op. cit.}, pp. 20-21.

\(^{141}\) Ibid., pp. 68-69.
patient must also learn how to live without alcohol, and to this end the therapy must be continued over an adequate period; this period occasionally requires two or three months, but more often from six months to a year. The number of weekly interviews are gradually decreased and the patient gradually returns to his work for two or three days a week until finally he is spending only his week-ends at the farm.142

The physical examination by a physician which always precedes the psychotherapy usually serves to reassure the patient that despite his drinking, he is still in pretty good physical condition and that alcohol has not eaten away parts of his vital organs as the older prohibitionist charts depicted. Durfee thinks it best to let a man taper himself off gradually over three days under the supervision of a patient who has been at the farm long enough to be safe. This also serves to give the old timer a sense of usefulness and responsibility inasmuch as he has full charge of a quart or more of liquor for three days. He finds that a night's sleep with an untouched glass of whiskey at his bedside gives the patient a new faith in himself and in his treatment.

Dr. Durfee considers it useless and unavailing to try to persuade a man at the beginning that he can never hope

142 Durfee, op. cit., p. 74.
to drink normally again. At this time a man is incapable of any real perspective and he always has mental reservations that somehow, some day, he will be able to drink like a gentleman. To express an opinion to the contrary is to discourage him needlessly; at a time when he has become better adjusted, he will see complete abstinence as his only solution. The cure lies in diverting the patient's attention away from the symptom - alcoholism. He is helped in establishing an inner harmony of mind. The therapist tries to make life so full and active for him that the problem of drinking automatically ceases to have any place in his life. Some landmarks in his recovery are: (1) the change of attitude from shame to pride concerning the treatment and the desire to help other fellow sufferers, (2) the ability to see himself and his former excuses for drinking objectively and thereby to realize that he was only fooling himself all the time. After the patient has been at the farm for a while he is made responsible for a newcomer which, besides helping the new recruit, develops in himself a sense of responsibility and satisfaction.\textsuperscript{143}

\textsuperscript{143} Durfee, \textit{op. cit.}, pp. 93-94.

During the inevitable periods of temptation Dr. Durfee suggests exercise such as squash or rapid walking or fifteen minutes devoted to relaxation or a short nap. During the periods just after leaving the office or just be-
before dinner (cocktail time) dangerous periods of temptation can thus be overcome. If a man just has to visit his club or favorite bar, he is advised to sip a tall glass of ginger ale and lime or some similar concoction. When a patient is tapering off either at home or at the farm, sedatives are frowned upon and the patient is reduced from six drinks of his favorite beverage the first day to two drinks on the third and last day of the tapering process.

In summing up, Dr. Durfee says:

Given a certain inner maladjustment, due to a deviation or insufficiency of personality, plus a certain constitutional or acquired intolerance of alcohol, plus long-standing habit patterns of drinking, the result is a problem-drinker. While the psychological difficulties may be adjusted, and the habit patterns submerged — always with the chance that they can be revived by an adequate stimulus — in my opinion a person's intolerance of alcohol must always be reckoned with.

The problem-drinker should, therefore, recognize and face the fact that he must forego intoxicants for all time, and learn to accept his intolerance of alcohol as an individual limitation just as others accept their limitations in other situations of life. If he has achieved the basic integration of personality which is the essence of cure, this should not be difficult for him. For he will find that life can have meaning for him without alcohol. 144

6. **Dr. Robert V. Seliger**

Dr. Seliger of Johns Hopkins has what seems to me one of the soundest approaches to the treatment of those afflicted with addiction to alcohol. As to apparent causes of addiction he usually finds one or more of the following: 145

1. As escape from situations of life which the drinker cannot face
2. As evidence of a maladjusted personality (including sexual maladjustments).
3. As a development from social drinking to pathological drinking.
4. As a symptom of a major abnormal mental state such as depression or schizophrenia.
5. As an escape from incurable physical pain.
6. As a symptom of a constitutional inferior - an individual who drinks because he likes the way alcohol makes him feel, knows he cannot handle it, but doesn't care.

Frequently it is impossible to pick out any one outstanding reason but it can be determined that "alcohol is taken to relieve a certain vague restlessness in the individual incident to friction between his biological and emotional make-up and the ordinary strains of life." 146

After ascertaining the apparent reason for drinking Dr. Seliger determines to which of the following classifications...
tions of alcohol addicts the patient belongs: 147

1. The individual who wants to abstain but can't do it by himself. This type of patient can be handled in outside office practice if he has good life habits, contacts, and intelligence with some maturity in his make-up.

2. Same as above but with poor habits and contacts. He must go to a rest home farm for psychotherapy and guidance away from his poor contacts.

3. Individual with good intelligence but immature make-up who ought to abstain but doesn't want to. Probably has poor habits and contacts. Should be placed on alcohol farm or sanitarium under the Inebriate Act for a definite length of time.

(Seliger's other three classes refer to patients with psychoses, alcoholic deterioration, D.T.'s and feeble-mindedness, so need not be discussed in this paper).

Seliger's office treatment consists of the immediate withdrawal of alcohol with the goal of total abstinence. The patient must be made to realize that his rehabilitation will be costly in time and money and that the goal is a long and a hard one. Interviews come at least three times a week and gradually decrease. Sedatives may be necessary along with increased sugar intake and heavy doses of Vitamin B. There may be poor vocational or marital adjustments. New hobbies and activities are suggested. Old drinking friends and meeting places must be given up. In all this the personality of the physician is very important

147 Loc. cit.
and he should approach the patient with sympathy and kindness rather than with recriminations, etc. Better results are usually obtained by physicians who are total abstainers themselves. 148

When I talked with Dr. Seliger in Baltimore, he presented me, among other things, with a little printed slip containing thirty-five excellent points 149 and entitled "Common-Sense Re-education of the Abnormal Drinker." They are so good and so comprehensive that I should like to list them here:

1. He (the drinker) must be convinced from his own experience that his reaction to alcohol is so abnormal that any indulgence for him constitutes a totally undesirable and impossible way of life.

2. He must be completely sincere in his desire to stop drinking once and for all.

3. He must recognize that the problem of drinking for him is not merely a problem of dissipation, but of a dangerous psychopathological reaction to a (for him) pernicious drug.

4. He must clearly understand that once a man has passed from normal to abnormal drinking, he can never learn to control drinking again.

5. He must come to understand that he has been trying to substitute alcoholic phantasy for real achievement in life, and that his effort has been hopeless and absurd.


149 All thirty-five of these points are taken directly from the works of the late Richard Peabody.
6. He must recognize that giving up alcohol is his own personal problem which primarily concerns himself alone.

7. He must be convinced that at all times and under all conditions alcohol produces for him, not happiness, but unhappiness.

8. He must come to understand that the motive behind his drinking has been some form of self expression, some desire to gratify an immature craving for attention, or to escape from unpleasant reality in order to get rid of disagreeable states of mind.

9. He must understand that alcoholic ancestry is an excuse, not a reason for abnormal drinking.

10. He must realize that any reasonably intelligent and sincere person, who is willing to make a sustained effort for a sufficient period of time, is capable of learning to live without alcohol.

11. He must fully resolve to tell the truth and the whole truth, without waiting to be asked, to the person who is trying to help him - and he must be equally honest with himself.

12. He must avoid the small glass of wine - that is, the apparently harmless lapse - with even more determination than the obvious slug of gin.

13. He must never be so foolish as to try to persuade himself that he can drink beer.

14. He must never be so childish as to offer temporary boredom as an excuse to himself for taking a drink.

15. He must disabuse his mind of any illusions about alcohol sharpening and polishing his wit and intellect.

16. He must learn to be tolerant of other people's mistakes, poor judgment, and bad manners, without becoming emotionally disturbed.

17. He must learn to disregard the dumb advice and often dumber questions of relatives and friends, without becoming emotionally disturbed.
18. He must recognize alcoholic day-dreaming - about past "good times", favorite bars, etc. as a dangerous pastime, to be inhibited by thinking about his reasons for not drinking.

19. He must learn to withstand success as well as failure, since pleasant emotions as well as unpleasant ones can serve as "good" excuses for taking a drink.

20. He must learn to be especially on guard during periods of changes in his life that involve some emotion or nervous fatigue.

21. He must try to acquire a mature sense of value and learn to be controlled by his judgment instead of his emotions.

22. He must realize that in giving up drinking he should not regard himself as a hero or martyr, entitled to make unreasonable demands that his family give in to his every whim and wish.

23. He must beware of unconsciously projecting himself into the role of some character in a movie, book, or play who handles liquor "like a gentleman", and of persuading himself that he can - and will - do likewise with equal impunity.

24. He must learn the importance of eating - since the best preventive for that tired nervous feeling which so often leads to taking a drink is food - and he must carry chocolate bars or other candy with him at all times to eat between meals and whenever he gets restless, jittery, or tired.

25. He must learn how to relax naturally, both mentally and physically, without the use of the narcotic action of alcohol.

26. He must learn to avoid needless hurry and resultant fatigue by concentrating on what he is doing rather than on what he is going to do next.

27. He must not neglect care of his physical health, which is an important part of his rehabilitation.
28. He must carefully follow a daily self-imposed schedule which, conscientiously carried out, aids in organizing a disciplined personality, developing new habits for old, and bringing out a new rhythm of living.

29. He must never relax his determination or become careless, lazy, indifferent, or cocky in his efforts to eliminate his desire for alcohol.

30. He must not be discouraged by a feeling of discontent during the early stages of sobriety, but must turn this feeling into incentive to action which will legitimately satisfy his desire for self-expression.

31. He must not drop his guard at any time, but especially not during the early period of his reorganization, when premature feelings of victory and elation often occur.

32. He must understand that, besides abstinence, his real goal is a contented and efficient life.

33. He must appreciate the seriousness of his re-education, and regard it as the most important thing in his life.

34. He must realize that most people seeking psychological help for abnormal drinking are above average in intellectual endowment, and that, while drinking means failure, abstinence is likely to mean success.

35. He must never feel that any of these commandments are in any way inconsequential, or secondary to business, play, or whatnot; and he must conscientiously observe every one of them, day in and day out.
CHAPTER V

EVALUATION OF SUCCESS IN TREATMENT

We have now surveyed the principal methods which have been used for the permanent rehabilitation of alcoholics during the past hundred years. There has been no reference to continental European methods of treatment for many reasons. This field was investigated in 1936 by Dr. Robert Fleming of the Peter Bent Brigham Hospital in Boston and in his reports and in conversations with me he has stated that, while there is much more social recognition of the problem in Europe, with the government providing free information and some low cost institutional treatment (in such countries as Sweden, Austria, and Switzerland), the usual treatment consists largely of mere physical rebuilding without much attention to the psychological maladjustments which must be removed before any permanent results can be obtained.

In Austria (1936) and Switzerland, Dr. Fleming found small clinics doing some sound psychological work in addition

to the method of physical upbuilding. Since then Austria has become a part of Greater Germany and is included in the latter's policy of sterilizing chronic alcoholics in order to attain ultimate racial purity. This leaves the United States at the present time as the leading exponent of treating alcoholics with psychotherapy to attain permanent results. So far as I have been able to ascertain, there are no unique European or other methods of psychotherapy for alcoholics which are not covered in this paper.

Dr. Fleming concludes that: 151

.... in no place [in Europe] is the problem of the treatment of chronic alcoholism being attacked in an objective, dispassionate, and experimental manner.

.... in Sweden social workers, in Germany the geneticists, in Switzerland the moralists, and in Vienna an overworked psychiatrist do the actual work, while in England the community has a laissez-faire attitude and no one is responsible ... In fact the whole field of alcoholic work is characterized by a lack of effective cooperation and intellectual distinction .... at one time or another practically every form of therapeutic approach has been successful — religious conversion, psychoanalysis, apomorphine counterconditioning, hypnosis, abstinence clubs, legalistic and economic reforms, the several varieties of institutional routine. The problem becomes one of determining the variety of therapeutic approach best suited to the personality and situation of any given individual drunkard.

I am in hearty agreement with this formulation.

I do not know of anyone qualified to judge of the percentage of permanent cures achieved by all of the methods of alcoholic psychotherapy described in this book. Claims of success are made by the practitioners of various methods which are at wide variance with the findings of impartial researchers. Definitions of recovery from alcohol addiction vary from total abstinence for a period of six months to a period of ten years. There have been relapses after fifteen years of abstinence. Also, is a man cured if his relapses have been made so infrequent as not to seriously interfere with his job and family happiness? For the typical alcoholic I prefer Dr. William S. Sadler's conception of recovery which is eighteen months without alcohol in any form. If a man can go that long without liquor he can go forever if he so chooses, and if he deliberately chooses to go back to drinking after so long a period of abstinence, the psychologist cannot be held responsible. To be fully cured, of course, the patient must develop real emotional maturity and not merely substitute some other (and perhaps worse) symptom of his inadequacy for his alcohol addiction. In giving this evaluation of success of the various methods I am using my own judgment combined with that of qualified psychiatrists and patients with whom I have conversed or corresponded. It must be remembered that most percentages of cure given out by various institutions
are based primarily on follow-up letters, returns from which are usually small; and it is usually assumed that those patients not answering are cured. It is my opinion that the contrary assumption would be more justified.

A. The Primarily Physiological Treatment

In this paper I have not discussed the commercial cures, by which I mean those hospitals and sanitariums which specialize in sobering the alcoholic off over a period of from two days to two weeks. This period is much too short for any constructive psychotherapy although some such institutions make some pretense of a two or three months follow-up with vitamins, etc., and refer their patients to free-treatment organizations such as Alcoholics Anonymous. In the body of this dissertation medical opinion is offered as to the general worthlessness of such "cures" although there will occasionally occur a case who was not a true alcoholic who claims to have been cured by such superficial methods.

Keeley

A scientific study made some years ago estimated that the Keeley method achieved permanent results in about one-tenth of its cases; this percentage is no better than chance and possesses no scientific validity.  

152 Quarterly Journal, Sept. 1940.
Dr. Cowles seems to believe that the patient is cured once his spinal pressure is reduced and the poisons removed from the spinal fluid. He feels that it is then the patient's own fault if he resumes his drinking. However, the patient may still be suffering from chronic food poisoning and emotional immaturity and inadequacy. This method is not generally accepted by the medical profession. I do not happen to know of any cases permanently cured by spinal punctures alone.

B. The Primarily Psychological Treatment

Conditioned Reflex

The refiners of this Pavlovian method of treatment at the Shadel Sanitarium in Washington believe that they have achieved cures lasting four years in about two-thirds of their patients. Cruder methods similar to this have been used for many decades without permanent results. These doctors assert, however, that by refinement of technique and conditioning to gin, wine, beer, brandy, scotch, rye, and ale separately they are getting the above results. Most of the medical men with whom I have talked were extremely sceptical.

Hypnosis

Bramwell claimed to have cured about two-thirds of
extremely difficult cases by hypnosis alone. His own personality must have had a great deal to do with it, since most physicians place no stock in such methods.

Psychoanalysis

The psychoanalysts have not been very successful with alcoholics. Somewhat better success is reported by the Jungians and the Adlerians, many of whose principles have been incorporated into the therapy of the Peabody-Strecker School.

General Semantics

General Semantics therapy has not been used widely enough by itself to justify any percentage estimates. Dr. Lynn found it extremely effective in two out of three cases some years ago.

Alcoholics Anonymous

Alcoholics Anonymous is too young an organization to be sure of any significant results as yet. Its great present popularity (as of Jan. 1942) and extensive membership is of only a few years duration. I should suspect the majority of its "cures" of being temporary and short-lived since no adequate provision is made for the gradual development of emotional maturity and for the elimination of food and other poisoning.
C. The Combined Approach

Nossen implies that most intelligent patients are curable if they will only continue the treatment and not become discouraged.

Dr. Norman Kerr both at his Dalrymple and Fort Hamilton Homes in England during the late 19th century was apparently achieving in the vicinity of 30 percent complete cures. Following is a breakdown of his figures for the two homes over an eight and one half years' period:

<table>
<thead>
<tr>
<th>Dalrymple Home for Alcoholics</th>
<th>Fort Hamilton Home</th>
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<tr>
<td>Discharged</td>
<td>305</td>
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<td>Heard from</td>
<td>220</td>
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<td>Doing Well</td>
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<td>Improved</td>
<td>23</td>
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<tr>
<td>Not Improved</td>
<td>102</td>
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Dr. Hugh Wingfield in the early part of the nineteenth century, out of 311 cases, reported 39% well after one year and 22% relapsed within the year. A year is, of course, not at present considered a permanent cure; estimates of the latter run all the way from 18 months to 5 years.

Dr. Charles F. Durfee estimates\textsuperscript{153} that approximately 70 percent of the men who spend an adequate period (in-

\textsuperscript{153} Stated in letter to me dated 12/19/41.
dividual variance from six weeks to six months) at his Farm can show a minimum of a year and a half of complete abstinence, and have successfully returned to normal life. Durfee considers as even more important than the abstinence, their ability to carry on successfully in their home and business situations, meeting their daily problems realistically and in a more adult manner.

It must be remembered, of course, that the results achieved depends in large part on the type of patient dealt with and on his willingness and ability to cooperate in the treatment. Bowman and Jellinek\textsuperscript{154} quoting from Wlassak in the Quarterly Journal regard the following as poor therapeutic risks: (a) those who were already heavy drinkers at the age of 20; (b) infantile alcoholics of higher age; (c) alcoholics over 50; (d) lonely, artistic drinkers; (e) schizoid drinkers; (f) alcoholics with organic brain changes; (g) alcoholics with disordered home conditions; (h) divorced alcoholics; and (i) drinkers in alcoholic professions who remain in the profession.

Voegtlin, as previously mentioned, had no success with patients under 28. Most of the alcoholic specialists with whom I have talked have agreed with me that successful treatment is very problematical under 35 and the prognosis

\textsuperscript{154} Quarterly Journal, June, 1941, p. 165.
is best over the age of 40. Women addicts are notoriously more difficult to cure than men. 155

Bowman and Jellinek conclude: Thus it seems safe to estimate that with fairly elaborate psychotherapy, a minimum of 25 per cent success may be expected in public institutions," 156 while pointing out that these are unselected cases whose treatment never really had a fair break because of the heterogeneous population of such institutions. They go on to say:

Thus, one could infer that if the indiscriminate application of psychotherapeutic methods results in 25 per cent success, variation of treatment based on selective principles would bring a considerably better result. 157

From private conversations, chiefly with followers of the Baylor-Peabody school, this is also my own conclusion. With selected cooperative patients they are probably achieving satisfactory results in anywhere from 40 to 50 per cent of their cases.

155 Quarterly Journal, June, 1941, p. 166.
156 Ibid., p. 167.
157 Ibid., p. 169.
<table>
<thead>
<tr>
<th>Alcoholism: a disease</th>
<th>Kerr</th>
<th>Clum</th>
<th>Wingfield</th>
<th>Bramwell</th>
<th>A.A.</th>
<th>Diethelm</th>
<th>Carroll</th>
<th>Nessen</th>
<th>Baylor</th>
<th>Peabody</th>
<th>Strecker</th>
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<td>Self-knowledge</td>
<td>Peculiar Temptation</td>
<td>Craving for Mental Effects of Alcohol, Not Alcohol Itself</td>
<td>Very Brief Confinement if any</td>
<td>Suggestion</td>
<td>Strengthen Will</td>
<td>Re-education</td>
<td>Occupational Therapy</td>
<td>See Through Excuses</td>
<td>Relaxation</td>
<td>Selected Reading</td>
<td>Daily Schedule</td>
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Source: Cited by above authors in body of Dissertation and in Bibliography, also personal conversations, letters, and general knowledge of their positions. V. B. T.
CHAPTER VI

COMPARISON AND ANALYSIS OF VARIOUS METHODS OF TREATMENT

Before arriving at any final conclusions and before outlining in some detail the particular techniques which I personally favor in the treatment of alcohol addiction, it may be well to get a bird's eye view as to how the various authorities agree as to the factors causing alcohol addiction and as to the most effective methods of treating this widespread disease.

Bowman and Jellinek give a good concise summary of the most common underlying causes: 158

Etiological theories usually consider one or more of the following: personality, heredity, constitution, psychotic or psychopathic tendencies, the emotional situation, environmental factors such as occupation and the drinking mores of the community, tolerance, and the physiological processes. The effect of alcohol on the total person, that is, the moral effect, is also an element to be considered in the etiology of the drinking habit.

These specialists quote further from the studies made by Dr. Phyllis Wittman of 100 chronic alcoholic patients without psychosis at the Elgin (Illinois) State Hospital, in which she was striving to find some typical personality deviation from another control group of "normal" individuals.

158 Quarterly Journal, June, 1941, p. 105.
A more or less characteristic picture of the alcoholic was found to be: He has a comparatively weak degree of restraint, mental poise, and stability; he has difficulty in controlling his moods and desires, as well as their overt expression. He is slightly more selfish, conceited, and hence more anti-social than the average individual. He has relatively strong cycloid tendencies, pronounced swings in mood and activity, together with distractibility and lack of attention. His moods alternate between the extremes of euphoria and optimism with heightened activity on the one hand, and irritability, with a gloomy, sad, apprehensive mental state with lessened psychomotor activity on the other. He is not particularly shy, sensitive, or given to daydreaming. The characteristic which definitely distinguishes him from the average is his strong paranoid tendency. He is consequently suspicious, self-conceited, stubborn, scornful of the ideas of others, and steadfast in adherence to his own ideas. 159

Dr. Wittman pointed out that there was no way of telling whether these were fundamental personality traits of the subjects or traits of the personality after many years of alcoholic indulgence.

Dr. Wittman made another study of developmental and personality characteristics of alcohol addicts which revealed the following outstanding traits: 160

1. A domineering but idealized mother and a stern, autocratic father whom the patient feared as a child.

2. A marked degree of strict unquestioning obedience demanded in family life, with little freedom allowed.

3. A feeling of insecurity as evidenced by an insistent feeling of need for religious security and a strong feeling of sin and guilt.

159 Loc. cit., pp. 116-117.

160 Ibid., pp. 117-118.
4. Marked interest in the opposite sex with many love affairs but poor marital adjustment.

5. Lack of self-consciousness with marked ability to get along with and be socially acceptable to others.

6. Occasional depression and periods of marked unhappiness.

7. A keyed-up emotional level - work done under high nervous tension.

8. A definitely expressed and disproportionately greater love for the maternal parent.

Dr. Wittman's findings agree for the most part with my own observations although, of course, each patient is a separate individual and requires an approach corresponding to his own personality and experience, as Miss Wittman would be the first to agree.

After going through huge masses of literature on the subject Drs. Bowman and Jellinek have separated abnormal drinkers into fourteen different types, which it may be well to list briefly here before getting into a comparison of treatment procedures:

True Addicts

1. The decadent drinker. Comes from families where pampering and intermarriage has been going on for generations.

2. The discordant or impassioned drinker. One whose belated or non-existent mental and emotional maturation unfits him to withstand the storms of instinctual life.

3. The compensating drinker. One whose inner sense of inferiority forces him to aggrandize himself by means of drink.

4. The Poverty Drinker. Drinks because it is the easiest and cheapest form of amusement.

Symptomatic Drinkers.

5. Symptomatic schizoid drinkers.

6. The schizophrenic drinker.

7. Early general paresis.

8. The Manic-depressive drinker. Periodic drinkers who may drink in either the manic or depressed phase but not in both.

9. Epileptic and epileptoid drinkers.

10. True Dipsomania. Drinking a symptom of an organic disease, not as yet satisfactorily proven.


12. The Exuberant Drinker. Goes to excess on irregular special occasions. Hypomanic in the normal sense.


14. The Occupational Drinker. Brewery and distillery employees, waiters, bartenders, heavy laborers, etc.

The above listing is more or less self-explanatory and, of course, includes not only the true addicts but symptomatic drinkers as well.

We have now reviewed briefly the various types of abnormal drinkers, the personality factors and developmental background likely to be found in the majority of addicts, and some of the principal causes impelling men and women to drink excessively. After quoting briefly from Rosanoff, as quoted in Bowman and Jellinek, as to the visible results of such

162 Loc. cit., p. 102.
drinking, I will go on with the analysis of the most effective methods of rehabilitation:

One is justified in speaking of pathologic alcoholism in cases in which, by reason of resulting disability or illness, the drinking gives rise to serious social maladjustments: neglecting work, losing jobs, getting into accidents, getting arrested for disturbing the peace, committing impulsive crimes, drifting into domestic trouble, having to be hospitalized for a psychotic breakdown, becoming involved in social scandals, etc. However, even in the absence of such maladjustments and illnesses, habitual drinking must be considered pathologic if the drinker has urgent craving for alcohol and has lost control of the situation to such an extent that he is no longer able to give it up even in the presence of a sincere desire to do so and following a definitely declared resolution.

With the above background in mind let us look at the table facing page 140 in which the therapeutical procedures of some dozen specialists are compared in tabular form: There is very little doubt but that alcoholism is a disease, albeit a psychological one, and there is no doubt at all but that the patient must cooperate in his own treatment. Most of the specialists agree on the immediate withdrawal of alcohol from the patient and all agree that the patient must make up his mind to give up the use of alcohol permanently unless he wants to find himself right back where he started from at the beginning of treatment. A highly individualized approach is predicated in which the patient must be treated with kindness and sympathy rather than with pity or condemnation. Suggestion and reasoning are utilized to strengthen the patient's will which has been weakened by the habitual use of alcohol. The patient must be taught to see through his former
excuses for drinking and his mind and body must be kept occupied with worthwhile activities so that he has no time left over to think of taking a drink.

The latter day specialists are typically not discouraged even by numerous relapses after the beginning of treatment; they believe in a thoroughgoing analysis of the total personality together with a change in the occupational or domestic environment if too unfavorable to recovery. They favor confinement only long enough to clear the alcoholic poisoning out of the patient's system. They understand that what the patient craves is not the alcohol itself but the way it makes him feel, and insist on his cultivating a thorough knowledge of his own particular forms of alcoholic temptation. They also believe in the use of relaxation, selected reading, and the use of a disciplined daily schedule to keep the patient occupied.

The unanimity of opinion revealed by this tabular comparison is very encouraging, for it shows that most of the outstanding specialists are very much in agreement as to the most effective methods of rebuilding the sufferer from alcohol addiction.
CHAPTER VII
A CORRELATED ATTACK ON ALCOHOL ADDICTION

Group A: Methods of Proven Value to All Patients
1. Medical Factors
It goes without saying that before beginning any extensive psychotherapy the patient must be given a thorough physical examination by a good physician, first, to ascertain whether or not he has any organic troubles which need to be dealt with, and second, to make sure that he gets and remains in good general health during the course of the treatment and afterwards. Heavy drinking over a period of years is likely to leave a man in a more or less run-down condition, and the complete restoration of his physical health will enable him to take more joy in the simple pleasures of normal living without the necessity of liquor for a pick-up.

Along with this goes moderate dietary regulation, which should not, of course, be carried so far as to cause hunger pangs which might cry out for alcoholic relief. The blood sugar curve of the patient should be carefully watched and additional dextrose given him at those hours when his blood sugar content tends to become dangerously low. Also, in many cases of prolonged drinking, the patient does not eat at all regularly and hence may be suffering from avitaminosis, particularly of vitamin B1. The physician should see to it that the patient is given sufficient
vitamin B1 to restore the patient's vitamin balance to normal.

If the patient has recently been on an alcoholic spree a decision must be made by the physician as to hospitalization for a few days, and if the patient is especially unruly it may be necessary to institutionalize him for a short time until his mental and emotional outlook is given a chance to clear up and return to normal. It is much better not to resort to institutionalization unless it is absolutely necessary and then only as a last resort when a man cannot control his actions on the outside. Some therapists refuse to treat a man while he is in an institution; others refuse to treat him unless he is in one. I do not think that a man should be treated against his will, wherever he is, but, if the patient is willing, I would favor beginning treatment even though he is institutionalized during not longer than the first month or two of the treatment.

2. Total Abstinence

Practically all alcohol addicts have gone through an initial period of more or less "normal" drinking, when they were able to drink without getting into serious difficulties. It is to be expected, therefore, that their original concept of an alcoholic "cure" will be one by means of which they will be taught to be able to drink moderately once more. This lingering delusion
must be eradicated once and for all. This is the unanimous opinion of physicians, psychiatrists, psychologists, lay therapists, and former alcoholics. Once a man has gone over the line from normal drinking into alcohol addiction, he must make up his mind to become either a total abstainer or continue as an alcohol addict. In severe cases of addiction it is usually impossible for the patient to simply give up liquor of his own volition. After he has tried to do so a few times, he must come to realize that he needs professional guidance over a considerable period of time - usually from ten to fifteen months.

3. Psychotherapeutic Interviews
One of the principal forms which professional assistance to alcoholic addicts takes is a series of about one hundred hours of interviews or private personal consultations extending over a period of approximately a year. During these interviews the patient is made comfortable and at ease and is then persuaded to talk to the therapist about whatever happens to come into his mind, whether the patient believes the subject to be important or not. The principal function of the psychologist is to be a good listener and accumulate material concerning the patient's past life experiences until he feels justified in diagnosing his underlying difficulties. Then, by the Socratic questioning method
the patient is gradually led to see his own weaknesses and shortcomings and the best methods of so correcting his personality defects that he will not have to depend on alcohol to make life worth living. During each hourly interview the psychologist gets a typical cross-section of the patient's mind during that day, and after a sufficient number of these cross-sections have been obtained the therapist can piece them together and get a good picture of what the patient's mental and emotional background is really like.

4. Attitude Toward Life
Very many patients begin to drink excessively because life seems to have lost its meaning to them. The therapist of broad interests and well rounded personality will first gain the patient's confidence and then try to get him interested in something outside of himself and work out a satisfying philosophy of life. In this endeavor religious faith or any other kind of faith plays an important part. This is discussed at some length in the body of the dissertation and several pertinent books are listed under Reading.

5. Relaxation and Suggestion
During the patient's interviews with the therapist he should be thoroughly relaxed for about ten minutes each
time and during this relaxed period he should be given various suggestions, such as that he is gradually becoming stronger in his ability to resist his temptations, that he is going to remain calm and unhurried, etc. There is a definite technique to learning how to relax, the principles of which have been set forth in the books by Jacobson and Baylor listed in the bibliography. Once a patient has achieved the relaxed state, he becomes highly suggestible and beneficial ideas are more easily and lastingly impressed on his mind than when he is wide awake and tense.

6. Pertinent Reading

The Peabody-Strecker system of therapy favors the use of about one hundred slips of about a third of a single-spaced typewritten sheet each dealing with one particular aspect of the patient's fight against alcohol. Most of these slips were arranged by Richard Peabody himself and they carry a great amount of conviction to most patients. One slip is to be copied and read over several times each night just before retiring so that the ideas brought out in the slip will sink into the patient's unconscious mind during sleep. The slips make the patient realize that at long last he has found someone who really understands his problem.

In addition, and depending entirely on the attitude of an individual patient, several books are assigned to be read and outlined.
One of the most important parts of the treatment is the reading and taking notes on a list of selected pertinent books. The patient is encouraged to buy these books so that he can mark the parts which particularly apply to his own case. I will list the books and articles which I would recommend, together with a few brief remarks as to the character of each work.

(1) The Common Sense of Drinking by Richard Peabody. This is an excellent and inspirational little book written by a man who went through tremendous sufferings from alcoholism himself and finally gave his life attempting to solve some of the as yet unsolved problems of this disease. He talks to the drinker as man to man with no attempt at preaching. He leaves the question of whether he can drink normally or not

168 Carroll, op. cit., p. 203.
up to the patient's own common sense and encourages him to think his problem through. He gives a concise case history of a rather typical alcoholic, and in the course of the book he answers most any argument with which the alcoholic has been trying to fool himself for the last several years. I would recommend this as the first book for patients to read.

(2) Alcohol - One Man's Meat by Strecker and Chambers. This work is rather more scientific and up to date than Peabody's on which it is based in part. It is less inspirational, and it includes a special chapter on diet, stressing the need of the alcoholic for vitamin B Complex and dextrose to rebuild his strength and resistance to alcohol. This book was written in collaboration by a nationally famous psychiatrist and a former alcoholic whose recovery was due largely to the Peabody system of psychotherapy. Needless to say, this is a happy combination of talents for any such work as this.

(3) Six very stimulating magazine articles of which I have made copies:

A. Coronet for February, 1939, "There Is No Drink Problem", by Doree Smedley. Outlines underlying causes of alcoholism and condemns preaching to alcoholics by relatives.

B. Your Life for November, 1940, "Hello, Drunk!" by Alissa Keir. Story of a minister who went into the gutter because of drink, made a comeback via the Peabody treatment, and is now helping others to find themselves again.

C. Your Health, Summer Quarter, 1940, "What's Your
Alibi For Drinking?", by Thomas E. Murphy. Lists the various types of alcoholics, the principal reasons for their drinking, the tests of the problem drinker, and the steps downward into drunkenness.


(4) Hayakawa's Language in Action. A brief exposition of the practical meaning and application of the principles of General Semantics. (New York, Harcourt, Brace, 1941.)

(5) Henry C. Link, The Return to Religion and The Rediscovery of Man. These two books try to give meaningfulness to life and praise the Church as a means to social contacts.

(6) Alcoholics Anonymous. Contains excellent alcoholic case histories. Fully described in the body of this paper.

(7) Karl A. Menninger's Man Against Himself especially the chapter on "Alcoholic Addiction". This excellent book points out the death or suicidal impulse in all of us, one form of which is alcoholism.

(8) William James' The Varieties of Religious Experience. Here is an objective psychological examination of religious experiences which can be proved or disproved only by personal experience.
(9) Edmund Jacobson's *You Must Relax* and *You Can Sleep Well*. These are popularizations of his *Progressive Relaxation* and are helpful in calming restless patients.

(10) Charles H. Durfee's *To Drink or Not To Drink*. This is another excellent book getting at the psychological mechanisms behind excessive drinking and showing methods of treatment.

(11) *Twelve Against Alcohol* by Herbert L. Nossen. An excellent book of case histories of alcoholics told in their own words. Nossen gives some pungent observations in his preface and conclusion.

(12) Wilfred Funk's *If You Drink*. This book is full of common sense but scientifically valid observations on how to test and check yourself before slipping over the line into abnormal drinking.

(13) Louis E. Bisch, *Be Glad You're Neurotic*. Helps remove some of the neurotic's morbid fears and emphasizes his strong points.


(15) *The Causes and Cures of Alcoholism*. This is the popularization of this dissertation, which I expect to bring out soon in book form.


(18) Dale Carnegie's How to Win Friends and Influence People. (New York, Pocket Books, 1940.) Extremely readable and a compendium of psychological methods on how to get along with people and make them like you.

(19) Levy and Monroe, The Happy Family. One of the best books on how to keep married life interesting and agreeable.

(20) Will Durant, The Mansions of Philosophy. One of the best books I know of to give meaning and interest to the art of living.


In recommending this or any other list of books, of course, a considerable amount of judgment must be used as to which patients should be encouraged to read what. Only the ablest and most intelligent patients would read all the books on this list. Some people do not grasp ideas readily from the printed page, and these should read two or three articles
and books and get the rest of the material in man to man conversations. It is unnecessary to add that the personality of the therapist and his ability to establish rapport with the patient is all-important in this work.

These books are readily separable into strictly alcoholic works and general works, but since we are treating the alcoholism only as the outstanding symptom of the disease and not as the disease itself, the actual reading of the books is not assigned on this basis but on the basis of the particular patient's individual needs and abilities.

7. Daily Schedule

The patient is encouraged to schedule each day's activities in advance and to adhere to his schedule unless some really valid reason prevents it. This serves the dual purpose of keeping him busy, keeping idle time at a minimum, and teaching him to not alter his plans merely on the basis of irresponsible whims, caprice, or rationalizations.

8. New Social Contacts

The alcoholic addict who sincerely wishes to work toward permanent recovery and rehabilitation has to learn not merely how to stop drinking, but how to live his future life that himself, his loved ones, and society will derive the greatest possible benefit and happiness from it. His real friends, those who love him and not
merely his liquor, will support him in his fight toward total abstinence. These friends he may continue to associate with. Those who are merely drinking companions, however, those who are unable to enjoy his company when sober, must be eliminated, although he must come to this decision himself. Since he has presumably been spending considerable amounts of time with these false friends, it will probably be helpful for him to cultivate new ones, perhaps some who are fighting the same battle against alcohol, perhaps some who have similar hobbies or avocations, perhaps those in his church, lodge, or business groups whom he has been neglecting because they didn't drink enough or because he was ashamed of his own excessive drinking.

He should also avoid drinking spots and drinking parties for a few months in order to keep temptation at a minimum during the difficult initial stages of his treatment. If and "dangerous thoughts" come into his mind concerning the "glorious" parties he and his"friends" used to have in the "good old daze", he must not repress these thoughts but follow them through to their ultimate conclusion in loss of job, home, wife, family, friends etc. If these disasters have not actually occurred, the alcoholic has in most cases been close enough to them to realize that it would have taken only a very few more straws to have broken the camel's back. If his business job offers temptation to drink, or if he feels ill-suited in his present job, the patient should take occupational adjustment tests and then look around for a job in which he can be happier. There is nothing like day in and day out occupational tension to key a man up to the point of taking a few drinks.
Group B: Methods of as yet Unproven or Doubtful Value

In addition to the above methods, which have proved helpful with practically all patients, there are five other techniques, some of which have as yet been insufficiently experimented with and others of which are considered by many physicians as quack methods, at least when used alone. With a full realization of this, I feel that in certain individual cases one or more of these techniques may be used with beneficial results.

1. General Semantics

The teachings of the elements of General Semantics as outlined in IV, G, has proved helpful in the orientation of disturbed patients in a topsy-turvy world. Moreover this therapy may be applied to many patients at one time, thus making the treatment especially important in group therapy.

2. Benzedrine Sulphate

In those cases where the patient feels a periodic compulsion to get a lift by alcohol, it is helpful to have a physician prescribe from one to three benzedrine sulphate tablets to be taken during the forenoon when the temptation is anticipated. The benzedrine gives the patient a considerable "lift" without being habit forming. It is also useful in lessening the after-effects of a hangover and thus helping the patient to suffer it out without beginning to drink again.
3. Endocrine Therapy
In bringing a man's courage and manly qualities up to par after years of debilitating drinking, it may be helpful to have an endocrinologist give him a few injections of testosterone propionate (male sex hormone). This is also helpful in cases of effeminacy. While this procedure has not been used much on alcoholics, it has proved very helpful in other forms of mental disease. 163

4. Hypnosis
In cases where the patient shows little initial progress because of continued periodical relapses, it may be helpful to have him see a reputable physician who does hypnosis. Although hypnosis results tend to be only temporary and to merely eliminate the superficial symptom, even this may be important in keeping the patient sober for two or three months so that other and more basic therapies may be brought into full play. Autohypnosis may also be helpful. 166

5. Lumbar Punctures
Extremely stubborn cases may be suffering from an excessive intracranial pressure. This may be tested by a reputable physician, and if found to be excessive, lowered by lumbar punctures given at ten day intervals.

163 Dr. Arthur Guirdham, British Medical Journal, January 6, 1940, pp.10-12
166 Andrew Salter, "Three Techniques of Autohypnosis", Journal of General Psychology, April, 1941
6. Castor Oil

The immediate temptation and even the compulsion to drink can in some cases be temporarily eliminated by taking a dosage of from one to two ounces of castor oil followed by a meatless meal. Although somewhat unpleasant and inconvenient, this method is extremely effective in relieving nervous tension and removing the desire for alcohol.
The Possibilities of Group Therapy

It will be obvious to the reader that such a long drawn out system of treatment lasting approximately a year and necessitating an average of two or three hours a week of private consultations, will be expensive in both time and money. Moreover, there are not more than fifteen or twenty therapists in the United States who are really qualified to handle alcoholic cases. Since not more than half of these specialize exclusively on alcoholics and cannot handle more than fifteen alcoholics at a time, it follows that, with our present facilities, probably not more than two hundred alcohol addicts could be treated simultaneously with a thorough therapy such as that outlined above. And these would of necessity be those who had some time and money to spare. What about those unfortunate alcoholics who either were always poor or whose drinking has reduced them to penury?

I believe that alcoholic psychologists should strive to work out effective methods of group therapy, using the lecturing techniques of General Semantics and the personal experience stories of Alcoholics Anonymous, among other things, as these techniques have proved effective with large groups assembled in one place. Free clinics should be supported by local, state and the national government, where advice and treatment would be available. I also believe that model isolated villages for alcoholics should be set up by the state governments, an open type for alcoholics who have enough insight to desire to be cured, and an closed type for involuntary patients whose insight is defective. With our present knowledge, considerable numbers of these unfortunates may well be rescued by such methods.
CHAPTER VIII

OUTLOOK - THE NECESSITY FOR EDUCATING THE PUBLIC

The same necessity for educating the public concerning alcohol addiction exists today as existed in former years concerning such diseases as insanity, tuberculosis, infantile paralysis, syphilis, etc. Many people still do not realize that alcoholism is a disease and that in many instances it can be cured with the right sort of treatment. During the last decade a number of books and popular magazine articles have appeared which have served to familiarize the more literate segments of the public with some of the latest conceptions regarding this disease and its treatment. Informative articles have appeared in such magazines as The Saturday Evening Post, Liberty, Time, Coronet, Esquire, Your Life, Your Health, The Readers' Digest, Pic and Harpers. The following books have appeared: The Common Sense of Drinking (Peabody), To Drink or Not to Drink (Durfee), Alcohol - One Man's Meat (Strecker-Chambers), Twelve Against Alcohol (Nossen), If You Drink (Funk), The Alcohol Problem Visualized (National Forum), and What Price Alcohol? (Carroll). In addition to these books and articles, The Research Council on Problems of Alcohol was formed in 1940 and the publication of The Quarterly Journal of Studies on Alcohol begun. The
Surgeon-General of the United States and his associates are vitally interested in this important problem. A nationwide educational campaign is expected in the near future. Membership in the Research Council is not restricted to physicians or psychiatrists but is open to all who are interested in alcohol problems and includes sociologists, educators, social workers, criminologists, superintendents of mental hospitals and correctional institutions, psychologists, former alcoholics, etc. The Council is thus in an extremely advantageous position to educate the public on the known facts about alcoholism as well as to undertake experiments for learning more about its treatment.

There are two major difficulties in the way of any all-out attack on alcohol addiction at the present time: a severe shortage of psychiatrists, psychologists, and institutions fitted to treat such cases; and the high cost of such extended individual treatment. I know of only one sanitarium fully equipped to treat alcoholics in the country and the cost of a year's treatment runs from $2500 up. Any such therapy is obviously restricted to the middle and upper classes. Moreover, even a well-to-do alcoholic is likely to have dissipated whatever financial resources he may originally have had by his alcoholic sprees. What is most needed today, therefore, is public enlightenment on the known facts about alcohol addiction, continued research into the most
effective and cheapest methods of group and individual therapy, and the establishment of state institutions to deal with poor alcoholics headed by psychologists or psychiatrists who have a comprehensive understanding of the whole problem. Today it is possible to say, as it was not ten years ago, that a hopeful beginning in this direction has been made.
Abstract

It is reliably estimated that there are at least one million alcohol addicts in the United States at the present time. An alcohol addict may be defined as anyone whose excessive drinking is continually getting him into serious difficulties and who cannot or will not control his drinking. Some idea of the seriousness of this disease may be gained from the following facts: 40% of the 25,000 annual admissions to New York City's famed Bellevue Hospital are for drunkenness; 32% of all male first admissions to mental hospitals in Massachusetts are directly connected with alcohol addiction; and women are gaining rapidly on their brothers in percentage of alcoholic admissions in all parts of the country.

The Research Council on Problems of Alcohol, whose membership includes numerous nationally known psychiatrists, sociologists, etc., considers alcohol addiction as "the nation's greatest disease enemy which is not being systematically attacked". One of the nation's greatest needs today is for the establishment of clinics for alcohol addicts headed by psychologists or psychiatrists who really understand this insidious disease in all its various manifestations. Our country's war effort would be strengthened immeasurably by an all-out attack on this silent-column enemy which is secretly sapping the strength of hundreds of thousands of our ablest men and women.
Most alcohol addicts do not drink because they like the taste of alcoholic beverages nor because they enjoy making their families and friends unhappy and getting themselves into all kinds of difficult situations. They drink because some deep-seated and hidden maladjustment is so painful to them that they crave the unconsciousness and forgetfulness that they know by experience alcohol can give. Many of them simply have not grown up emotionally. They have not been "psychologically weaned" and brought to a mature state of emotional and mental balance so that they are able to face realistically the actualities of life. Instead of facing and overcoming their difficulties, they run away from them (temporarily) by achieving the false self-evaluation and ultimate unconsciousness that alcohol brings.

Alcohol addiction has always been looked upon by the great majority of people, including most physicians, as a sign of moral delinquency or lack of will power. The drunkard has historically been looked upon as an outcast from society, as a no-good individual who deliberately chooses to drink himself into the gutter with no thought whatsoever for his loving wife and family. The only treatment which most people believed the drunkard needed was preaching and lecturing on his general worthlessness. Physicians, to be sure, usually tried to relieve the acute symptoms of his excessive drinking by brief periods of hospitalization, but if the patient went back to drinking again a ter being thus de-alcoholized, he was considered as hopeless and as not desiring to help himself.
Psychiatrists, too, neglected this vital problem for a great many years, with the result that few of them even today are well qualified to treat severe cases of alcohol addiction. These accusations are not from laymen or non-medical therapists alone, but from two of the leading medical psychiatrists in the alcoholic field—Dr. Neil Dayton of Massachusetts and Dr. Robert S. Carroll of North Carolina. The recent foundation of the Research Council on Problems of Alcohol and the publication of their Quarterly Journal of Studies on Alcohol promise to go far in relieving the present unhappy situation in this respect.

In reviewing briefly the historical development of the soundest therapeutic procedures for dealing with alcohol addiction, we must first mention The Washingtonian Movement which sprang up in the Eastern part of the United States almost exactly one hundred years ago (1840). This society emphasized several basic principles oftreating alcohol addiction which are still highly regarded by contemporary psychotherapists:

It was recognized that, while lecturing on the evils of drink by temperance workers resulted in very little good to the drinker, straight talking and reasoning by a person who had himself suffered greatly from drink was very effective. It was also realized that total abstinence was a prerequisite for recovery, that there was no possibility of compromise with liquor, and that it was the "just one little drink" that caused most of the trouble. Drunkenness was rightly considered to be a disease, and there were no religious strings attached to membership in the society. The relating of personal experiences by former addicts was recognized as having remarkable therapeutic effects, and associating with new non-drinking friends who were fighting the same battle, was known to be extremely helpful in keeping away from liquor.
Despite its great popularity over a period of several years, the Washingtonian Movement eventually died out. Contemporary psychiatrists would tend to conclude that one reason for this fading away may have been the neglect of emphasis on professional consultations over a period of from ten to sixteen months. Today it is realized that merely ceasing to drink is not the basic problem, but that the addict must learn to find happiness in normal living, and must be taught how to carry on successfully in his home and business situation, meeting his daily problems realistically and in a more adult manner.

In England, during the latter half of the nineteenth century, a few far-seeing physicians arrived at the following contemporary-sounding conclusions concerning the attack on alcohol addiction:

Total abstinence is an absolute necessity. The two-month period immediately following the post-alcoholic melancholia is extremely critical. Many periodic addicts drink during a period of hyper-exaltation rather than during a depressed period. Confinement is sometimes necessary, and discipline is helpful in re-education. Association with other men fighting the same battle is helpful. The mind and body should be kept as fully occupied as practicable to cut to a minimum the amount of leisure time available for abuse. A highly individualized approach is necessary. The patient must sincerely desire and work to assist in his own rehabilitation. (In other words the recovery is active rather than passive.) Dipsomaniacs drink because compelled by an irresistible impulse. The doctor should neither curse or pity the patients, but treat them matter-of-factly as men. The struggle should not be given up despite frequent relapses. Thoughts of former drinking places, gay parties and companions should be counteracted by thoughts of happy non-alcoholic associations. Patients should cultivate self-knowledge of their own peculiar types of alcoholic temptations. Inebriates cannot be cursed by punishment or scorn.
It is my considered opinion that if the techniques of these nineteenth century British therapists (Drs. Kerr and Clum) plus those of the American Washingtonian Movement were to be collated and carried out consistently by able professionals over adequate periods of time, very little improvement could be made on them by the twentieth century psychiatrists. Unfortunately these excellent verbal techniques were not collated and applied, but, even so, the 30% complete recovery rate of Dr. Norman Kerr compares favorably with institutional recovery rates today.

Since the time when the above-mentioned therapists wrote, new psychiatric developments have taken place, which put considerable amounts of new and living meat have been added to their bony verbal outlines. Freud's emphasis on the earliest childhood experiences and unconscious memories, on hidden sexual and self-destructive tendencies, and on the emotional rather than the strictly mental factors affecting addiction, have given modern therapists far better probing tools with which to work. Similarly, Adler's emphasis on overcompensation for feelings of inferiority and on revising one's life-goals in accordance with one's actual abilities, has been extremely helpful. Jung's calling attention to the middle-aged breakdown as caused by spiritual unrest and a feeling of the meaninglessness of life, is applicable to very many cases of alcohol addiction.
The psychobiologists, the personologists, and the configurationists have drawn attention to the necessity for considering the total personality in its entire socio-economic setting. The new tool of general semantics is extremely helpful in enabling the patient to understand more clearly both himself and the universe around him. Thus, the words used to describe the treatment for alcohol addiction in the nineteenth century have now come to be imbued with a much enlarged and deepened meaning, so that, as present-day psychiatrists gradually learn how to use these newer tools and approaches more skillfully, the percentages of recovery from alcohol addiction should show a steady upward trend. The great need today is for more research by qualified experts, for the training of greatly increased numbers of therapists in the techniques already understood, for reliable statistical data on the long-term results of treatment by various methods, and for the nation-wide education of the public and of the medical profession as to the actualities of the disease of alcohol addiction and its treatment.
APPENDIX I

THE PHYSIOLOGICAL EFFECTS OF ETHYL ALCOHOL

Most authorities agree that alcohol is a narcotic and that it depresses and retards the action of the nervous system. (The outstanding exception to this general statement is Dr. W. Burridge, a British physician, who, in his Alcohol and Anesthesia\(^1\) contends that alcohol simultaneously stimulates and depresses.) When one drinks alcoholic beverages the passage of the nerve impulses is delayed and behavior is slowed up and altered. The only bodily function known to be stimulated by alcohol is the secretion of the digestive juices by dilute alcohol (4-7%); higher concentrations and large quantities, however, have the opposite effect. Alcohol frequently gives the appearance of stimulating bodily activities because the higher control centers are dulled.

The degree of alcoholic intoxication (literally "poisoning") depends on the percentage concentration of alcohol in the blood and also, to some degree, upon the alcoholic tolerance of the person imbibing the alcohol. The following table shows how various concentrations of

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\(^1\) London, Williams and Norgate, 1935.
alcohol in the blood affect the behavior of the typical individual:

<table>
<thead>
<tr>
<th>DROPS OF ALCOHOL PER 1000 DROPS OF BLOOD</th>
<th>EFFECT ON MIND AND BODY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near 1 drop</td>
<td>Some inhibitions removed</td>
</tr>
<tr>
<td></td>
<td>Sociable and confident</td>
</tr>
<tr>
<td></td>
<td>Skill and judgment less accurate</td>
</tr>
<tr>
<td>1 to 2 drops</td>
<td>Tends to overdo things</td>
</tr>
<tr>
<td></td>
<td>Talkative - careless - funny</td>
</tr>
<tr>
<td></td>
<td>Skill decreased - will weakened</td>
</tr>
<tr>
<td>2 to 3 drops</td>
<td>Sees double - totters</td>
</tr>
<tr>
<td></td>
<td>Incoherent - fumbling - boisterous</td>
</tr>
<tr>
<td></td>
<td>Feeling and pain lessened</td>
</tr>
<tr>
<td>3 to 4 drops</td>
<td>Action slow - breathing difficult</td>
</tr>
<tr>
<td></td>
<td>Staggering - muttering</td>
</tr>
<tr>
<td></td>
<td>Indifferent - semi-conscious</td>
</tr>
<tr>
<td>4 to 5 drops</td>
<td>Down and out</td>
</tr>
<tr>
<td></td>
<td>Dead Drunk</td>
</tr>
<tr>
<td>5 to 6 drops</td>
<td>In danger of death</td>
</tr>
</tbody>
</table>

Alcohol affects the highest level of behavior first. "This level consists of mental skills acquired through education and experience, and includes ability to reflect on facts observed, to make sound judgments, to exercise self-criticism and caution." When these brakes are released and the drinker's inhibitions removed, he appears stimulated and becomes talkative, unusually sociable, and careless. The next level of

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behavior to be affected by alcohol consists of acquired physical skills learned early in life, such as walking, talking, hearing, athletic and technical skills. The last behavior level to be affected consists of the innate and biological functions such as breathing, blood circulation, and digestion, functions which are well developed at birth.

The maximum effect of alcohol is reached about three quarters of an hour after drinking it, and persists for about another half hour. The degree of intoxication for any particular individual is determined by many factors, among the most important of which are:

1. The kind of beverage consumed.
2. The total amount of alcohol consumed.
3. The amount of food taken along with the alcohol.
4. The rate of drinking.
5. The individual's constitutional or habitual tolerance for alcohol.
7. Temperature of the surrounding atmosphere.
8. Altitude.
9. The temperament of the drinker.
10. The immediate physical condition of the drinker.

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4 The National Forum, loc. cit., p. 23.
5 Ibid., p. 22
The effect of alcohol on the eyes varies with the quantity consumed and with individual tolerance. The following effects are common:

1. Blurred or double vision.
2. Narrowed or tunnel vision.
3. Shortened range of sight.
4. Color blindness.

The following skills are definitely affected by even small quantities of alcohol (1 3/10 ounces on an empty stomach):

1. Time required to make a decision is increased 9.7%.
2. Time required for muscular reaction is increased 17.4%.
3. Errors made from lack of attention are increased 35.3%.
4. Errors made from lack of coordination are increased 59.7%.
5. Errors made by skilled typists are increased 39% after taking 2/3 of an ounce of alcohol, and by 72% after taking 1 1/3 ounces.

Scientists disagree as to whether or not alcohol should be classified as a food. It does not build body tissue or repair waste tissue and it cannot be stored for future use; it does, however, furnish energy and heat. "Since no more...

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7 Ibid., p. 36.
8 Ibid., p. 43.
than two teaspoonsful of alcohol can be burned up in the body in an hour, it can be used as a food in this way only to a very limited extent."\(^9\) "The use of alcohol...as a substitute for food...is physiologically unsound."\(^10\)

When immoderate drinkers do "substitute alcohol for food" they incur vitamin and mineral deficiency and are likely to develop neuritis and gastritis.

**Stomach**

Small amounts of light alcoholic beverages may stimulate the appetite but the heavy drinker often gets gastritis or inflammation of the lining of the stomach. Heavy drinking also is likely to take away the appetite so that the drinker does not get the proper food and thereby develops vitamin and mineral deficiency. Such deficiency contributes to gastritis as well as to neuritis.

**Heart**\(^12\)

Alcohol does not directly stimulate the heart muscles, but drinking strong liquor may cause the heart beat to increase and the blood pressure to rise because of the irritating effect of alcohol on the mucous membrane of the mouth, gullet, stomach, etc. Alcohol does not cause heart disease.

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9 Bogen and Hisey, *op. cit.*, p. 35.
10 The *National Forum*, *loc. cit.*, p. 49.
Like any narcotic, it may quiet a restless patient with a weak heart, and this sometimes causes the patient to become over-confident and over-active, leading to heart failure.

Liver

There is no experimental evidence that alcohol causes cirrhosis of the liver. However, it may cause the liver to store excessive fat, thus bringing on an unhealthy condition favorable for the development of cirrhosis.

Kidneys

"Experimental studies on animal and man fail to reveal that the consumption of alcohol in moderate doses is harmful to the normal, or even to the diseased kidney; the arteriosclerotic kidney is perhaps an exception to this rule." (Bruger)

Resistance to disease

Heavy consumption of alcohol lowers the resistance of the body to disease in two ways: first, it actually lowers the resistance of the body to disease germs; and secondly, it causes the drinker to neglect his health when he is under the influence of alcohol. Langmead and Hunt studied 3422 cases of lobar pneumonia in the Cook County Hospital, Chicago,

14 Ibid., p. 50.
15 Ibid., p. 49.
16 Ibid., p. 51.
over a period of eight years and found that while 42.5% of
the heavy drinkers and 29.1% of the moderate drinkers suc-
cumbed, in the case of total abstainers only 18.4% died. 17
In his study of the incidence of syphilis Forel found that
76% of the men and 66% of the women were infected while in-
toxicated, presumably because of the carefree mental attitude
brought on by alcohol. 18

Nerves 19
The chronic drinker is often afflicted with neuritis
because of vitamin B deficiency brought on by his failure of
appetite due to excessive consumption of alcohol.

Mental Disease 20
"Chronic alcoholism appears as a prominent etiological
factor in one-fifth of all admissions to mental hospitals in
Massachusetts. This applies to 32% of all male first admis-
sions and to 6% of female. Between the ages of thirty and
sixty over 40% of male first admissions are intemperate users
of alcohol." (Dayton)

18 Ibid., p. 52.
19 Ibid., pp. 52-53.
20 Ibid., p. 53.
21 Ibid., pp. 52-53.
Mortality Expectation

Pearl found that at age thirty the expectation of life of abstainers and moderate drinkers was about eight years more than for heavy drinkers; at age forty-five the expectation was about six years more. The death records of two million policy holders in forty-three American life insurance companies show a death rate of 186 for drinkers indulging in more than two glasses of beer or one glass of whiskey a day as compared with a basic rate of 100 for all insured men including drinkers.

22 The National Forum, loc. cit., pp. 54-56.
23 Ibid., p. 53.
APPENDIX II

A TYPICAL SPREE

Since the words "alcoholic" and "alcoholism" will be used rather frequently in this dissertation, and since many readers may have only an academic acquaintance with alcoholism or only an objective external view of what may be presumed to go on within the alcoholic's mind, I think it will be worth while to describe in some detail a more or less typical spree as indulged in by a typical pseudo-dipsomaniac (a periodic drinker who feels no craving for the drug until after having taken his first drink).

Let us say that such an individual hasn't had a drink for two months; he is back in the best of health and hasn't a worry in the world. Just before the close of work one afternoon an old college chum phones him, says he is in town for a couple of days, and suggests that he drop over to the hotel. Well, he hasn't seen Bill for four years, so he tells him he will meet him in his room at six and then they will have dinner together.

When he arrives, he finds Bill sipping from a quart of King George IV scotch and feeling very happy. Bill pours Jim out a drink and is very much surprised and hurt at his refusal to drink it. So Jim tells him the story of his in-
ability to take one or two drinks without getting started on a spree. Bill laughs at this, since his own drinking has always been kept under control, and keeps after his old friend to join him in a couple of drinks before dinner. He tells him that if he drinks and then eats a good meal right on top of the drinks, he won't feel like taking any more. Finally Jim gives in for old times' sake; they have two or three whiskeys and then go down to dinner. During the meal they have several more drinks and this continues during the evening. Finally at about midnight they say "Good night" and Jim starts for home. But by this time he has raised the old thirst again and after the hour's long trolley ride he is ready for a few more drinks before going home to meet the wife. So he stops in at the corner tavern and keeps on drinking there until the closing hour at three A.M., and before leaving he is so dry that he buys a pint of whiskey to take home with him with only a couple of dollars left in his pocket.

Mrs. Jim is pretty disgusted when she sees her husband in this condition for she knows his weakness, but he assures her that he will be all right and on the job the first thing in the morning. Jim gets to bed about four o'clock and is dead to the world when the alarm goes off at seven. His wife tries to get him up but he tells her he is sick as a dog and couldn't possibly work today. She keeps after him, however, gets a couple of cups of black coffee into him and gets him
under the cold shower. Then a crafty idea comes into his drunkard's mind: by promising his wife to go down to the office he will be able to get five dollars out of her, as she handles all the money by mutual consent. He is successful in this ruse and walks out of the house with seven dollars in his pocket feeling like a millionaire, for he knows he can get good and drunk on this amount. He stops in at the corner tavern for a couple of eye-openers before getting out of the neighborhood. These drinks only make him more positive that he can never put in a day's work today; however, he promises himself that he will get to work tomorrow without fail. He takes the street car downtown, goes to Bill's hotel, catches two more drinks at the hotel bar and then picks up a pint of rye at the liquor store across the street. Fortified with this he goes up to Bill's room and offers him a drink.

Bill refuses, saying he must get out on his selling job, and says he can't bear the smell of liquor the next morning anyway. So Jim finishes the pint all alone while his friend is getting dressed and shaved. Bill invites Jim down to breakfast with him, but Jim says he couldn't eat anything and so they part company, but not before Jim has borrowed ten dollars from Bill to replenish his depleted supply of funds.

At nine o'clock Jim phones the office to tell them he is sick and won't be able to come in today. Then he takes the subway over to a cheap midtown dive where none of his
friends would ever run into him and where he usually drinks when he is on a spree. As usual, he meets there several barflies who spend most of their time looking for newcomers to supply them with drinks. The price they pay for these drinks is listening to the strangers tell what important men they are in their offices. A couple of these spongers attach themselves to Jim and it isn't long before his fourteen dollars has disappeared.

He then gets on the wire to a friend at the office and asks him to meet him down at the corner drug store and lend him twenty dollars. The friend lends him ten and back Jim goes to his "buddies" and the "dive". About ten o'clock that night his money is gone, so he goes home, but not before getting trusted for a pint at the corner drug store. His wife is naturally very angry and threatens to call the police and give him a chance to sober off in the city jail. She doesn't carry out the threat, however, as Jim promises to get a good night's sleep and be on the job in the morning. He finds he can't sleep, however, and has to take a "hooker" out of the bottle every hour or so. Finally the pint is finished and he falls into a restless slumber, twisting and turning every ten or fifteen minutes.

The next morning Jim gets up, pretends to be feeling fine, tries unsuccessfully to get a few dollars out of the wife, and sets out supposedly for the office. He gets trusted for three drinks at the tavern and this gives him the
necessary courage to phone up and borrow some more money — but five is all he can get this time. Back in the same tavern this is soon gone and the only thing left is for him to put his watch and overcoat in the pawn shop, which he does without much hesitation. This twenty dollars looks pretty good to him and it keeps him and his two "pals" going all day long. Finally at four the next morning he shows up at home dead drunk and broke again. The wife tries to make him understand that he is in danger of losing his job because she had phoned him at the office, supposing him to be at work, to tell him about an important telegram which she had received. The general manager had happened to answer the phone and asked where Jim was if he wasn't at home sick. She had tried to tell him that Jim had gone to the drug store for some medicine. "All right," said the boss, "tell him to phone me as soon as he gets back." This had been at eleven in the morning and, of course, Jim hadn't "come back".

The next morning there was a special delivery letter from the boss saying that unless a satisfactory explanation was forthcoming, Jim's connection with the company would be severed. Well, of course he was too sick to do anything about it that day. All Jim could do was to lie in bed and worry, worry, worry. The same old worries over and over again until he thought he would go crazy. He couldn't sleep, he couldn't relax, and he couldn't eat. He couldn't even hold water on his stomach. His wife fixed nice chicken broth and
milk toast for him but he vomited these up too.

Finally, in desperation, his wife phoned for the doctor, who put him to sleep with a double dose of an opiate. Thus Jim found peace for a few hours. But when he awoke his fears and worries were as bad as ever. What a fool he had been; what suffering he was causing his wife and children; how ashamed of him his mother was; what a total failure he had been in life - he who as a young man had been pointed out as a shining example to all the boys in his home town - and now he was ashamed to even go back to his home town because everyone there knew all about his being a drunkard. Here was another job probably lost through drinking, and only a thirty-five dollar a week job at that; they had warned him about these absences before. He had lost five other jobs previously. It was just no use. He thought seriously of committing suicide. He would if it wasn't for Mary and the babies. And all because he had succumbed to the temptation to take just one little drink. He hadn't felt any desire or craving to drink; he had just taken it to be sociable. Well, he had been sociable all right. That "one little drink" was going to cost him his sixth job lost inside of two years; he would have to go the long tedious rounds of all the employment agencies again, and jobs weren't easy to get now; and what about references - who would recommend him now? This was the last time they could afford to lower
their own reputations by endorsing him, three of his friends had told him last time. And now they were through. And how could he look for a job in January without an overcoat; and his watch was in the pawn shop too. What a fool he had been - and all for that "one little drink".

This story is typical of the milder variety of spree. Usually the spree lasts for a week or more and the man may even pawn or sell his clothes, shoes, furniture, and other possessions for just a few more drinks. It is a terrible disease - and it must be scientifically studied and attacked.
When George Rogers was a small boy his father died, and his mother married again. His step-father was harsh and domineering, and jealous of his wife's love for her child by another man. George's mother tried to make up for the lack of father-love by showering an excess of mother-love on him. She bought him everything that he asked for without teaching him that in the real world most people cannot get the things they want without working for them. George became so accustomed to getting what he wanted by simply asking for it, that whenever he didn't get it, he would stage a temper tantrum -- roll around on the floor, kick, and bawl until his wish was fulfilled.

The result of this early training was that George grew up with no clear idea of how to face the real world. He expected it to be either cruel and unsympathetic like his stepfather, or kind and loving like his mother.

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1 The National Forum, "The Alcohol Problem Visualized" Chicago, p. 59-64. Based on actual cases studied by myself as a research project.
George received excellent grades in school. His stepfather never commented on these grades, but his mother praised them excessively. Because he learned so easily, George skipped two grades and was thrown in with boys older and stronger than himself. For this reason he was unable to make the athletic teams, and came to think of himself as inferior to the other boys. He became "introverted" and spent more and more of his time reading. His stepfather never failed to call attention to his failure to make the school teams and referred to him as "that sissy".

When George got to college he found all the boys two or three years older than himself. Again he failed to make the teams and was looked on as a "kid". As proof of his "manhood" he soon learned to find amusement and consolation by "stepping out" in the evening. His lessons came easily and he had plenty of time for "parties". He soon found that a few drinks would help him forget his feeling of inferiority and put him "on top of the world". This was an easy method of getting to feel like "a big man on the campus".

One morning in the fraternity house George came downstairs complaining about his "big head" from the night before, and about the lecture on English History which he had to attend next period. An "old grad" laughed and said it was
foolish to "suffer out" a hangover like that. He poured the young man a drink from his pocket flask. Thus George learned that a hangover can be temporarily relieved by taking a drink or two the next morning. This practice is considered by many psychologists to be the dividing line between moderate and abnormal drinking.

After his graduation George landed a good job as salesman for a big steel company and soon won recognition and promotion. His job called for a certain amount of "entertainment" which meant furnishing liquor and throwing parties for prospective customers. By the time he was thirty-five George was somewhat proud of his reputation as a man-about-town, and of his ability to "handle his liquor". Despite his five thousand dollar a year income he was continually in debt, and frequently had to ask his mother for money. This continuing dependence on his mother indicates that he was not yet "psychologically weaned".

By the time he was forty, George wasn't getting as much kick out of his liquor as before. His system was pretty well run down and he felt the need of liquor as sort of a medicine to keep him "up to scratch", and "full of pep" at parties. He felt "low" and "nervous" on his mornings after, and got in the habit of taking a couple of bracers on his way to the office. Before long he started taking a few drinks with his lunch, and he began to look forward eagerly
to the afternoon cocktail hour. It wasn't that the liquor made him feel hilarious any more; it just seemed as if he "had to have it" as a tonic to bring him out of his feeling of depression. His appetite began to fall off and he couldn't sleep at night. He wasn't producing the sales results that he had been, and the big boss would occasionally criticize him for allowing his drinking to interfere with his work. His frazzled nerves couldn't take this justified criticism and he "forgot his troubles" by drinking more than ever. This typical practice of drowning his humiliation in a spree corresponds to his childhood "flights from reality" in the temper tantrum.

As George's sales fell off, his income dropped. Debts piled up and he was forced to borrow more and more from his friends and from his mother. He finally got to the stage in his drinking where somebody had to help him home two or three times a week. His friends now began to look on him as a pest instead of a "good fellow". His wife was frantic; she became a "nervous wreck" and "nagged" her husband continually. This gave him still another excuse for drinking. Thus, we find a "vicious downward spiral" of drink -- troubles -- nagging -- more drink -- more nagging -- more troubles, etc., etc. Finally his wife was forced to consider divorce as the only possible way out.

George's friends persuaded him to take a two weeks "cure". He paid a hundred dollars a week for food, rest,
and conditioning, and returned to his job looking and feeling a hundred per cent better. His friends now thought that everything would be fine; but after another month he was back drinking as hard as ever. He lost his job. His family and friends lectured and preached at him about his lack of "manhood" and "will power". All of this only made him feel more guilty and ashamed than ever, and drove him to "forget himself" in one drunken stupor after another. His wife, in desperation, divorced him, took the children home to her mother's, and found herself a job in order to support them. George became still more desperate and hopeless, and continued to sink lower and lower.

As a last resort, he was committed by his parents to a state hospital. There he soon learned that public institutions are not at present equipped to give permanent relief to those suffering from alcoholism. After three months George was released, hurt and angry at the "disgrace" of his confinement, and discouraged at its failure to rebuild his personality. The very next day he borrowed ten dollars from a friend and was off on another spree. Three days later he ended up dead drunk at his mother's home, with most of his clothes and valuables in the pawn shop.

We are not going to finish the story of George Rogers. We do not know how it will end. If the ending is to be happy, George must have help — professional help and
help from his family and friends -- both in cash and in sympathetic understanding. It is almost impossible to make the comeback alone. If George still has someone who has confidence in him, and enough understanding of the problem to suggest that he consult a competent psychologist or psychiatrist, he has a good chance of getting back on his feet. But before this can happen, George must realize that his nervous system is "allergic" to alcohol, and that if he wants to be cured he must give up drinking entirely. In other words, he must WANT to want to stop drinking. The psychologist will show him how. Unless these conditions are fulfilled, he is likely to keep on going down hill until he becomes another member of that army of broken-down "bums" who inhabit the barroom areas of our cities.
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I was born on September 18, 1909 in Lynn, Massachusetts, to Herman C. Twitchell and Lena E. (Bronson) Twitchell, both families of old New England stock. The Twitchell family goes back to the Puritan, Benjamin Twitchell, who settled in Dorchester, Massachusetts, in 1632, and the Bronson family (through Lovering and Davis) to the emigrant, James Davis, who settled at Newburyport (then Newbury) in 1634.

After attending grammar schools too numerous to mention because of change of family residence, I graduated from the Tilton-Northfield Graded School in 1922 and from Tilton Seminary (now Tilton School) in 1926. From 1926-28 I studied at Amherst College, spent the summer of 1928 in Western Europe, and studied for one quarter at Stanford University in Palo Alto, California. During the second semester of 1929 I took several extension courses at Boston University, then spent the two following college years taking a pre-medical course at McGill University in Montreal. The summer of 1931 was spent at William and Mary and The University of Virginia summer schools, at the latter of
which I met and married Phyllis Maxine Wicker of Richmond, Virginia.

During 1931-1932 I completed work for my A.B. in Asiatic History at Boston University College of Liberal Arts, then spent two years at the Harvard Graduate School of Business Administration, whence I received the degree of Master in Business Administration in 1934. After spending three years in various types of office work, I returned in 1937-38 to the Harvard Graduate School of Education and completed the courses necessary for the degree of Master of Arts in Teaching the Social Studies. In February, 1939, I began work for my Ph. D. in Psychology in the Boston University Graduate School.

promised a First Lieutenant's commission of The Army of the United States, upon his degree, and on the advice of army that the Ph.D. degree be granted me on the requirements for it in January, 1945 customary in peace time, in June.

Vernon B. Twitchell