The contribution of the Alcoholics Anonymous group at the Boston State Hospital to the community adjustment of ten alcoholic patients

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THE CONTRIBUTION OF THE ALCOHOLICS ANONYMOUS GROUP AT
BOSTON STATE HOSPITAL TO THE COMMUNITY ADJUSTMENT
OF TEN ALCOHOLIC PATIENTS

A thesis
Submitted by
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(B.S., Tufts College, 1950)
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CHAPTER I

INTRODUCTION

Purpose of the Study.

The purpose of this study is to determine the contribution of the Alcoholics Anonymous group at Boston State Hospital toward the post-discharge adjustment of alcoholic patients. The study will attempt to answer the following general questions:

1. How effective is the hospital Alcoholics Anonymous group in bringing about contact of its discharged members with A. A. groups outside the hospital?

2. Is the rehabilitation of alcoholic patient-members enhanced by the hospital A. A. group?

Scope of the Study.

Ten male patients were selected for follow-up study on the basis of the following criteria:

1. Each was diagnosed by staff doctors as suffering from some form of alcoholism.

2. Each had attended the hospital Alcoholics Anonymous group at least twice during his stay.

3. Each had been returned to the community from nine to twelve months prior to being investigated. The period of time covered by this investigation ranged from February of 1953 to February of 1954.
Sources of Data.

Data for this study were obtained from case records of patients, ward records, and interviews with patients.

Method of Procedure.

In order to gain a personal impression of Alcoholics Anonymous the writer attended several meetings at the hospital and in the community, and took the opportunity to speak with group leaders.

After obtaining the names of alcoholic patients from ward lists, the writer consulted their case folders to select those who came within the scope of this study, the criteria for which are given above. Background material on each patient was drawn from his case record, and each patient was interviewed by the writer for the follow-up study. The data sought included relevant past history, the meaning to the patient of his contacts with the hospital, especially with regard to his drinking problem.

As a means of answering the general questions, the follow-up procedure included the use of the scheduled questions to be found in the appendix.¹

¹ See Appendix I, p. 67.
Value of the Study.

The extent and seriousness of alcoholism will be discussed in Chapter II. In general, it is of considerable interest to social workers to know what Alcoholics Anonymous has to offer as a treatment resource and what it has actually accomplished. In particular, social workers who are concerned with the rehabilitation of alcoholic mental patients look to Alcoholics Anonymous groups such as that at Boston State Hospital as perhaps the only or at least the most promising resource in cases which respond poorly to other methods. With greater knowledge of the community adjustment of patients who have attended this group, social workers and psychiatrists will be able to make more effective referrals.

Limitations of the Study.

The size of the sample used in this study is large enough to include the major clinical types of alcoholism yet small enough to allow an individualized presentation of each case. However, a more reliable and valid quantitative study could have been made by comparing the progress of alcoholic patients who have attended the hospital A. A. group with those who have not. This would limit the amount of error involved in subjective decisions as to whether particular improvements in a patient's situation resulted from or simply came after his experience with the hospital A. A. group.
Without intending to minimize the various other sources of help offered by hospitals and communities, this study is mainly concerned with A. A. as a factor in the rehabilitation of alcoholic patients.
CHAPTER II

ALCOHOLISM: CHARACTERISTICS AND TREATMENT

Definitions.

What is alcoholism? To the general public the term refers to a wide variety of drinking habits starting somewhere beyond occasional or moderate social drinking and extending to the extremes of heavy drinking. The term calls forth certain mental pictures: the "skid row" derelict for whom there is no help; the week-end spree drinker depicted in books and plays; the brutal, irresponsible husband; the drunken play-boy whose only waking hours are spent in night-clubs. The accompanying emotional reactions are consistent with the lack of real understanding revealed in these stereotypes. Depending upon prejudices and assumptions of the observer, these drinkers evoke anger, disgust, fear, humor, and even admiration. Popular media of communication not infrequently present the alcoholic as a cherished American institution, either as a comic or a tragic hero. The melodramas of an earlier era, while presenting the tragic results of alcoholism, often by their strained sentiment detracted from realistic appreciation of the problem.

To those who for professional reasons have been concerned with the investigation and solution of problems
associated with drinking, alcoholism has deeper and more specific meanings. The efforts of psychiatrists, psychologists, sociologists and others have not yet produced final solutions or theoretical unity, but reflect a shared conception of the problem as expressed by the Subcommittee on Alcoholism of the World Health Organization Expert Committee on Mental Health:

Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance, or a interference with their bodily or mental health, their interpersonal relations and their smooth social and economic functioning; or who show the prodromal signs of such developments.¹

The above definition indicates that alcoholism is not synonymous with mere inebriety, but embraces a broad but distinctive array of symptoms, physical, emotional, and social. A more inclusive definition would cover many drinkers who occasionally get drunk, or even get into trouble, but who are not considered problem drinkers. As Dr. Sidney Vogel states, alcoholism refers to a need for alcohol rooted in a deficiency in the drinker.² The strength of this need and the compulsive nature of its operation in the individual is vividly described by Selden Bacon:

What is an alcoholic? Alcoholics may be distinguished from other drinkers primarily by the purpose for which they drink. Some people drink to

² Sidney Vogel, An Interpretation of Medical and Psychiatric Approaches in the Treatment of Alcoholism, p. 621.
fulfill a religious ritual, others in order to be polite, still others for a good time, or to make friends, to experiment, show off, get warm or cool, quench thirst, or because they like a particular alcoholic beverage as a condiment, or because they want to go on a spree. None of these is the purpose of the alcoholic, although he might claim any or all to satisfy some questioner. The alcoholic drinks because he has to if he is to go on living. He drinks compulsively; that is, a power greater than rational planning brings him to drinking and to excessive drinking. Most alcoholics hate liquor, hate themselves for succumbing, but they can't stop. Their drinking is as compulsive as the stealing by a kleptomaniac or the continual hand-washing of a person with a neurosis about cleanliness. It is useful to think of their drinking behavior as a symptom of some inner maladjustment which they do not understand and cannot control. The drinking may be the outward, obvious accompaniment of this more basic and hidden factor.3

Etiological Considerations.

The intrinsic factor which the author just quoted refers to has been sought for by many investigators. One approach has been in the field of genetics, where scientists have asked whether there is any truth in the popular belief that alcoholism "runs in the family." If heredity were indeed the determining factor, then rehabilitative measures would seem futile. The present status of the heredity hypothesis has been studied by E. M. Jellinek, Consultant on Alcoholism of the World Health Organization. He found that most research into the heredity of alcoholics has failed to separate biological from social factors, with the result that where heredity

seems to have been a decisive factor, actually the alcoholic pattern was acquired as a learned response. Furthermore, those cases showing a heredity taint were susceptible in a general way to maladjustive possibilities, including psychopathology, crime, and drug addiction. Only about 35 per cent of alcoholics show this indirect hereditary liability, and these are significantly associated with mental deviations.⁴

In one study in which an effort was made to distinguish between genetic and environmental factors, it was shown that children of alcoholic parents when raised in foster homes did not differ significantly from children living with non-alcoholic parents in their rate of alcoholism as adults.⁵ The importance of such studies is evident considering the implications of hereditary or constitutional theories for alcohol education. The alcoholic who is regarded as having been "born that way" is not likely to receive adequate treatment under tax-supported programs.

Other attempts to explain alcoholism have produced physiological hypotheses. Such factors as endocrine gland disease and dietary deficiencies have been proposed, but as yet without sufficient evidence or clear interpretation.⁶

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⁶ Vogel, op. cit., p. 621.
No doubt psychological approaches embrace the greatest number of observations, assumptions, and speculations. In the broadest sense these include any attempt to observe and interpret human behavior, whether by philosophers, theologians, scientists, or the man in the street. With varying degrees of precision, every man is a psychologist in this sense. The accrued experience of mankind is replete with descriptions of the causes and effects of alcoholic excess. These are evident in folk-lore, superstition, rational observation, and authoritative pronouncements as communicated in speech and in writing. Weakness of the will, demonic possession, perversity, sensuality, fatalism, inborn craving, and insanity have been indicted as causes of problem drinking (or of drinking in general).

Modern psychological theories, whether developed within the disciplines of professional psychology, psychiatry, or sociology, for the most part consider alcoholism to be a symptom of a basic personality disorder. The alcoholic, instead of following social custom in his use of alcohol, deviates from accepted usage in his reasons for and manner of drinking.

Noyes points to anxiety as basic to the alcoholic’s need for alcohol. Although anxiety is a common human experience, it takes many forms and can be handled in many ways. The

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7 Ibid., p. 622.
alcoholic is less able to cope with and tolerate psychic stress, and seeks relief and escape. Alcohol is not the only outlet, but it is one of the most available and potent ones, and once its effects are experienced, habitual use is easily developed.\(^8\)

The temptation is to think of alcoholism as applying to a single, unique type of personality. As one studies the personal histories of alcoholics, listens to their testimonial narrations at Alcoholics Anonymous meetings, and reads the literature of alcoholism, there indeed seems to be much to say for the existence of a unitary alcoholic personality. However, certain precautionary questions arise. First, does the existence of common traits or constellations of traits among alcoholics mean that non-alcoholics do not manifest such characteristics? Second, are the psychological traits ascribed to alcoholics the causes or the effects of alcoholism? These questions can be useful in studying the role of personality in the development of alcoholism.

Strauss describes alcoholic personality factors in terms of early experiences prior to actual drinking and at the same time suggests some specific emotional needs which characterize full-blown alcoholism.

Considerations of the etiology of alcoholism must include factors of personality development and

\(^8\) Alfred Noyes, *Modern Clinical Psychiatry*, p. 172.
of environment. Although a physiological basis for alcoholism has not as yet been determined, the possible existence of such a factor should be considered as a limiting if not a primary cause. Early environmental experiences and their role in the development of the pre-alcoholic personality are considered of major etiological importance. The alcoholic is characterized by the survival of early emotional responses to situations of stress, particularly those involving extreme pleasure or extreme pain. Alcohol for the addictive drinker represents the most valued means of gratifying keenly felt basic needs for achieving pleasure or avoiding pain.... Stress on the etiological importance of early environmental experiences and their role in the development of the pre-alcoholic personality seems justified by the fact that addiction to alcohol often appears in persons who have experienced relatively untroubled adult lives but whose problems are associated with neurotic tendencies tracing back to childhood. 9

Strauss also emphasizes that alcoholics represent a number of personality types and that aside from some unique traits they differ from non-alcoholics only in degree.

Landis, Associate Professor of Abnormal Psychology at Columbia University, has reviewed and evaluated several studies made of alcoholic personality. He states without qualification that

"...all of the studies which have been made thus far lead to the conclusion that there is no unitary grouping of personality traits or attitudes which truly characterize any considerable number of individuals addicted to the use of alcohol." 10

Although the above conclusion was current as of 1945, it was reaffirmed by Jellinek in 1952. 11


11 E. M. Jellinek, Phases of Alcohol Addiction, p. 683.
Wittman compared non-psychotic chronic alcoholics with non-alcoholics by means of objective-type personality tests. Aside from mild differences in traits such as mood stability, control of impulses, and open-mindedness, in the direction of maladjustment, the only distinguishing traits claimed for the chronic alcoholic were ease of social acceptance, lack of self-consciousness, unfavorable early childhood, and poor sexual adjustment.\textsuperscript{12} With reference to the preliminary questions posed by the writer above (p. 10), Wittman's characterization seems applicable to maladjusted persons in general rather than to alcoholics exclusively. A more intensive investigation carried out by the Yale Research Council on Problems of Alcohol led to the conclusion that:

In general, then, the evaluation of these three contrasted groups (alcoholics, recovered alcoholics, and non-alcoholics) indicated only that the intemperate use of alcohol affected those life and social adjustments which depend upon sobriety. Personality differences did not seem to be related to any of the background factors which have been thought to be of determining nature.\textsuperscript{13}

Up to this point the writer has reviewed a number of approaches to the subject of alcoholic personality with the main conclusion that alcoholism is not the inevitable result of any exclusive trait or set of traits, but is one of a number of possible

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\textsuperscript{12} Landis, \textit{op. cit.}, p. 132.
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\textsuperscript{13} \textit{Ibid.}, p. 133.
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avenues by which emotionally deficient or disturbed individuals seek solution of their problems. Social opportunity and imitation play a role in deciding what device the disturbed individual will adopt.

**Alcoholic Personality.**

Having explored the possibility of emotional factors belonging exclusively to alcoholics but not due to alcohol per se, the concept of personality types arising through the use of alcohol can be studied.

At the stage where alcoholic consumption ceases to be an auxilliary feature of social life and becomes disruptive there can be seen behavior patterns representing a functional interaction between the dynamics of the individual and the psychological effects of alcohol. The most conspicuous products of this combination are loosely synthesized in the popular mind into the stereotypes already mentioned. The tendency among professional workers is to classify types of drinkers according not only to outward behavior but, more importantly, to the covert emotional factors expressed through abnormal drinking.

Bacon distinguishes two major personality types of drinkers: primary and secondary. For both types drinking is compulsive and progressive, resorted to as a solution to or escape from psychic pain. The primary type has a history of warped, immature emotional development with overt signs of
this before problem drinking begins. Alcohol provides relief and subjective feelings of adequacy as long as it remains in the body. Without alcohol, old feelings are less endurable than before, and guilt and remorse over alcoholic behavior are added. A vicious circle is established, leading to further psychosocial maladjustment.14

The secondary type appears like the primary type in the fully-developed stages of alcoholism. However, he differs in his pre-alcoholic personality and in his prognosis. Before the onset of alcoholism he seems to be a well-adjusted, socially integrated person. He tends to be more aggressive in ways which indicate a need to work harder than others in order to be successful and accepted. At first he uses alcohol to ease the tensions of his routine adjustment, then he begins to use it as a substitute for social techniques. This leads to what is looked upon as a marked change in personality, which is actually a reaction to his realization that he is no longer adequate socially and vocationally. He rationalizes, isolates himself, reacts in a self-centered way. But because of his previous personality skills and experience, he responds better to treatment than the primary type.15

Strauss describes three types: uncontrolled drinking in an obviously maladjusted person; uncontrolled drinking in a

14 Bacon, op. cit., (pages unnumbered).
15 Ibid.
person whose outward responses appear normal and acceptable; excessive but controllable drinking by the social misfit who seeks excitement to offset an otherwise lonely or colorless existence. All three types exhibit early emotional responses carried over into adult life, especially with reference to escape from pain and attainment of pleasure. 16

Tiebout, instead of describing types of drinkers, observes that a fairly typical personality pattern arises in the development of alcoholic illness. The following tendencies are found:

1st: Tense and depressed;
2nd: Aggressive, or at least quietly stubborn;
3rd: Oppressed with a sense of inferiority, at the same time harboring feelings of superior worth;
4th: Perfectionistic and rigidly idealistic;
5th: Weighed down by an overpowering sense of loneliness and isolation;
6th: Egocentric and all that implies in the way of a basically self-centered orientation;
7th: Defiant, either consciously or unconsciously;
8th: Walled off and dwelling, to a large extent, in a world apart from others. 17

The various descriptions, given by prominent investigators of alcoholism, though differing in many respects, include

16 Strauss, op. cit., p. 422.
17 Harry M. Tiebout, Conversion As A Psychological Phenomenon, p. 1.
common aspects of alcoholism, such as loss of control over drinking, the isolation and hostility in the personality of the drinker, and the vicious circle of the drinking process. If these descriptions have a static quality, a more dynamic one is available in the work of E. M. Jellinek,¹⁸ whose method of study is not only more functional but also shows how the differences of presentation by the other authors may be reconciled.

Jellinek follows the problem drinker through several "phases" in the development of alcohol addiction. Each phase embraces a sequence of symptoms which represent the average trend. Individual differences in the order and duration of symptoms are recognized. First is the "Prealcoholic Symptomatic Phase," which begins with the conventional social use of alcohol and gradually becomes more and more drinking for relief of tension. Overt intoxication rarely occurs at this stage, but relief drinking becomes a daily routine.¹⁹ When regular drinking produces episodes of amnesia known as "alcoholic palimpsests," the "Prodromal Phase" has begun, indicating increased susceptibility to alcohol and accompanied by preoccupation with alcohol, guilt and denial, and fear of being without alcohol near at hand at all times.²⁰ The "Crucial

¹⁸ Jellinek, op. cit., p. 675.
¹⁹ Ibid., p. 676.
²⁰ Ibid., p. 678.
Phase" is reached when drinking is definitely beyond control and a physical demand is felt. That is, the drinker can refrain from alcohol in particular situations, but once he decides to take one drink he cannot stop until thoroughly intoxicated. The alcoholic at this stage is usually still able to hold his job.21 Motivation permits marginal social adjustment until the "Chronic Phase" is reached. Then prolonged "benders" occur and social and psychic deterioration accelerates, since resistance is broken down and drinking is obsessive. The need to control the psychic and physical symptoms of drinking by more drinking exceeds the original need engendered by the original personality conflicts.

Jellinek considers this phase and the latter part of the crucial phase to be the only ones to which the disease concept can correctly be applied. Whatever personality factors may have led the sufferer to resort to alcohol for symptomatic relief, when these phases are reached, alcoholism becomes an addictive disease relatively independent of the original factors.22

**Medical-Psychiatric Aspects.**

Since the individuals to be considered in this study have been mental hospital patients, it is appropriate to review

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21 Ibid., p. 680.

22 Ibid., p. 682.
the major mental and associated physical disorders found in advanced alcoholism admissions.

**Delirium tremens** is an acute psychosis characterized by fearful agitation, hallucinations, tremors, and confusion. It occurs usually a few days at a time in chronic alcoholics over thirty years of age.23

**Korsakoff's psychosis** includes symptoms of confusion as to time and place, amnesia for recent events, falsification to compensate for memory loss, and euphoria. If damage is not permanent partial recovery may occur after about six weeks. Both this disease and delirium tremens are due not to the direct effect of alcohol but to poor nutrition, especially vitamin B deficiency, typical in chronic alcoholism of many years duration.24

**Alcoholic hallucinosis**, as the name implies, refers to an acute psychotic episode with hallucinations as the main feature. The patient hears accusing, threatening voices usually blaming him for sexual offenses. Delusions develop with relevant fear, anger and suspicion. This condition develops in introverted personalities and may lead logically to schizophrenia. Otherwise recovery can be expected in from five days to a month. Homosexual guilt is considered a basic


emotional dynamic in this disease. 25

Alcoholic paranoia is distinguished from the various paranoid conditions of non-alcoholics only in its being precipitated by the use of alcohol in a paranoid personality. As an exaggeration and release of life-long tendencies, the symptoms include delusions of jealousy, behavior based on strong feelings of guilt, fear, and suspicion, and an irritable, demanding approach to others. The outcome is poor. 26

Alcoholic deterioration covers a broad class of organic and psychosocial signs of the long abuse of alcohol. The victim shows diminished psychological and physical efficiency, is unrealistic and primitive in his thoughts and actions, and lacks the usual quality of social ties and ambitions. Superficially he may be friendly and cheerful, but is easily stimulated to wrath. The outcome depends on the recency of the disease, though at the time of admission to a mental hospital it is often too late to bring about complete recovery. 27

In addition to the above diseases there are several others less commonly found, such as alcoholic pellagra, alcoholic beriberi, and other nutritional diseases indirectly due to the predominance of alcohol in the diet. About one-fourth of all alcoholics so use alcohol to the exclusion of necessary

25 Ibid., pp. 182, 183.
26 Ibid., p. 184.
27 Ibid., pp. 185, 186.
vitamins that physical and mental symptoms of nutritional diseases appear.28

Social Significance of Alcoholism.

As of 1948 the drinking population of this country numbered sixty-two million. Of this number, nearly four million were alcoholics, of whom one million showed the physical and mental complications described in the above section. There are about six times as many men as women alcoholics, although this difference in proportion is diminishing.29

In a highly industrialized, heterogeneous society such as ours, the individual does not find life, purpose, social acceptance and understanding, or freedom from the stress of excessive competition as easily as he would in a simple community. In the latter setting alcohol would be used usually as a ceremonial drink or at least without clear and rigid sanctions. In America alcohol is used more as a device for creating social moods which are otherwise hard to create as quickly and easily as in more spontaneous, homogeneous groupings. Sanctions still prevail to the extent that it is considered poor taste to drink too much or at all at certain times and places, and a sign of something wrong to drink much in private. The alcoholic, however, uses alcohol not to enhance his ability to enjoy social occasions but to achieve

28 Lolli, op. cit., p. 2.

the effects of alcohol as an end in itself, as is described above in discussing definitions of an alcoholic. At this stage the alcoholic is out of touch with society to some degree. This involves disturbed family relationships, occupational maladjustment, and often difficulty with the law.

Business and industry, according to industrial statistician Dr. Benson Landis, lose about one billion dollars annually to alcoholism. This does not take into account the intangible losses caused by the influence of drinking problems upon the morale and effectiveness of those who work alongside of the alcoholic.\textsuperscript{30} Difficult to measure is the total additional cost to government agencies, public and private social service agencies, and other groups and persons who are called upon to cope with the results of alcoholism. In 1940 state mental hospitals admitted an average of eleven thousand alcoholics a day (including readmissions). The cost that year for all types of hospitals for handling alcoholics was about thirteen million dollars. These figures represent patients with alcoholic psychoses.\textsuperscript{31}

The effect of excessive drinking on American family life has been described by a variety of sources ranging from temperance movements to studies reported in scientific journals.


Well-known are some of the gross results of alcoholism—marital strife, abuse and neglect of children, and economic hardship. Less commonly understood is the fact that aside from the disruptive influence of alcoholism upon family life, alcoholics as a group are less likely than non-alcoholics to enter marriage. Bacon reports that in a representative survey it was found that only 23 per cent of arrested male inebriates were married and living with their wives, in contrast to the 72 per cent rate for the ordinary male population. Over half of the inebriate group was single as against one-fifth of the normal population. The divorce rate among inebriates was twelve times that of the general population. The role of personality traits commonly found in alcoholics is described by Strauss in relation to family life:

Considering the basic institution of the family, which is the center for interpersonal contacts on an intimate level, it is known that alcoholics either never marry or suffer from marital discord. Often the same personality traits which are associated with his excessive drinking act also to make the alcoholic ill-suited for family living. The family demands a giving of oneself and a sharing of personal and emotional experiences and of such factors as affection, prestige, and self-respect. All this is particularly true amidst the growing complexities of life in specialized society for more and more the family is becoming the only medium by which the individual can achieve these personal gratifications. Yet it is demonstrated that the alcoholic is often a person who is incapable of sharing on an intimate personal level and that he

will frequently make completely unrealistic and unreasonable demands of those around him.\footnote{33}

It should not be thought that alcoholism, together with crime, mental illness, and high taxes, is simply a morbid influence present in an otherwise healthy society. All persons, unless they be those creatures of folk-lore brought up by animals or elves, develop psychologically through processes of human interaction, modified by and modifying the actions and reactions of other persons. To the extent that currents of anxiety, fear, confusion and contradiction run through human groups, to that extent are persons born into that social climate in danger of faulty adjustment such as alcoholism. A detached analysis of social forces operating against individual emotional health is given by Dr. Robert Seliger,\footnote{34} who depicts the alcoholic as one who, unable to cope with life as he finds it, tries to escape through drink and finds that he has thereby increased his problems.

Treatment.

Having considered alcoholism in terms of definition, etiology, personality, clinical manifestations, and social factors, the question of what to do about it remains.

At the societal level legislative and educative solutions have been applied. A historic measure was National

\footnote{33 Strauss, \textit{op. cit.}, p. 422.}

\footnote{34 Robert V. Seliger, \textit{A Guide on Alcoholism for Social Workers}, pp. 83-87.}
Prohibition, the results of which are still a matter of controversy. As a governmental experiment it led to the development of legal controls at state, county, and city levels. In the process of creating and the repealing by constitutional amendment a national prohibition of alcohol the American people recognized the importance of alcohol as a social problem by twice changing the structure of their government.35

For both treatment and preventive purposes education from several sources is being carried on to inform and arouse the public as to the extent and nature of alcoholism, what is being done, and what can and should be done. Outstanding among these are:

1. Innumerable local groups of Alcoholics Anonymous.
2. Forty-six Community Committees for Education on Alcoholism affiliated with the National Committee on Alcoholism.
3. Forty-five State Commissions.
4. A number of scientific and professional groups; initiated in the Department of Applied Physiology at Yale University.36

At the individual treatment level two facilities have been traditional—the jail and the mental hospital, at both of which custodial care and absence from alcohol was and in many places today still is the extent of treatment. Under such

35 Edward B. Dunford, Legal Aspects of Prohibition, p. 348.
conditions the alcoholic pattern is resumed as soon as the incarceration ends. Despite the high cost of maintaining alcoholics in jails and state hospitals, the results have been poor in terms of cures or knowledge gained concerning alcoholism. The reason, according to Novick, is that only a separate institution where a program organized especially to treat and study alcoholism would be feasible.37

Such a program is now being carried on in numerous clinics, some separate and others associated with hospitals. In Massachusetts, in 1950 legislation authorized the setting up of alcohol clinics under the Department of Public Health to be operated in cooperation with general hospitals. The plan includes the use of multiple services such as medical, psychiatric, and social service, coordinated by the physician in charge.38

Where funds and facilities permit, several treatment approaches are possible. Non-specific medical treatment aims at restoring the alcoholic's nutritional state, especially in those advanced cases suffering from vitamin deficiencies. Also, patients admitted with acute intoxication are relieved by the use of insulin and glucose. Specific therapy, however, is likely to be fruitless as far as long-term results are

38 Massachusetts Department of Mental Health, Alcoholism: A Public Health Program for Massachusetts, pp. 5, 6.
concerned if the patient denies his problem or does not desire to stop drinking. More so than with many illnesses, treatment success depends on the attitudes and understandings of all who are involved in the therapeutic relationship. The patient is to be seen not as a moral problem but as a sick person—emotionally in terms of physical addiction, usually both—and one who requires infinite patience and acceptance plus sometimes a tactful firmness.

Above all, and regardless of the method used, the following condition obtains:

All agree that total abstinence is the sine qua non of successful therapy—some think it is the only goal—and that the patient, in some way or other, must incorporate within himself a deep belief that he will never be able to drink socially. All believe that no matter how foolproof the scheme he devises, the odds are heavily weighted against him should he attempt to drink moderately. For him to accept this—and this applies to any addiction—is extremely difficult. The way he accepts this, how intensely, honestly, and deeply, determines the ultimate therapeutic outcome.39

Noyes aptly states that "...the object of treatment should be directed toward preventing the patient from desiring alcohol rather than toward restraining him from having it."40 There are several means of doing this. Most direct and dramatic are the conditioned reflex and the antabuse methods. In the conditioned reflex or aversion treatment the patient is

39 Vogel, op. cit., p. 622.
40 Noyes, op. cit., p. 187.
encouraged to drink, smell, and see various liquors while under
the influence of emetine, a drug which produces nausea. After
a course of eight treatments reconditioning is done six months
later. As high as 65 per cent of recovered patients have been
reported, based on a standard of four years of abstinence.
Recovery rates vary according to the means of selecting
prospective patients.41

A similar conditioning process is used initially in the
antabuse method, except that for an indefinite time thereafter
the patient takes a daily dose of antabuse which causes him to
become violently nauseated if he takes alcohol. The success
of this method justifies its continuance, but its proponents
stress that it is only a partial solution of alcoholism. Its
main value is in making more inclusive and long-range measures
feasible, so that the patient's attitudes and socio-economic
condition favor the working out of basic personality problems.
This qualification is applied to all such conditioning methods.42

Another qualification is that the success of antabuse as part
of the total treatment program depends on the relative psychic
normality of the patient and on the cooperation of his family.43

With or without the above aids, treatment should aim at
solving as far as possible the drinker's emotional conflicts.

41 Robert Fleming, Medical Treatment of the Inebriate,
p. 397.
42 Charles T. Brown and Edward C. Knoblock, Antabuse
Therapy in the Army, pp. 201, 202.
43 Erik Jacobson and O. Martinsen-Larsen, Treatment of
Alcoholism with Tetraethylthuiram Disulfide, p. 922.
social malfunctioning, and often as a first step, the meeting of emergency needs in the immediate situation of the patient and his family. In doing these things the clinic or hospital is greatly aided by having available a psychiatric social worker and a recovered alcoholic. (The value of the latter will be discussed in the next chapter.) A team offering several coordinated services is consistent with the principle that the alcoholic presents not just one problem or needs just one treatment approach but a number of problems and needed measures. This involves the use of environment as well:

No therapeutic approach can dispense with a study of, and when required, a manipulation of the addict’s environment. Because of his deviating behavior, the addict has been facing and painfully reacting to a sense of isolation from the society to which he belongs. This sense of isolation, which in many cases precipitated the addiction, almost invariably plays an important role in its perpetuation. Hostility of relatives, unemployment, and conflicts with the law are only a few examples of environmental difficulties whose solution should be attempted whenever they are present.

The sense of isolation referred to above often carries with it resentment, suspicion, negativism, and cynicism which must be recognized and dealt with by those who would help the alcoholic. Minor delays may cause the alcoholic to avoid treatment by rationalizing and exaggerating whatever is counter to his weak motivation. These negative forces make for poor

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45 Lolli, *op. cit.*, p. 3.
success of methods such as psychoanalysis which requires more motivation and psychic endurance than many alcoholics can supply as long as they still feel unable to live without alcohol. It is important to make the most of the early setting of therapy by by-passing resistances and providing quick relief of psychic and physical symptoms.46

In summary, this chapter on the characteristics and treatment of alcoholism presented a consideration of definitions of alcoholism, some theories as to its causes, and the role of personality in the different stages of alcoholism. Alcoholism was seen to be based on a compulsive, uncontrollable need to drink in persons of immature, unstable emotional make-up who come to rely upon alcohol as a solution or escape from anxieties experienced in personal-social life. Several classifications of alcoholics were presented and compared, the significant factor seeming to be the drinker's stage of transition from drinking as symptomatic relief of pre-alcoholic anxieties to chronic addictive drinking as a psycho-physical disease. The results of long chronicity—the major alcoholic psychosis—were described, with malnutrition given as a major factor.

In its social aspects alcoholism was shown to be a major national public health program arising not simply as the

46 Vogel, op. cit., pp. 622, 630.
effect of excessive drinkers upon society but as a complex result of the wide availability of a powerful drug in a confused, stressful society. The significance of alcoholism in family life was stressed. The average alcoholic is not inclined to enter marriage, and lacks the quality of maturity necessary to fulfill the role of spouse and parent.

Turning to treatment, social and individual approaches were indicated. Emphasis was given to the principle areas of individual therapy. Sincere motivation as a condition and the ability to live totally without alcohol as an indispensable goal were found basic to all major therapies. Treatment goes beyond mere cessation of alcohol intake; it must combine physical, emotional, social and economic rehabilitation through the coordinated help of a clinical team. The concept of alcoholism as an illness, and of the alcoholic as a person with a manifold problem, favors the attitudes of acceptance, patience, and understanding essential to intelligent treatment.
CHAPTER III

THE ALCOHOLICS ANONYMOUS MOVEMENT

A fellowship of over 150,000 alcoholics meeting in five thousand groups in this and many other countries constitutes that loosely organized association known as Alcoholics Anonymous. Its purpose and description appear in most of its literature as follows:

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is an honest desire to stop drinking. A. A. has no dues or fees. It is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

The movement started in Akron in 1935 when a businessman, achieving sobriety after many years of drinking, undertook to help a doctor whose professional and private life had deteriorated through alcoholism. They found that by helping other alcoholics they could perpetuate their own sobriety, and by attracting others to this idea they started the informal fellowship which at first slowly, then with more momentum

1 Alcoholic Foundation, A. A.—Questions and Answers, pp. 12, 13.

2 Alcoholics Anonymous, This is A. A., p. 3.
became known internationally by 1939. Today though it is still loosely structured, it has a name, books, pamphlets, a periodical, and service centers.3

Although Alcoholics Anonymous (hereafter referred to as "A. A.") has no official creeds, theories, or requirements beyond the desire to stop drinking, it has evolved a tradition and certain viewpoints with which most members identify. These common elements are not static but change with experience. The nucleus of the movement, however, is a consistently presented Program of Recovery--The Twelve Steps:

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.

3 Ibid., p. 13.
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 the message to alcoholics, and to practice these principles in all our affairs.4

This plan is not urged upon the alcoholic. It is suggested as steps to be taken gradually and as an ideal way of living to be assimilated according to individual needs and readiness. With a realism acquired through painful experience, older members advise newcomers to strive for abstinence a day at a time. Such a program avoids the tremendous feeling of despair evoked by the idea of trying to face an indefinite period of time without alcohol; and having gone twenty-four hours without liquor increases one's confidence in the possibility of doing so tomorrow.

In its relationship to society at large, A. A. has no legal structure, carrying on its co-ordinating and informational functions through rotating committees of non-salaried members. It cooperates with individuals and groups but without forming official connections or affiliations or accepting large contributions from any sources. Anonymity is an absolute rule of members when representing the group publicly as

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4 Central Service Committee of Boston, *Introduction to A. A.*, p. 6.
speakers, writers, or delegates. In private life anonymity as an A. A. member varies according to situations and judgment. According to the pamphlet "A. A. Tradition", early secrecy impeded the work of A. A. groups by not reaching enough people through making their presence known. The guiding principle is that personal glorification and publicity detracts from the spiritual aspect of the movement.

The alcoholic coming for the first time to an A. A. meeting may be surprised to discover that the kind of approach which has aroused his guilt, anger, and disgust in other settings is not there. Instead of lectures, sermons, or exhortations he hears former alcoholics take their turns at telling the part alcohol played in their lives and how they came to live without it. Their styles of narration bespeak every level of education and vocation; but whether haltingly or fluently spoken, their stories usually catch the newcomer off guard, because it is evident that they know all the rationalizations, intricate self-deceptions, fantasies, self-disgust, and isolation that the listener has experienced. Details differ, but the themes are surprisingly familiar.

The prospective member learns that no one is telling him what to do—that would be futile—but that he may if he chooses do what other more or less confirmed alcoholics have done. The pressure to change comes from himself, but with the

5 Alcoholics Anonymous, A. A. Tradition, p. 15.
help of other members available if he wants it. For most alcoholics the A. A. group is the only social occasion where they can feel accepted and understood, worthy and equal. He is no longer grappling alone with an affliction that nobody, perhaps including himself, can understand and forgive. Few alcoholics profess to know why they drank or exactly how they came to lead a happier life, but are content with the knowledge that for them A. A. works.

From direct observation and through contact with various fields of research, A. A. members have acquired certain understandings about alcoholism. They define alcoholism as an illness consisting of "a physical compulsion coupled with a mental obsession," meaning that the alcoholic has a physical craving stronger than his capacity for control and which transcends good judgment. When the alcoholic admits that he is in this category, he has made the first step toward recovery. This does not mean that he can regain his ability to drink moderately, for A. A., along with professional students of alcoholism, have found that an alcoholic can never drink in a controlled manner. A dramatic example of this fact, as told in A. A.'s "Big Book," is of an alcoholic who recovered and was abstinent for twenty-five years. Then, imagining that he could now drink like other men, decided to

6 Alcoholics Anonymous, This is A. A., p. 8.

7 Alcoholics Anonymous, The Story of How Many Thousands of Men and Women Have Recovered From Alcoholism, p. 43.
try, and in two months was in a hospital. Only two choices are possible for the alcoholic: either he stops drinking completely or he lets his alcoholism become progressively worse.

When an alcoholic has attended local group meetings long enough to know by his own experience how successfully alcoholics can help others to stop drinking, he has already filled the void produced by abstinence and is ready to increase his own new sense of meaning and worth in his life by contributing time and effort to help others. This is a most important treatment method in A. A. It may consist of giving testimonials, staying with another alcoholic during a period of temptation, or helping him get a job. It may involve visiting a chronic alcoholic at a state hospital or jail to show him that if the visitor could "hit rock bottom" and recover, then there is hope for him also.

As for the change that occurs in an alcoholic who responds favorably to A. A., it often has the quality of a conversion experience. Tiebout has studied this at length, and reports:

Perhaps the most striking change of all is the total loss of the sense of isolation and loneliness. The alcoholic patient does not feel merely isolated and alone; he feels that he actually exists in a world apart from other people and that something almost tangible keeps him from any deep human contact. Various he calls this almost tangible something a wall, a shell, a barrier. One patient dreamed of it as a moat between himself and the

world. Whatever it is, it vanishes with a conversion experience and in its place the patient begins to feel, perhaps for the first time in his life, a sense of the nearness and reality of other people. This feeling of nearness is closely akin to non-sensual love, and is described in such terms as "a great feeling of humanity," "a real inner friendship toward people," and "now I feel nice to everybody and I think they are nice to me." Others in telling of the disappearance of the wall will say that they can really like people and be tolerant of them, even if they know much about them which once would have kindled strongly hostile attitudes.9

In another discussion Tiebout distinguishes between compliance and surrender as significant terms in therapy. Compliance is an acceptance at the conscious level of the advice and persuasion of others. This may arouse guilt in the alcoholic because he is dishonest in agreeing to proposed changes of behavior which underneath seem impossible or undesirable to him. This is a state of conflict which is resolved only when unconscious change, usually gradual but sometimes sudden, appears as surrender to a plan or goal and subsequently the feeling, described above, of being at peace with self and others. In many cases A. A. alone can make a non-alcoholic way of life seem possible, desirable, and personal, as opposed to socially imposed or merely reasonable.10

The experience of A. A. has been that its program will work for almost any alcoholic who honestly admits his illness

9 Harry M. Tiebout, Conversion As A Psychological Phenomenon, p. 2.

and sincerely wants to stop drinking. Successful members include those who have been in jails, mental hospitals, and "Skid Row." In addition to the usual community groups A. A. holds meetings in more than sixty-two prisons and in over one hundred and two hospitals, mostly state hospitals.

In the hospitals A. A. has not only put alcoholics on the road to recovery, but has also helped change the attitudes of many doctors regarding alcoholism. Because traditionally few alcoholics responded adequately to treatment and would be readmitted frequently to "sober up," they were, and in many places still are, regarded as nuisances and not appropriate cases for the average institution. When doctors observed what A. A. can do, a trend of welcome and cooperation began, with A. A. individuals and groups invited to the hospitals.

To A. A. hospitalization is not a rival method or an unrelated one. It is often seen as a necessary first step in terms of physical rehabilitation and a chance to become sober under supervision. It is also an ideal place to present A. A. to the prospective member. His situation makes it difficult for him to deny his need for help, his coming to the hospital being a clear instance of his inability to manage alcohol. While confined he is visited by A. A. members and may be


12 Boston Committee on Alcoholism and the Massachusetts Department of Public Health, New Developments in A. A. p. 29.

assigned a "sponsor" before or after admission, to see that he has full exposure to A. A. inspiration.\textsuperscript{14}

Under the alcohol clinic program operated by the Massachusetts Department of Public Health jointly with hospitals, local A. A. groups are contacted routinely as part of therapy for many patients.\textsuperscript{15}

At the Rockland State Hospital, Orangeburg, New York, with the encouragement of that institution, an A. A. group held meetings there and took patients outside to an A. A. clubhouse. Eleven months after the start of this program, hospital records showed that of fifty-four patients released to A. A., seventeen had remained abstinent, and fourteen had only one relapse. The rest either resumed their old patterns or returned to the hospital. Considering that most of these were old chronic and "skid row" men, the results were promising, being a 54 per cent higher recovery rate than the usual 5 to 6 per cent rate achieved by public hospitals.\textsuperscript{16}

Hospitals serving higher socio-economic levels of population have had even greater success, one suburban hospital yielding as high as 80 per cent recoveries in groups aided by A. A.\textsuperscript{17}

Statistical studies on a national scale have produced an "A. A. Index," whereby a relationship between the number of

\textsuperscript{14} Alcoholics Anonymous, \textit{A. A. Tradition}, p. 23.

\textsuperscript{15} Massachusetts Department of Public Health, \textit{Alcoholism: A Public Health Program for Massachusetts}, p. 5.

\textsuperscript{16} Jack Alexander, \textit{Alcoholics Anonymous}, p. 12.

\textsuperscript{17} \textit{Ibid.}, p. 13.
alcoholics is compared with the number of A. A. members by geographic regions, in addition to comparative rate of alcoholism changes between 1940 and 1948. The results suggest a definite decrease in alcoholism where A. A. activity is strongest, with New England showing the most progress. ¹⁸

Representative of the enthusiasm of leading medical specialists in the field of alcoholism is the following:

As a physician who has watched the growth of Alcoholics Anonymous from the day of its inception, I can personally vouch for the recovery of scores of alcoholic cases which were of the type with whom other methods failed completely. These facts seem to be of extreme medical importance; because of the extraordinary possibilities of rapid growth inherent in this group they certainly mark a new epoch in the dark annals of alcoholism.¹⁹

In this chapter the Alcoholics Anonymous movement has been described. Its unique feature is in the proved value of alcoholics helping each other to stay sober and to establish a new life. The "Twelve Steps" is the suggested program whereby the alcoholic, beginning with the requisite sincere desire to live without alcohol, gradually undergoes a wholesome change of thought, feeling, and action. The fellowship of A. A. recreates the social identity of the individual, removing the need to perpetuate the destructive cycle of alcoholic adjustment. Belief in a power greater than oneself,

¹⁸ E. W. Jellinek and W. Keller, Rates of Alcoholism, p. 53.

acknowledgment of being now and forever unable to drink moderately, and practice of the important therapeutic principle of helping other alcoholics are basic A. A. principles.

With the spread of A. A. activity and of knowledge concerning its frequent superiority over other methods, hospitals and clinics are cooperating increasingly with A. A., and in many state hospitals A. A. is the only major therapy available after physical recuperation has been effected.
CHAPTER IV

A. A. AT THE BOSTON STATE HOSPITAL

Since 1946, at the invitation of Boston State Hospital, the main A. A. group of Boston has provided for weekly A. A. meetings within the hospital. Arrangements are made for members of various community groups to take part in these weekly meetings. The group is moderated by an A. A. representative who has done likewise at other state hospitals.

The main purpose of the meetings is to acquaint alcoholic patients with the A. A. program so that they will be encouraged to join A. A. groups in their own communities after they have left the hospital. Also, A. A. is often able to assist patients at the time of discharge with problems of family relations, employment, or housing. The meetings are open, so it is an opportunity not only for patients, but for psychiatrists and other staff workers to learn about A. A. as a resource.

Except for an occasional patient becoming disturbed during a meeting, the scene is typical of A. A. groups. The moderator opens the meeting by explaining what A. A. is, and speaks briefly of his own alcoholic history and subsequent recovery through A. A. Then he introduces the speakers, using only their first names. Each speaker begins by stating that he is an alcoholic, then tells the story of his drinking
problem and how A. A. helped him. These histories cover the range of alcoholic experiences, including prison, hospitalization for alcoholic psychoses, divorce and desertion.

This first hour of the meeting closes with a group recitation of the Lord's Prayer. During the second hour refreshments are served and patient-members are encouraged to talk with the leader and speakers. This is often the means whereby patients meet outside members who later bring them to a community group or make other contributions to their rehabilitation. The patients also can discuss their problems with staff social workers, at least one of whom is present at each meeting and can carry on a liaison function between A. A., patients, and staff.
CHAPTER V

CASE STUDIES

The following ten cases are presented in descending order of success, and are sufficiently disguised to protect the anonymity of the persons involved.

CASE A

Since the age of fourteen this twenty-eight year old father of three children has been drinking at an increasing rate. The youngest of four children, he had an unsettled childhood, his mother having divorced his father and married again to an alcoholic. The boy lived alternately with each parent, then lived with his mother and stepfather, but was not treated with affection by the latter. The patient was at that time a frequent truant and under these conditions began to drink. After graduating from trade school and working a while, he joined the Army during World War II. His drinking had become conspicuous in this period, and he was hospitalized after a series of alcoholic fugues. He was honorably discharged, returned to his welding job, and married. Although ambitious and conscientious as a husband, he became easily upset by financial responsibilities. In an anxious and irritable condition, he would argue with his wife, then go out to become drunk, sometimes being arrested. In 1946 he underwent psychiatric observation after two episodes of excited, abusive behavior while drunk. In 1951 he attempted to solve his problem by returning to the Army, but was in only a few months when his alcoholism led to a discharge for "fugue states." The pattern became more pronounced and in 1952 he attempted to kill his wife and himself.

In April 1953 he was arrested for threatening behavior while drunk and was sent by the Court to Boston State Hospital for observation. At the hospital A. A. group, which he attended twice, he quickly formed acquaintances with the speakers by
reason of his charming, friendly personality which is evident in his sober moments. He admitted being an alcoholic in need of help and agreed to act on an A.A. invitation to join a community group. At the same time he was awaiting action on his request for psychotherapy at a V.A. Hospital.

Follow-up: When interviewed in January 1953 the patient stated that his A.A. experience at Boston State Hospital was his first A.A. contact and that he began going to his local group right after discharge. He has remained sober, and has attended weekly, but has had several occasions to ask the assistance of A.A. friends to help him through anxious moments. He still considers alcohol a danger for him, and believes that he will need both A.A. and psychotherapy for some time. At work he has been regular and has advanced a grade. At home he has entertained A.A. members, whose talks have enabled his wife to help him with greater understanding. This was initiated by the local member who contacted him through the hospital A.A.

CASE B

This patient is a forty-five year old white male whose drinking began at the age of fifteen. His early childhood was uneventful except for the death of his alcoholic father when the patient was twelve. He was the third oldest of four boys, the oldest being the patient's favorite and also an alcoholic. Before joining the Navy at age fifteen, the patient had finished the eighth grade. Upon leaving the Navy three years later he worked a short time as a painter, then set up his own business. He disposed of this business after his brother died in an accident, and in a mood of grief started on his first long "binge." As his drinking progressed he began to stay away from his friends and relatives, and though he was previously well-liked and sociable, he no longer formed close friendships. Despite heavy week-end drinking he was able to hold his job, and at present believes that his employer has been unaware of his alcoholism.

When in his late thirties he felt the need to establish a home, and to accomplish this he met and married a girl much younger than he who eventually
left him when he objected to her entertaining her old lovers. He claimed that since he married not for love but for a home he was not greatly disappointed.

In recent years he has been arrested and sentenced several times for drunkenness and has been to several hospitals for treatment of delirium tremens. Just prior to his latest hospitalization he had attended two A. A. meetings in Boston, but this had no effect on his drinking pattern. In January 1953, the day before coming to Boston State Hospital, he had been drinking heavily and had not eaten adequately for weeks. When he began to experience the early signs of delirium tremens, he contacted A. A. for help in getting to a hospital. He was taken to a general hospital, but later was found running frantically down the street in a johnny, and was brought by police to Boston State Hospital.

Upon examination the patient was found to be a thin, malnourished person of average intelligence and good memory. The patient referred to himself as no good when drunk but an agreeable person when sober. He was diagnosed as a chronic alcoholic in an acute state of delirium tremens. Remorseful and depressed, he promised to attend A. A. He attended three times, the last time as a discharged patient in February 1953.

Follow-up: Eleven months later, in January 1954, the patient was interviewed at his rooming house. He appeared eager to describe his experiences and expressed the hope that his story would be useful. Since leaving the hospital he has remained sober although on several week-ends he came close to obeying the impulse to drink. He called an A. A. friend to sit with him during these times, but later found that he could attend one of the many A. A. groups any evening in the week as a means of avoiding liquor. Now he feels much safer, but still goes to weekly meetings, sometimes giving testimonials. He works for his former employer regularly. Before coming to Boston State Hospital he had been to two meetings at his present A. A. group but was not then ready to accept the program. At the hospital his recent delirium tremens and his sobriety on the ward caused him to be more receptive to the program presented by the hospital A. A., so that this experience he considers the real beginning
of his sobriety and his contact with his local group. Before the patient was discharged, a hospital A. A. worker arranged for a member to visit the patient's brothers to gain their help in returning him to social habits. The patient recalls that he had come to shun people for fear of disapproval of or interference with his drinking. He now spends most of his time in the company of relatives and A. A. friends, and is hoping to bring his older brother to A. A.

CASE C

This case concerns a thirty-six year old married Negro who was admitted to Boston State Hospital for the third time, in February 1953. He suffered from alcoholic hallucinosis.

The patient grew up in a family of four children of whom he was the youngest and the only male. His mother, who died of pneumonia when he was twenty, was indulgent and protective toward him as were his sisters also. His father, who died of heart disease a year before the mother's death, was a good provider and a devout man, but strict with his family, especially the patient. The latter felt inadequate to live up to his father's ambitions for him.

As a child the patient was healthy, did well in school, and was fond of being active in groups. He was more a follower than a leader. In late adolescence he socialized with mixed groups but was not strongly attracted to any particular girl.

According to the patient his drinking began when he was seventeen. He drank socially at first, not using alcohol heavily until 1941 when he joined the Army. At that time he began using alcohol to relieve unexplainable tensions and sleeplessness. Extensive combat experience had no immediate traumatic effect on him, but after the war he experienced greater anxiety and agitation than ever, and his drinking increased correspondingly. In 1949 he was discharged and went to live with a married sister. He could not keep a job because of drinking, and was beginning to have black-outs. After several episodes of destructive, assaultive
behavior due to alcohol he was brought to Boston State Hospital in January 1950. On admission he was extremely apprehensive and had visual and auditory hallucinations, the latter in the form of dead comrades calling him a homosexual. During examination he was found to be of average intelligence but lacking insight as to the seriousness of his drinking. He denied the problem, attributing his difficulties to nervousness beginning when he joined the Army. At the insistence of his sister he was released against advice, having improved but still having psychotic symptoms. He declined an invitation to visit the hospital A. A. meetings.

For about a year thereafter he was able to abstain for long periods of time so that he worked steadily and married. Then he began heavy drinking again and lost his job because of hallucinations. In February 1953 when this condition became worse he was returned to Boston State Hospital. He responded well to physical care, and this time accepted a social worker's invitation to attend the hospital A. A. group. After the meeting he said that the pronouncements of many doctors in the past combined with what he heard at the meeting convinced him that he was an alcoholic with an urgent need for help. In March 1953, shortly after his second visit to the A. A. group, he was discharged to his wife.

Follow-up: Soon after leaving the hospital the patient was introduced to an A. A. group in his community by a member whom he had met at the hospital group. He has attended the local group about twenty times, at first going weekly and for the past few months going less often as his need for support diminished. Occasionally he visits the hospital group for "sentimental reasons." Through the intercession of an A. A. member he was rehired by his former employer and has worked regularly. With the exception of one slip the patient has been abstinent. The exception occurred when he thought he had regained his ability to stop at one drink.

At the time of the follow-up interview the patient had been out of the hospital ten months. He felt that the hospital A. A. group had not only led him to a realistic picture of himself as an alcoholic but had provided faith in his ability to live without alcohol. His wife, who once shared
his denial of his alcoholism, has been able to understand and support his efforts by going to meetings with him. A. A. at the hospital was his first experience of it, and led to his sobriety. He still has periods of tension, but these are relieved by seeking the company of friends, and recently by giving his first testimonial.

CASE D

This forty-year old white, married, restaurant worker came in March 1953 for his fourth hospitalization for alcoholism.

His early history includes life with alcoholic parents who separated when he was very young, several foster homes, and a difficult school career. He did poorly and was sent to a class for retarded pupils. After leaving the sixth grade at age fourteen, he worked in a factory steadily for several years until he was fired for stealing. In his late teens he began a career of armed robbery and burglary, for which he received a total of seven years. Good behavior reduced his time to two years. Trouble finding work resulted in an irregular employment history ending in attempts to join the Navy. He was turned down but served three years in the Merchant Marine. After this he lost a series of jobs through drinking, but succeeded in getting married. Since 1935 he has been arrested for drunkenness and robbery several times and has been abusive at home.

In addition to this, he has been subject to a variety of anxieties, mostly sexual. His several hospital stays were for treatment of schizophrenic like reactions released by alcohol, and he has made suicidal attempts. His last admission to Boston State Hospital followed an acute alcoholic state in response to fears of persecution and destruction. This was in December 1952. Examination revealed homosexual fears, hostile feelings toward wife and mother, and poor capacity for responsibility and abstract thought. His intelligence tested at low average. A year later, after good response to insulin shock therapy, he attended hospital A. A. meetings in the company of his wife, who is more intelligent and mature than he is. Social case work had relieved much of their marital tension, and although the patient remained a dependent personality, his chances
of readjustment looked better. In February 1953 he was discharged.

**Follow-up:** As of February 1954 the patient had remained sober and had attended the local group to which the hospital A. A. group referred him. He had been working at the same job but plans to change to a better one. He still seemed dependent on his wife but was less resentful of this fact. He no longer attends A. A. as often as at first, but goes about once a month. A. A. friends see him often and he feels that their fellowship is gratifying after his former feelings of being locked down upon as a drunk and a criminal. There have been medical problems with the children, judgment and resourcefulness which the patient exhibits. His adjustment depends heavily on such help and the supportive features at A. A.

**CASE E**

This seventy-year old white, single, deaf restaurant worker was brought from a rest home where he attempted to bleed himself to death after a drinking bout.

Much of this individual's history is obscure, he being too deaf and confused to provide much information, the only other informant being a brother who had lost contact with him for many years. Born into a family of five children of Irish immigrant parents, the patient went through grammar school, then worked in groceries until he acquired his own business. This failed during the depression, and the patient drifted away from his old environment. Both parents were dead and only one brother remained in this state. The available history re-opens in 1940, when the patient began officially to be a problem drinker by being arrested over one hundred times and was known by many aliases. At the rest home he developed alcoholic hallucinosis, as evidenced by his hearing voices accusing him of being a homosexual and by delusions of being poisoned and electrocuted.

At Boston State Hospital in January 1952, he conceded that he had trouble with alcohol, and explained that he turned to liquor to escape the
awareness that his age and deafness prevented him from finding work. He felt that he had lost the desire to live. During his year at Boston State Hospital he attended the A. A. group often, saying that he could hear enough to know what it was all about, and that he wished he had known of A. A. earlier when he could have profited by it. He was returned to the rest home in February 1953 in an improved condition.

Follow-up: When contacted in February 1954 at the rest home, the patient was of a different opinion concerning the possibilities of A. A. in his situation. At the hospital, an A. A. member arranged to provide him with part-time work in a small factory. This member also conferred with a hospital social worker about a hearing aid, which was obtained through a public agency. The patient stated that the hospital A. A. group, his first A. A. contact, had opened the way to help and companionship that enabled him to stop drinking and find enjoyment in living. He attends a community group regularly. He wished to visit his brother but was hesitant after being out of contact so many years. An A. A. friend made a preliminary visit and paved the way for a reunion.

CASE F

The patient is a thirty-four year old, single, white, mechanic who came to Boston State Hospital after seven years of intensive drinking and was admitted in a state of incipient delirium tremens.

The youngest in a family of six children, he was the spoiled member. When he was two years old his father died, leaving the support of the family to the mother. He lived with her until he entered the Navy at age twenty-five. He finished a year of high school and worked as a factory mechanic eight years before entering the service. During his enlistment he was deeply affected by the sudden death of his mother. Soon after he was honorably discharged and returned to live with his aunt. She complained that he was no longer responsible and ambitious as he was before, but that he drank heavily and behaved recklessly. Because of his uncontrolled drinking his fiancee left him.
He acquired a record of many drunk arrests, and for several months prior to his first hospitalization he had been on long drinking sprees, and had slept in doorways, and was beginning to have tremors and convulsions. In November 1953 he tried to gas himself and was taken to Boston State Hospital in a state of terror from delirium tremens. At that time he was described as a chronic alcoholic with acute brain symptoms (D. T.). He did not visit A. A. during this admission and refused outpatient treatment. After recovering from his acute episode and being discharged, he remained sober for a month but stayed at home refusing to work. In December 1953 he was ousted by his aunt because of his being drunk again, and later was arrested for strange behavior when he wandered into a neighbor's house, presumably by mistake. Admitted for the second time at Boston State Hospital, he was studied more thoroughly and considered to be suffering from a prolonged anxiety reaction incident to his return to civilian life, with alcoholism as part of this reaction. He showed average intelligence and a friendly disposition when relatively at ease. At the invitation of an A. A. friend, he sat through two meetings of the hospital group. After the second meeting he told a social worker that one of the testimonials bore a resemblance to his own history insofar as it involved an unduly prolonged reaction of self-pity and resentment toward a bereavement.

Follow-up: Discharged two weeks later, he was sponsored by an A. A. worker at a community group and from this person received a loan to maintain him until he could get a job. Soon after he received his first week's pay he celebrated his good fortune by taking the one drink which inevitably leads to more. This was his only slip, however, and he has since remained sober. In addition to the regular attendance which he feels is necessary for sobriety, he has undergone therapy at a psychiatric clinic. He has worked on a regular basis and at work has practiced the "Twelfth Step" by talking with other alcoholics about A. A. He feels that without A. A. he would have continued to drink and would have resisted other kinds of help.

The above cases represent the success of the hospital A. A. group in reaching alcoholics who are sufficiently intact
emotionally and organically to respond to the A. A. method and atmosphere, even though other methods may not have worked. Combined group appeal and personal interest had a positive influence on post-discharge adjustment.

The remaining cases show poor response to A. A. associated with certain deep-seated personality patterns or organic deterioration, as discovered in the course of psychiatric examination, which limit the social perceptions and motivations necessary for change.

CASE G

This patient is a forty-eight year old, white, married, father of eight children. His is a case of alcoholic paranoia.

The patient spent his early years in a slum district of Boston, where he lived with his parents and ten siblings. There were four boys and six girls, the patient being second oldest. Although his mother, still living, gave an idealized account of their home life, reliable informants described the family as emotionally unstable, impulsive, and argumentative. The father was quieter than the rest, but nervous. He died in 1948 of heart disease. Despite the aggressive climate of the home, family ties were strong, the members coming readily to each other's defense.

After a reputedly normal birth and development the patient entered school at five years, finished ninth grade, then went to work in a market for six years. Later he worked in a foundry. He was said to be a hard-working, sociable person. However, he has a record of forty-charges dating from his nineteenth year. These include mostly drunkenness but also assault, malicious destruction, and non-support. His drinking began in the company of fellow workers. By 1932 he was arrested more frequently for drunkenness. He was married in 1936, and had no serious marital trouble until 1946 when his drinking
was more pronounced and he became verbally abusive. By this time they had eight children. He developed sexual impotence and began to accuse his wife of perversions and infidelity. To prove her unfaithfulness he went to extremes to find evidence, and finally left to live with his mother. He returned often to restore their marriage, but his wife secured a separation and then in 1951 had him jailed for non-support. As soon as he was released he returned to assault her. For this he again went to jail. When he repeated his behavior in 1952 he was committed to Boston State Hospital for observation. He showed delusions, impulsiveness, and sexual conflicts. The delusions were centered about his marriage. On the ward he was grandiose, overbearing, overactive, and full of complaints about his wife's mistreatment of him. Having a poorly integrated personality with strong resentments and paranoid projections, he proved an unpleasant person to deal with. Two months later he was allowed on a series of trial visits, but each time was returned drunk, excited, and confused. He attended several A.A. meetings at the hospital, but irritated the others by his attempts to dominate the meetings. By February 1953 he had reached a state of clinical remission so that he could again be released on trial visit.

Follow-up: When interviewed in February 1954, the patient tended to be defensive, tense, and abrupt, but outwardly cooperative. He said the hospital group was his first A.A. contact, and he experienced at the meeting an improved feeling toward himself by discovering that other people had troubles like his, sometimes worse. He found that other fellows were mistreated by their wives just as he had been. Now he stays away from her and has been able to stay sober for three months at a time. He has had three fairly steady jobs as a warehouse worker, with several weeks in between jobs. Although not attending A.A. meetings, he plans to start his own group some day. In accordance with trial visit regulations he reports monthly to the hospital and shows his negative traits with less intensity.

CASE H

The patient is a fifty-eight year old white, single male who has been in the care of Boston State Hospital from 1951-1953. He was diagnosed as having
alcoholic hallucinosis with chronic alcoholism.

The patient grew up in a mill-town in Northern Ireland where his father worked. Both parents were staunch Protestants opposed to drinking, and put a high premium on proper behavior. When the patient was twelve his father died of T.B., making it necessary for the boy to work to support his mother and two younger brothers. His mother died when the patient was fifty. The patient recalls being afraid and angry over having to take on family responsibility. At fifteen he entered the British Army. He worked in the officers' mess where with easy access to liquor he began to drink. By the time he was discharged in 1918 his alcoholic habits were quite conspicuous, so that he shocked his family. They sent him to America, hoping that better opportunities would change his habits. Here, he did not work steadily, remaining at each job just long enough to earn drinking money or until he was fired. Although he socialized easily and could make a good initial impression on prospective employers, he failed to form close friendships or become involved with women. His impression of himself throughout his adult life has been that of a lonely, misunderstood person rejected by his family.

By 1951 he had been arrested sixty times for drunkenness and had served several short sentences in jails and at the State Farm. He was sent from jail to Boston State Hospital suffering from depression, delusions, and hallucinations. He denied his alcoholism, blaming his troubles on a plot by prison officers to poison him. Physically, he was thin and malnourished, with evidence of some brain damage.

For two years he made a series of trial visits under the supervision of a lawyer who took an interest in him. The patient showed a reduction of social capacity, strong dependency, and poor judgment. On each visit he would adjust at a marginal level for about a month, only to be returned by the police in a state of hallucinosis.

In January 1953 he attended the hospital A. A. group three times, for the stated purpose of something to do. He was not convinced that the program would benefit him, nor was he sure that the speakers were really alcoholics.
Follow-up: From February 1953 to February 1954 the patient was on trial visit. During this time he was required to report once a month to the hospital. He had not contacted an outside A. A. group but claimed to be abstinent. His work adjustment apparently had improved, although he had changed jobs three times. He had been doing fairly well within the limits of a weak, deteriorated personality. He was indifferent toward A. A., and he declined any discussion of his drinking. Just before his trial visit time was ended, he became drunk and was sent from court to Boston State Hospital. This time he was pronounced sane and sent back to court, where he received a jail sentence of thirty days.

CASE I

This forty-five year old white, married, father of four children shows signs of alcoholic deterioration.

Third oldest in a family of seven children, he spent what was described as a healthy childhood without neurotic traits. After graduating from high school with honors, he worked as a furniture sales- man until 1940, at age 31, when he broke his legs in an auto accident which killed his father. After recovering from this, he changed from moderate to heavy drinking, losing several jobs as a result. He had been married since 1933 and got along well with his wife until his drinking became worse. He worried about sexual impotence, but later ascribed this difficulty to her. He managed to hold one job for two years, until his behavior required hospitalization. At that time he was spending most of his pay for alcohol and for extravagant gifts to casual acquaintances. When first admitted to a state hospital in 1940, he thought he was a police inspector being hunted by enemies, including his wife. At other times he was grandiose and euphoric. He responded well to treatment, but was periodically in need of further visits to hospitals, mostly Boston State Hospital.

In March 1953 he escaped and was brought back intoxicated. Examination showed organic brain damage evidenced by poor ability to plan, concentrate, and form social perceptions. On the ward he was verbose, impulsive, and superficially friendly but quickly offended. He came to the hospital A. A. meetings
four times, but denied being an alcoholic or anything but a mistreated gentleman. He sometimes disturbed the meetings. Further treatment was advised, but the court would neither authorize commitment nor receive him as an offender, so the patient left against medical advice.

Follow-up: The patient was eager to give his story but evasive about negative factors. As of February 1954 he had worked regularly, first as a shipping clerk, then as a food salesman. He lost the shipping job because, as he said, he was too ambitious to suit his immediate superior. As for his drinking, he has not stayed sober or attended A. A. Recently he spent ten days in jail but is not sure that he was really drunk. He was not living with his wife, explaining vaguely that he does not approve of her conduct, but offering no explanation of this.

CASE J

This is a thirty-seven year old salesman, father of three children, who was committed by the Court to Boston State Hospital for observation.

This oldest of three sons of a submissive father and an aggressive, rigidly religious mother, was expected to become a priest. He was indulged to the extent that he lived up to her expectations, which he did until his second year in a seminary when he decided that he was not suited to live a religious life. His rebellion incurred his mother’s wrath and permanent rejection, and his subsequent behavior reflected the strong effects of her attitude.

He became a salesman with an advertising agency and earned well despite his tense, self-abasing personality. By the time he married at the age of twenty-nine he had saved enough to begin paying for a large house. To help pay for the house the couple held dances for the Polish community of which they were members. They did well until the strain of overwork caused him to commit a financial blunder which led to the loss of his house.

This blow to his security and prestige was followed by recourse to alcohol, which shortly made
him susceptible to pathological intoxication—in which condition he would scream out the window, smash furniture, and have visual hallucinations. He had no memory for these attacks, which were witnessed by his wife and the police. However, these disturbances were repeated over a period of years without resulting in any care other than that given by a general practitioner. The patient refused to seek psychiatric help, but managed to avoid liquor for months at a time. With or without alcohol, his nervous, hysterical temperament made home life one of frequent arguments and frenzied accusations, so that when he got into trouble with the police, the social leaders in this well-to-do community prevailed upon him to leave town. He was bankrupt at this time.

From this initial economic and social failure he has yet to recover financially and emotionally. His wife had him summoned for non-support, and he began a pattern of appearances at court with reviews and extensions of probation. He derived secondary emotional gains through the attention given to his anxious, depressed, but ambitious behavior, although he complained that he was ashamed and frightened by his court experiences. He kept trying to find sales work, but succeeded only in getting temporary work and refused to take menial jobs that would give him a chance to live securely until he could regain his health and emotional stamina.

In December 1952 while under arrest for passing a bad check during a drinking episode, he had a convulsion and was sent to Boston State Hospital. At the hospital he proved to be of above-average intelligence but of an immature self-punishing character type. He was preoccupied with the belief that he had to earn one hundred dollars a week to satisfy his wife, and accused her of being unfaithful and a shoplifter. This was contrary to the knowledge of public welfare workers who were helping the family. His productions were considered to be paranoid rationalizations of his situation, and he was adjudged to have tendencies toward alcoholic paranoia. He resisted social work, psychotherapy, and A.A., but attended two meetings to divert himself from his anxieties. When he did allow an A.A. member to help find a better apartment for his family, he began to believe that his wife and the member were having illicit relations together. He was discharged to the court in January 1953.
Follow-up: The patient was granted more time to find work, but resumed periodic drinking, neglected his health, and spied on his wife. When drunk he would telephone or visit his wife to shout, swear, and weep. Several months later he was given the choice of going to jail or going voluntarily for out-patient treatment at an alcohol clinic. He chose the latter only because he would keep his freedom and self-respect. At the clinic he refused to use A. A. as part of his treatment but accepted the supportive aspects of psychotherapy to the extent that he could work and stay sober for long periods of time. In January 1954 he was brought by police to Boston State Hospital in a state of alcoholic frenzy and delusions.
CHAPTER VI

FINDINGS

From the above case studies the answers to the scheduled questions presented in Chapter I are:

1. For nine of the ten patients studied their attendance at the Boston State Hospital A. A. group was their first A. A. experience.

2. Six of the ten patients made contact with A. A. groups after leaving the hospital.

3. Six of the ten patients credit their contact with outside A. A. groups to their experience with the hospital group.

4. Of the ten patients, six were abstinent during the interval evaluated in the follow-up study. In two of the six cases one or two early relapses occurred before sobriety was established.

5. Six patients attended their local A. A. groups regularly during the greater part of their post-discharge time (at least twice a month).

6. Five of the ten patients were individually introduced or sponsored at their local groups through hospital A. A. action.

7. Six of the ten patients attribute their sobriety to the influence of A. A.
8. Six of the ten have been steadily employed.

9. In four of the ten cases help of a practical nature was given by A. A.

10. Four of the patients were helped in terms of family relationships by A. A.

Six out of ten generally, or about 60 per cent of the cases show in common the following community adjustment characteristics through A. A. help initiated by experience at the hospital A. A. meetings: contact with A. A. local groups; consistent sobriety; regular A. A. attendance after discharge; ability to work steadily.
CHAPTER VII

SUMMARY AND CONCLUSIONS

In this study the contribution of the Alcoholics Anonymous group at Boston State Hospital in the rehabilitation of patients admitted with alcoholism was investigated in terms of its leading these patients to contact A.A. groups upon their return to the community and of its influence upon their subsequent adjustment as seen nine to twelve months after discharge.

Sixty per cent of the patients studied responded favorably to the A.A. program introduced to them at the hospital. The rest made a precarious adjustment and were generally not amenable to the A.A. program.

The relatively smaller proportion of practical and social services performed under A.A. auspices is no doubt due to the fact that where the need exists, these services are routinely rendered by staff social workers.

Just as the early chapters were intended to give background and perspective to the problems of alcoholism met at the hospital, so the cases presented in Chapter V were organized so as to set the follow-up results in their personal-history contexts. Most of the cases were in advanced stages of alcoholism as described in Chapter II. The results of A.A. work with these cases are broadly consistent with
those obtained by other state hospital groups as reported in Chapter III (p. 39), the sixty per cent success of the Boston State Hospital group falling between the 54 per cent results with the most socially deteriorated population and the 80 per cent rate reported for higher socio-economic samples. Since Boston State Hospital handles a more representative population the in-between percentage is not a surprising result.

The results of the efforts of the Boston State Hospital A. A. group tend to favor its continuance as a treatment resource of the hospital. It has proved influential in guiding alcoholic patients toward A. A. membership in outside groups, and has played a vital part in their rehabilitation. Sobriety, better social and work adjustments, and renewed personal courage have followed initiation to the A. A. way of life. As a treatment resource its methods and possibilities should be made known in a systematic way to doctors, social workers and other staff specialists in order that referrals and co-ordination of efforts can be brought about in the most effective way.

Approved:

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APPENDIX I

1. Was the patient's attendance at the hospital A. A. meeting his first experience in an A. A. group?
2. Did the patient attend community A. A. meetings after leaving Boston State Hospital?
3. Does the patient attribute his attending an outside group to his experience with the hospital group?
4. Has the patient been abstinent since leaving the hospital?
5. Has the patient been a frequent attendant at A. A. meetings in the community? (At least an average of twice a month.)
6. Did an A. A. member invite or bring the patient to an outside group?
7. Does the patient attribute his sobriety (if he has been sober) to the influence of A. A.?
8. Has the patient been regularly employed?
9. Was any material or practical aid given through A. A.?
10. Did A. A. contact the patient's relatives or friends in his behalf?