Boston University

OpenBU http://open.bu.edu

Boston University Theses & Dissertations Dissertations and Theses (pre-1964)

1959

Characteristics of the abstaining and relapsing groups of conditioned reflex (response) therapy patients at the Washingtonian Hospital

https://hdl.handle.net/2144/22497

Downloaded from DSpace Repository, DSpace Institution's institutional repository

BOSTON UNIVERSITY

SCHOOL OF SOCIAL WORK

CHARACTERISTICS OF THE ABSTAINING AND RELAPSING GROUPS OF CONDITIONED REFLEX (RESPONSE) THERAPY PATIENTS AT THE WASHINGTONIAN HOSPITAL

A thesis

Submitted by

Florence Barbara Rudkin

(A.B., Boston University, 1950)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1959

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK
LIBRARY

TABLE OF CONTENTS

CHAPTER PAGE

I. INTRODUCTION 1

Purpose of the Study 1
Background for the Study 2

II. SETTING OF THE STUDY 8

III. TRADITIONAL METHODS OF TREATMENT AND CONDITIONED REFLEX (RESPONSE) THERAPY 11

IV. A TYPICAL GROUP-THERAPY MEETING OF CONDITIONED REFLEX (RESPONSE) THERAPY PATIENTS 20

V. THE ROLE OF THE SOCIAL WORKER 25

VI. SELECTION OF A CONDITIONED REFLEX (RESPONSE) THERAPY PATIENT AND FACTORS TO BE EXPLORED 28

VII. METHOD OF THE STUDY 32

Selection of the Sample 32
Sources of Data 33
Method of Data Collection 34
Limitations of the Study 34

VIII. PRESENTATION OF STATISTICAL DATA 36

Introduction 36
Definition of Abstaining and Relapsing Groups 37
Descriptive Information 38
Religion 38
Birthplace 39
Health 40

Table of Contents...continued

CHAPTER PAGE

VIII.

Patient's Pattern of Drinking 41
Type of Beverage 41
Age When Patient First Drank 42
Age When Drinking Became a Problem 42
Longest Sober Period Prior to CRT 43
Age at Time of Treatment 43
Prior Admissions to Other Hospitals 44
Social Class Membership 45
Education 45
Occupation 46
Marriage 47
Number of Children 48
Membership in Organizations 49
Personality 50
Personal Interests 51
Social Personality - Psychiatric Rating 51
Early History 52
Sexual and Marital Adjustment 53
Predominant Personality Type 55
Reinforcement Record 58
Number of Treatments Completed 58
Attendance at CRT Meetings 59
Changes Following Treatment 63

IX. SUMMARY AND CONCLUSIONS 66

Characteristics Common to Both Abstaining and
Relapsing Patients 68

Characteristics Differentiating Abstaining and
Relapsing Patients 69

APPENDICES 73

BIBLIOGRAPHY 80

LIST OF TABLES

TABLE PAGE

1. A Comparison of Success and Failure According to Religious Affiliation 39
2. Age When Patient First Drank 42
3. Longest Sober Period Prior to CR Treatment 43
4. Age at which Patient came for CR Treatment 44
5. Patients' Occupation and Outcome of Treatment 47
6. Ages at Which CRT Patients Married 48
7. Membership in Organizations 49
8. Psychiatrist's Rating of Social Personality 51
9. Statements of CRT Patients Concerning Their Sexual Relationship 54
10. Somatotype Distribution in the S, F, and U Groups 57
11. Treatments Completed in the S and F Groups of CRT Patients . 59
12. CRT Meeting Attendance Record of CRT Patients 62
13. Abstinence Record of the Relapsing Group of CRT Patients . . 63

CHAPTER I

INTRODUCTION

Purpose of the Study

Down through the mists of the ages there has been handed down to us an accumulation of lore concerning the drinking of alcoholic beverages. Poems have been written in praise of it; dramas have pointed out the shattering consequences to the individual who cannot free himself from his desire to drink. There have been few maladies upon this earth which have provoked such a variety of strong feelings as the problem of alcoholism. History tells us that in all societies, wherever alcohol has become a problem, there have been attempts to cope with it. Throughout these writings however, describing the various cures and philosophies, there has seemed to run a thin thread of hopelessness. It can be seen that the problem is still with us in both its moderate and extreme forms. This study will present one of the present-day methods of treatment for alcoholism, Conditioned Reflex (Response) Therapy, at the Washingtonian Hospital in Boston, Massachusetts, where it is felt that success can be achieved in the treatment of some cases. It may be that this new treatment method is at last on the way to removing the aura of hopelessness, that is, if patients can be selected from the larger alcoholic group who can be considered to have a fairly high probability of success. This Conditioned Reflex treatment group has a high percentage of successes. There are also a certain number of failures. The purpose of this study is to look more closely at the characteristics of both groups of patients, the successes and the failures, to

see if the number of successes can be increased by an even more careful selection of candidates for treatment. Before discussing the Conditioned Reflex treatment group, it would seem useful to discuss the larger group from which these patients are chosen and some of the theories of alcoholism.

Background for the Study

A general study of alcoholism serves to emphasize the elusive and compelling quality of an escape which the alcoholic knows, without help, can end in only one way. To society the alcoholic seems an unfortunate individual who cannot be relied upon to consistently carry his share of responsibility. Large numbers of persons feel the alcoholic is not "unfortunate", but merely lacks the moral fibre to carry on with his life. To himself, the alcoholic dreads his feelings of insecurity and inability to cope with his environment except when drinking. His daily living turns into a nightmare of guilt and self-loathing buffered by an air of bravado which he does not feel.

Psychiatric literature describes the alcoholic as an individual "who is unable to stop drinking although fully aware that drinking is detrimental to his life".[1] This dependency upon alcohol usually develops in persons who have a life-long pattern of feelings of inferiority and social tension. However, it should be noted, that alcoholics are usually of average intelligence, and some even far above the average.
The alcoholic, psychologically, presents a picture of reduced efficiency, while physically the main effect is in the cortical area of the brain.

---

[1]Joseph Thimann, "A Few Relevant Facts about Alcoholism and Alcoholics," p. 2.

The more visible change is the change in mood. It is this change in mood which is so easily observed by the lawman. The alcoholic himself, through his drinking, seems to gain, at least in the first stages, in self-confidence, helping us to understand the feelings of insecurity and the deeply rooted needs of the alcoholic for love and acceptance. A recent statement of an alcohol bears out this need for an enhanced self-image when he said, "When I drink, I feel ten feet tall!"

Alcohol, then, "serves a specific purpose - even if a destructive one - in the alcoholic's bodily and psychic economy, just as any neurotic symptom or character trait may serve the same purpose."[2]

There are many frameworks for the discussion of the problem of alcoholism. These include psychoanalytic, environmental, genetic, and physiopathological. The psychoanalytic theory emphasizes the theory of instincts with the alcoholic's regression from genital sexuality to a variety of fixation points. Thimann refers to the "latent heterosexuality" of the alcoholic,[3] that is, the individual never having quite obtained this genital sexuality. Vogel mentions Horney's cultural theories of the alcoholic's helplessness in a hostile world, Sullivans's "search for self-esteem", and Adler's "drive for superiority."[4] Vogel recognizes a common denominator in these various basic theories.

---

[2]Sidney Vogel, "An Interpretation of Medical and Psychiatric Approaches in the Treatment of Alcoholism," Quarterly Journal of Studies on Alcoholism, vol. 14 (December, 1953), p. 620.

[3]Joseph Thimann, Medical Director, Washingtonian Hospital, Boston, Mass., personal communication.

[4]Vogel, op. cit., p. 622.

The strong oral needs of the alcoholic with the frustrations he encounters in his object relations are dominant. All reflect the alcoholic's constant search for a safe haven, a place where he can rest from the insecurities within himself.

Although the psychoanalytic theory of alcoholism and the physical addiction to alcohol is the framework for this study, it does not imply that the door is closed to all other thinking on the subject. Perhaps this is one of the most attractive aspects for the caseworker considering the field of alcoholism; there is still so much to be done, and still so much to learn. In the field of genetics much work is being done, while new concepts are being developed considering the alcoholic as the victim of malfunctioning of some various bodily systems such as the endocrine.

It has been mentioned that the alcoholic, in his internal psychic structure, has a great need for increased self-esteem and social acceptance. In a sense, therefore, he is dependent, in a large measure, upon his society. "Alcoholism is not only a problem of individual treatment but of social attitudes."[5] Culturally we are a nation which condones "social drinking." It has become an accepted part of entertaining on a social level, while business views the "cocktail and the highball" as part of good business methods.

It comes as a surprise usually to the average person to find that addictive drinking may develop from continuous heavy social drinking.

---

[5] Paul Schilder, "Psychogenesis of Alcohol", Quarterly Journal of Studies on Alcohol, vol. 2 (September, 1941), p. 291.

Hoff feels that,

> The term social drinking should be applied only to those drinking occasions in which the social relations are the primary purpose, and the drinking secondary and supportive. A party in which the main purpose is to drink, lies outside the definition of social drinking, and falls under some other definition such as psychological drinking.[6]

The actual physical addiction to alcohol often follows, taking over as a part of the individual's life. Thimann feels that for the alcohol addict, therapy for the underlying neurosis is not enough. There is a point in some individuals at which relieving the personality disorder still leaves the addiction relatively untouched unless they are specifically treated for the removal of the craving for alcohol.[7] This concept is in effect the basis of the Conditioned Reflex (Response) Therapy.[8] It is also known in the literature as the Conditioned Reflex treatment, the aversion treatment, or as simply CRT.

> There have been very few studies which have systematically explored factors relating to success of CR treatment. In a study of 830 patients at Shadel Sanitarium, Seattle, Washington, Lemere, Voegtlin, Broz and O'Halloran,[9] in 1942, found that "the percentage of cures could be greatly improved by a proper selection of patients." The authors concluded that those patients considered "unfavorable for treatment" were the "financially indigent, the uncooperative patient, the constitutional psycopath, the inadequate, the psychotic, the deteriorated patient, and women".

---

[6]Ebbe Curtiss Hoff, "A Cultural View of Man's Drinking Habits," Inventory, (January, 1959), p. 29.

[7]Joseph Thimann, personal communication.

[8]Although Thimann has referred to this in the literature previously as Conditioned Reflex treatment, the newer and more correct term is Conditioned Reflex (Response) Therapy.

[9]F. Lemere, W. L. Voegtlin, W. R. Broz, and P. O'Halloran, "Conditioned Reflex Treatment of Chronic Alcoholism", Northwest Medicine, vol. 41 (March, 1942), p. 88.

A second study in 1943 by Carter[10] at the Mount Airy Sanitarium in Denver, Colorado, concluded that CRT is a "simple, economical and reasonably sure method of developing abstinence in the more socially adjusted patient, "and that failures were found largely in patients under thirty years of age, doctors, business executives, bankers, musicians, artists, and psychopathic personalities".

In a third study in 1945 at the Chicago State Hospital, Chicago, Illinois, Edlin, Johnson, Hletko, and Heilbrun[11] studied a sample of one hundred patients. In an unselected group, fifteen per cent remained abstinent for a period of five to fifteen months, while in a selected group with a "commendable sociological background," in fifty-two per cent of all patients treated. The authors concluded that, "a patient's superior sociological and financial status, with all its socio-dynamic implications, is an auspicious prognostic factor in treatment".

A later study by Voegtlin and Broz[12] at Shadel Sanitarium analyzed 3,125 admissions over a period of ten and one-half years. They concluded that such factors as age, marital status, occupation, financial status, interest in abstinence clubs, and reinforcement record of the patient, all "have been shown to effect prognosis favorably or unfavorably". Voegtlin and Broz felt that as age increases, so do chances of remaining abstinent. Their highest percentage of abstainers were found in the age group from thirty-one to forty. Optimal marital circumstances appeared in patients married for the first time. Of 1,329 patients married only once, fifty per cent remained abstinent. In the relationship between occupation and abstinence in this study, the authors found the more highly skilled the occupation of the patient, the higher the probability of success, with the exception of physicians, attorneys, and dentists, where the proportion of success was extremely low. The "wealthy" group of patients obtained 62.1 per cent abstinence. Of those patients regularly attending abstinence clubs (with the exception of local AA groups) 87.4 per cent remained abstinent. It was also found that those patients who complied with the reinforcement schedule as recommended achieved 86.1 per cent abstinence.

---

[10] H. R. Carter, "Conditioned Reflex Treatment of Alcohol Addiction", Rocky Mountain Medical Journal, vol. 40 (May, 1943), p. 318.

[11] J. V. Edlin, R. H. Johnson, P. Hletko, and C. Heilbrun, "The Conditioned Aversion Treatment in Chronic Alcoholism", American Journal of Psychiatry, vol. 101 (May, 1945), p. 806.

[12] Walter Voegtlin and William Broz, "The Conditioned Reflex Treatment of Alcoholism", Annals of Internal Medicine, vol. 30 (March,1949), p. 580.

A later chapter will give the reader a detailed picture of the Conditioned Reflex treatment at the Washingtonian Hospital.[13] Here treatment combines the removal of the addiction itself by medical treatment with psychotherapy on an individual and on a group basis. The group-therapy or Conditioning Club[14] of Conditioned Reflex treatment patients is a "pilot community" enabling the patient to make a more satisfying adjustment to the larger community. At the Washingtonian Hospital where this study was made, constant research is being undertaken acknowledging the possibilities of these various theories, with recognition of the multiplicity of factors operating in each individual alcoholic.

---

[13] The Washingtonian Hospital, Medical and Psychiatric Treatment Center for Alcoholism, Boston, Massachusetts.

[14] The Conditioning Club meets twice a month and attendance is recommended for all CRT patients in whatever phase of treatment they may be.

CHAPTER II

SETTING OF THE STUDY

The Washingtonian Hospital in Boston is thought to be the oldest American Institution for the treatment of alcoholism having been opened in 1857.[1] Its original name seemed to be well suited to the thinking of the times for it was called "The Home for the Fallen." This was superceded by the name "The Washingtonian Home", and within the last twenty years it has assumed a name more appropriate to its functions, "The Washingtonian Hospital". This hospital is a modern, well-equipped psychiatric and medical treatment center treating both alcohol and drug addiction. It has a highly trained staff including psychiatrists, social workers, medical personnel, and a dietitian. The needs of the total personality of the alcoholic are considered, for every effort is made to make the patient's stay in the hospital not only profitable to him in building for his future rehabilitation, but cheerful as well. A multidiscipline approach is in evidence everywhere with the patient never out of contact with any Department within the hospital, whether it be saying good morning to the Director of the hospital, or whether the patient is lingering in the doorway of the kitchen watching the preparation of a home-cooked pie. The patient's admittance to the hospital may be a quiet, orderly procedure or it may be somewhat more dramatic with the patient resistive, profane, and uncooperative. Once on the ward surrounded by other alcoholics and

---

[1]Council on Professional Practice, Committee on Hospital Treatment of Alcoholism, Institutional Facilities for the Treatment of Alcoholism, p. 1.

the nursing staff, the patient generally becomes quieter. Most patients seem to view the nurse as the mother figure and usually show her a great deal of respect. For the patient who continues to create a disturbance, there is the "Brig". The Brig is not as ominous as one would perhaps expect. It is a small room designed to isolate the patient for the purpose of preventing injury to himself or to other patients. It has a grill-type window through which the patient can be seen at all times by both the staff and other patients. The time spent in the Brig is a matter of hours and the time spent on this Acute Ward, as it is called, usually does not exceed three days.

By the time the patient is able to move about the hospital he has been "graduated" from the Acute Ward where he received medication heavy enough to "dry" him out, to the Sub-Acute Ward where medication is decreased according to his needs. A daily medical check is made on each patient. He is not "lost". His own individuality is stressed and his talks with a Social Worker help him to decide what course of treatment he wishes to follow within the hospital setting or upon his release. A large number of patients come back for Out-Patient treatment with either a psychiatrist or a social worker after an evaluation by a psychiatrist to determine which treatment will be more beneficial to the patient.

A relatively small number of patients are selected for the Conditioned Reflex (Response) Therapy since most do not meet the eligibility requirements for this kind of special treatment. Many patients are referred to other hospitals and physicians for more complete evaluation of their physical condition (special tests such as electrocardiograms) and some for psychometric testing. Relatives are encouraged to participate in

the recovery of the patient and often become as involved on a casework basis as the patient himself. Referrals are also made to such agencies as seem best suited to solve problems of an environmental nature such as employment. For many patients this individual therapy is his first experience in a professional helping relationship.

Perhaps the most unusual aspect of the Washingtonian Hospital is that it does not consider itself "a perfect institution". It's personnel and Board of Directors are constantly involved in research and new methods of making its program more progressive.

CHAPTER III

TRADITIONAL METHODS OF TREATMENT AND CONDITIONED REFLEX (RESPONSE) THERAPY

As yet there has not been any specific therapy discovered or developed which will permanently cure all alcoholics. There are, however, many types of treatment that have an appeal and a certain degree of success in "cures" for some alcoholics. One of the most well known of the traditional methods of treatment is Alcoholics Anonymous. "A.A.", as it is popularly known, feels that one alcoholic can help another since he can best understand the problem of alcoholism. There is no designated leader. A.A. meets in small groups, and there are several hundred of these throughout the U. S. A. There are no staffs of paid workers and there is no overall planning committee since each A.A. group manages its own affairs in its own way. Although A.A. has been highly successful in many cases and is respected for its fine and sincere work, the criticism has been made that it is lacking in objective leadership, that is, the kind of guidance one finds in a well-planned group therapy meeting. A CRT patient who had completed his treatment and was attending one of his first meetings of the CRT club remarked that, "When the Doctor (meaning the group therapy leader) leaves the room and we're left on our own to discuss this stuff, things really go to pieces!"

The Danish Antabuse treatment is still used also with good results in some cases. In this treatment, the patient takes Antabuse (a medicine in pill form) each day. Any drinking after the consumption of these pills may produce extreme nausea in the patient. One of the dangers of this

treatment is the likelihood of extreme prostration if the patient continues to drink at the same time he is taking his pills.

Like A.A., the Antabuse treatment does not relieve either the addiction to alcohol or any underlying neurosis which may be present.

For those patients who go on periodic "sprees" and regress to the point where they cannot take care of themselves, "drying out" seems to be the first step in any treatment program. This consists of in-patient service at a hospital treating alcoholics. Here the patient is put to bed and given some medication such as paraldehyde or chloral hydrate. The patients, for some reason not known, call this "paraldy". This medication relieves the symptoms and is gradually withdrawn. Usually a lighter medication such as tranquilizers are prescribed after this and vitamin therapy initiated. Ideally, medical treatment is followed by psychotherapy either at a casework or psychiatric level. Unfortunately the repeaters are more often those alcoholics who do not care to follow through with out-patient therapy and have a strong need to deny their helplessness.

In Chicago some years ago there was established a type of convalescent home called the Portal House. This was a project started by the Department of Public Welfare and patients lived in on a self-governing basis. Just recently the office of the Commission on Alcoholism has completed a study of conditions at the Bridgewater Correctional Institution and recommended a Half-Way House somewhat similar to the old Portal House plan. Here, upon release from the prison, chronic alcoholics would not return to "Skid Row" but to a well-organized, tightly supervised home where they would learn the principles of self-government and prepare

themselves for a full return to the community. The Half-Way House, unlike Portal House, would be operated according to psychotherapeutic methods and principles.

Since 1940, the Washingtonian Hospital has had a "night hospitalization" plan whereby the patient goes to work each day yet returns to the protective setting of the hospital each night. Some patients make use of this plan as a temporary measure, while others cling to it as the only home possible for them.

Conditional Reflex (Response) Therapy

Although the Washingtonian Hospital makes consistent use of the psychoanalytic approach it does differ from other traditionally psychoanalytically oriented approaches in that it splits away from the theory that drinking is merely an indication of the underlying personality disorder.

The Conditioned Reflex (Response) Therapy is based on the conviction that in many cases it is not enough to remove the personality disorder unless the physical addiction to alcohol is also removed. This treatment has its origins in the Shadel Sanitorium in Seattle, Washington, where Drs. Voegtlin and Lemere in 1934 first used it.[1] Later this treatment was used extensively at the Washingtonian Hospital in Boston, Massachusetts, and at the Chicago State Hospital, Chicago, Illinois.

The three Hospitals differed somewhat as to techniques and the type

---

[1] Joseph Thimann, "Conditioned Reflex Treatment of Alcoholism," *New England Journal of Medicine*, vol. 241 (September, 1949), p. 368.

of drugs they felt were most effective in this treatment, as well as having some differences of opinion as to supplemental psychotherapy. Basically, however, all were dedicated to the removal of the addiction itself.

The Conditioned Reflex (Response) Therapy is sometimes referred to as the "aversion treatment".[2] It is related to the experiments of the Russian physiologist, Pavlov, who was able to produce certain conditioned reflexes in dogs. Pavlov's method consisted of ringing a bell and then offering the dog food. Soon the ringing of the bell meant food in the mind of the dog. The dog would salivate whenever Pavlov rang the bell. Later, even though the bell was rung and he received no food, he would salivate as his mind made the association with food. He had made an "idea association". This same principle is utilized in the CR treatment.

The patient who enters the hospital for the Conditioned Reflex treatment is, as a rule, put to bed in a room on the Sub-Acute Ward. This is the ward reserved for those patients well on the road to recovery in the "drying-out" process. It could almost be said that the arrival of the CRT patient establishes an alcoholic hierarchy. The new arrival is viewed with a deep sympathy for what he is about to face, for the treatment is far from pleasant, but he is also viewed with admiration mingled with awe. Sometimes an older successful CRT member will visit the patient and sets in motion another undercurrent of mixed feelings. The nervous, shaky, insecure, almost dried-out alcoholic leaning against the wall of the

---

[2] Charles Shadel, "Aversion Treatment of Alcohol Addiction," Quarterly Journal of Studies on Alcohol, vol. 5 (September, 1944), p. 212.

hallway where the convalescent group gathers can be observed watching the "success" carefully. This time his admiration is entwined with some envy and a little resentment for he cannot identify so easily with this confident, happy, well-dressed individual. However, there is still a bond of sorts that comes with the knowledge that success or failure one has been an alcoholic and knows what it means.

The CRT patient himself (from direct observation of CRT patients) is usually quiet and thoughtful. Although his door is open he does not invite conversation nor does anyone intrude upon his privacy. He seems anxious, but less tense than his friends in the hall.

The arrival of the doctor creates a bustle of activity and a stir of excitement. Magazines are held but not read, and all eyes fix themselves upon the door until it closes after the doctor and it is certain that treatment has begun. The CRT patient's room is darkened to remove distractions from the treatment itself. A preliminary medication is given to sensitize the patient to the emetic.

In the Conditioned Reflex treatment alcoholic beverages take the place of the ringing bell of Pavlov (the conditioned stimulus), while food (the unconditioned stimulus) is replaced by an emetic. The emetic is injected hypodermically before giving the alcohol. The alcohol given is usually that type (scotch, rye, etc.) which the patient is used to drinking. Extreme nausea and vomiting follows. The patient is watched closely for any adverse physical effects and the doctor speaks with him as he would in any psychotherapeutic session. There is no question but that the patient is miserably ill and worn out. The treatment is emotionally charged as well as physically exhausting and usually the doctor will treat only one patient

in a single day. This is the first of a series of treatments that will go on from eight to ten days.

There were many factors to be considered before the treatment was developed to its present stage of perfection. It would seem that the extreme nausea resulting from the treatment would forevermore deter the patient from the desire for alcoholic beverages. In practice, however, it was found that a multiplicity of factors entered into successful conditioned reflex making it a highly skilled procedure. In some patients nausea was unusually delayed. Upon analysis of the process it was found that an alcoholic who had not entirely freed his system ("dried-out") from recent sprees did not develop a reflex because the already existing alcohol in his system acted as a depressant. The timing of the administering of the emetic was also important since any absorption of the alcohol before nausea and vomiting would simply intoxicate the patient slightly and also inhibit the reflex. The choice of the proper emetic was also vital to success since some emetics leave the patient in a pleasant state of euphoria. The emetic used at the Washingtonian Hospital is pure emetine which is considered less toxic than several others used in other hospitals. It is also given hypodermically before giving the alcohol to avoid alcohol absorption which would prevent a reflex development.

After the initial series which last about ten days, the patient is left in a rather weakened state physically and is usually conveyed to various parts of the hospital by wheelchair to prevent physical strain. Emotionally, however, there are many individual responses. Among the individual responses to the treatment itself is one Thimann describes as the patient's feeling of heroic accomplishment. The alcoholic usually

suffers from low self-esteem and guilt and very often views the therapist as a father figure and the treatment as punishment. Ability to withstand this "punishment" raises the patient's estimate of his own adequacy and thus the term "heroic accomplishment".[3] This is a valuable asset in success since in many instances this is the first time the patient has felt able to resolve any conflict with a father figure.

In emphasizing the individuality involved in this treatment, Thimann says:

> The conditioned reflex treatment is based on the physiologic laws of a reflex which depends upon the formation of new functional connections in the central nervous system and which is, therefore, peculiar to the individual.[4]
>
> It is well to keep in mind that the treatment should be used in common with psychotherapy and social therapy, and the results of the therapy depend largely on the selection of patients suited to this therapy.[5]

With some patients it is enough to remove the addiction to alcoholic beverages, while with others intensive psychotherapy is indicated. For some patients the therapist continues in this substitute father role as he conducts the group-therapy meetings which will be described in a later chapter. All patients seem to benefit according to their individual needs from continued contact with the hospital, the therapist, and other members

---

[3]Joseph Thimann, personal communication.

[4]Joseph Thimann, "Conditioned Reflex Treatment for Alcohol Addicts," Clinical Medicine, vol. 53 (August, 1946), p. 220.

[5]Joseph Thimann, "The Conditioned Reflex as a Treatment for Abnormal Drinking," New England Journal of Medicine, vol. 228 (March, 1943), p. 333.

of the CRT group with whom they discuss their new freedom.

Some mention should be made of a most important area, that of the patient's continued contact with the hospital for reinforcements. Treatment is not considered to be completed until the patient has taken the full reinforcement program. After his release from the hospital he returns for one day reinforcements over a period of a year. The patient enters the hospital and goes through the same treatment that he experienced during his initial series except that it lasts for only one day. Usually six reinforcements (one every four to ten weeks) within the year are adequate. Six have proven to be the minimum recommended.

The theory of reinforcement is based on earlier experiments showing that the individual needs a combination of conditioned and unconditioned stimuli for some time after the initial series. If the patient does not take these reinforcements as recommended and exposes himself to only the conditioned stimulus, eventually the reflex will grow weaker and fail. This is described as "quantitative failure," and is an area of concern in the study of the relapsing group of Conditioned Reflex (Response) Therapy patients.

Although the removal of the physical addiction to alcohol has been emphasized thus far, attendance at group therapy meetings is recommended for all CRT patients as an integral part of the treatment program. It must not be forgotten that ridding the patient of his physical addiction to alcohol is only a part of the Conditioned Reflex (Response) Therapy program. The patient must also be guided towards a better understanding of his own individual personality difficulties, and through the interpersonal relationships experienced in the group therapy situation, be

helped to achieve a more satisfactory social adjustment. To get an idea of how this part of the therapy program functions, the following chapter will describe a typical group-therapy meeting.

CHAPTER IV

A TYPICAL CONDITIONED REFLEX (RESPONSE) THERAPY MEETING

At regular intervals the Conditioning Club, a group therapy session of Conditioned Reflex (Response) Therapy patients, is held at the Washingtonian Hospital. The combination dining-room and lecture hall in which these patients meet is painted in bright, cheerful colors. The patients seat themselves at a long oblong-shaped dining table with the leader (the psychiatrist) equally distant from each end of the table. The setting is informal and an air of expectancy is sensed in the attitudes of the patients. Even those patients who have been attending regularly for the past seventeen years are seen greeting their old friends enthusiastically. In fact, one wonders if there is not a certain gratification in coming in late, for all discussion is suspended until the latecomer is greeted and it is established that he is well and happy. The leader says very little during the initial stages of the meeting. The patients are allowed to express themselves as freely as they wish. Except for the occasional interruptions greeting each latecomer, the meeting gradually settles down.

The older members participate in loud, confident, "booming" male voices. The newer members reply less spontaneously and more carefully, but still display confidence that they belong with the group. At the particular meeting described there were four guests, one a visiting physician, two a sociologist and his secretary who wished to tape an interview with a CRT patient, and the writer. It seemed that the visitors were more uncertain than the patients for the patients delighted in playing host. The

success of the guest participation is due directly to the skillful management of the leader who never allows the patients to be outnumbered by guests and invites only those guests with a real professional interest in alcoholism.

As the meeting warmed up the leader became more active and problems that the patients had since their last meeting were brought up for discussion. All patients showed a genuine concern for the patient experiencing the problem. Even the seventeen year abstainers relived incidents that happened when they were drinking and described in detail how their own problem and its solution was related to the discussion.

A very new member was present in his wheelchair since he had just completed his initial medical treatments and was still not strong enough to be allowed out of the hospital. He told his story to the older members who listened attentively. He described himself as feeling "like a teenager" in a group with such long abstaining records. This patient said before CRT he had gradually increased his drinking until he could no longer face the day without first having a drink. Heads all around the table nodded in understanding. He thought that the hardest part of starting the day was keeping the liquor down and that often he would be nauseated and vomit up the second or third drinks until finally he was able to keep the drink down and face the day. An older member said in all seriousness, "did you ever try putting a little pepper in your drink, that often does the trick", to which the young patient replied, "What are you telling me this for now, it's much too late!" Laughter followed this and the leader picked up on several points for further discussion. One of these was the question of how did the patients present feel about there being perhaps

several kinds of "relapsers" and possible reasons for this. The patients were asked what they thought the reasons were for a patient relapsing, for example, after seven years. They thought about this for awhile, then said that one reason perhaps was because the patient never really accepted that he could not drink, that is, even though he undertook the treatment he had never really accepted that he could not take even one drink. Another patient felt that maybe the relapser gained so much confidence that he felt too secure in his ability to abstain just as a patient recovering from T.B. might get to feeling fine and overdo and find himself back in the hospital. All patients seemed to agree that a patient who had not completed his reinforcements and had begun to drink had never really completed treatment.

These varied reactions, as expressed by the comments of the patients during the meeting, guided the therapist in his understanding of the patients' problems as reflected in the group discussion. The therapist might then single out some patients for more intensive individual therapy.

The reader may now have a fairly good picture of what one would expect to find in a Conditioned Reflex (Response) Therapy meeting. But what actually is an individual patient like? When all these things are put together what kind of person would one expect to meet at a CRT group-therapy session? The following is a description from a case record with some of the material disguised to protect the patient's identity. This is a successful CRT patient.

> Mr. Smith came to the hospital for help when he was forty-three years old. He is Protestant and married and has lived in the Atlantic coast area most of his life.
>
> He told the doctor that when he is drinking he becomes "nasty and irritable." He took his first drink when he was in college (when he was about twenty years old). His drinking became a

problem approximately fifteen years later, and his longest sober period was for six months after he had been hospitalized for alcoholism. He was diagnosed upon his admittance as a chronic periodic alcoholic.

The admitting physician found that he had no psychotic tendencies, his general information was very good, and his judgement was good.

The patient was a college graduate and in one of the professions. He was a member of a very prominent and popular community-type organization.

In his pre-marital sexual relations he said that he had never had any sexual relations with the girl he eventually married and that he never really felt adequate sexually without liquor.

In describing his family he felt that his father was always easy-going, a good-mixer, and that he "spared the rod." Although he was the favorite son of his mother he felt that she was dictatorial, "bossy," rigid, and aloof. His brothers and sisters could always do things around the house better than he could. His father died of a heart condition, while his mother and siblings are still living. The patient's own health was excellent and he had no unusual history of illnesses.

In his discussion of his problem he was very inhibited and was classified as to personality type as fifty per cent in Group I (Endomorphic) and twenty-five per cent in each of the other two groups.

This patient did have psychological tests which revealed that he had considerable energy, showed a marked insecurity in his personality, was of superior intelligence. It was felt that he represented the kind of professional person who was very able, ambitious, and conscientious in his profession, whose intellectual faculties made him self-conscious and insecure in relation to other people. College drinking habits (social drinking) superimposed on this, led him to alcoholism and nervous exhaustion. In his marriage, he used alcohol to eliminate embarrassment and tension.

A very difficult job to which he was assigned in his professional capacity increased his already heavy drinking and precipitated his decision to do something about his life.

This patient was considered well-qualified for CR treatment. He completed all his reinforcements and attended as many meetings as his schedule would allow. He became extremely helpful to other alcoholics because of his interest and educational training. His work problems are no longer insur-

mountable and he states "I now face the future happy and unafraid."

In addition to the varied roles played by the psychiatrist in the life of a CRT patient, the social worker often is a very important link in the treatment process, and some idea of her role will be described next.

CHAPTER V

THE ROLE OF THE SOCIAL WORKER

In a setting such as the Washingtonian Hospital, with its recognition of the valuable contributions the social worker can make to any treatment program undertaken for the patient, the role of the social worker is varied to meet the needs of the individual situation just as in any other casework problem. The social worker does not select the Conditioned Reflex candidate for treatment. However, she may aid in this selection in her daily contacts with house patients in which she may be asked to explain the various kinds of treatment available in the hospital. She may then bring the doctor's attention to a particular patient who seems to her to have adequate motivation for the treatment. The social worker can also aid the addicted patient already in casework treatment in his thinking about whether he could accept the Conditioned Reflex (Response) Therapy program. The social worker's role in these areas is the minor one of implementation.[1]

The patient already in CR treatment is usually not ready for any dilution of his relationship with the doctor and except for very superficial contacts at the request of the doctor, the social worker is in no close contact with the patient. The social worker can and does frequently work with the wives of CRT patients in much the same way as with other cases.

---

[1] Gladys M. Price, Director of the Social Work Department, Washingtonian Hospital, Boston, Massachusetts, personal communication.

Wives of the CRT patients are often rather ambivalent about the change in the patient during treatment since, as a rule, she must be the one to handle their social life in such a way as to avoid contacts with friends who might enjoy heavy social drinking. The wife may also wonder whether she should tell her relatives, or his, that the patient is in the hospital. She may not understand the patient's craving for sugar which the alcohol previously supplied. She may resent the considerable sum of money the entire treatment costs and very often displays her anger directly or indirectly that she is the one who is left at home to cope with the routines of living while the patient is in the hospital, the recipient of warmth, understanding, and constant attention. It was mentioned earlier that the wife herself may be insecure in the marital relationship once the patient is no longer dependent upon her. She may not be able to face, or perhaps not recognize, that she herself had a great need to control and that this covered up many of her own dependency needs. This new balance in the life of the patient and his wife may generate an anxiety in the wife which she may express, often at an unconscious level, in her efforts to sabotage his treatment. Another facet of this same process is the feeling of guilt that the patient himself experienced while he was drinking and which the wife may have used to cancel out any criticism of herself. How can she protect herself now from this more critical view of herself? These are areas in which the social worker can help.

The suddenness of the patient's giving up drinking has its effects upon the whole family, even though the family has perhaps wished many times that the alcoholic in their midst would leave them, abrupt separation on this new basis is difficult. The patient has not only left home, but his

return promises to be different, and he is undergoing an experience now which he is not sharing with them. While his problem of drinking involved the whole family, now it is something he is sharing with strangers to whom he is showing not his disagreeable, unhappy, moody personality, but the sober, cooperative, desire-to-get well side of his nature.

In the alcoholic "hierarchy" the CRT patient forms the elite group. He is not just an alcoholic who has given up drinking, but an alcoholic who has undergone an extremely unpleasant experience in order to achieve sobriety. He has a sense of "heroic accomplishment" which his wife does not share except as an onlooker. The social worker can help her be a part of this positive experience in both their lives.

CHAPTER VI

THE SELECTION OF A CONDITIONED REFLEX (RESPONSE) THERAPY PATIENT AND FACTORS TO BE EXPLORED

It can be seen from the background discussion of alcoholism that there will be as many differences in alcoholics in the community as there are, for example, differences in individuals in any given community who suffer from heart disease. Some will have deteriorated physically to a point where the taking of specific curative drugs in their case would be actually harmful rather than beneficial; others, psychologically, could not benefit sufficiently from the treatment because of severe anti-social activities with a corresponding lack of incentive to get well. Therefore, all alcoholics are not eligible from a standpoint of being able to use or undertake the Conditioned Reflex treatment. Members of the Conditioned Reflex treatment group are selected only after careful evaluation of their total situation, internal and environmental. Those chosen have no evidence of psychoses, do not suffer from cardio-vascular diseases or other marked physical weaknesses, are not addicted to drugs, have an I.Q. which is not below one hundred. The candidate for treatment must also have no evidence of constitutional psychopathy and no record of any serious criminal offenses. The patient must be able to maintain himself financially during his period of hospitalization which lasts about six weeks, since the external pressure of worrying about his job or family would diminish the effects of the treatment. The patient has to be well motivated toward treatment and willing to continue in psychotherapy after the initial medical program. A member of the Conditioned Reflex treatment group may have

been drinking many years longer than an individual who has been rejected for treatment, however, his total evaluation may indicate that he is a patient who can achieve success.

In the total evaluation, in addition to the very basic requirements listed as indicating or contra-indicating treatment, there have emerged many other similarities in the Conditioned Reflex treatment group such as, for example, age and relationships with father, mother, siblings, or wife. This study will describe the characteristics of a typical Conditioned Reflex (Response) Therapy group.

Although the Conditioned Reflex (Response) Therapy group has over fifty per cent successes, there are some patients who are not cured. The reasons for some of these failures can be seen clearly, while others are considerably more obscure.

By a comparison of the two CRT groups, abstaining and relapsing, this study will attempt to isolate those factors in the abstaining CRT patient's personality, background, and environment which have led him to success. At the same time the study will try to bring out some of the characteristics of the relapsing group, as well as characteristics which both groups have in common.

Over the years there appears to be a suggestion that certain factors in the successful patient's life history and personality structure make him better able to offset external pressures when they occur. Factors that seem to promote success point to a higher educational level for the successful (abstaining) patients, as well as a history of jobs held in which the patient was employed primarily as a "white collar" worker, that is, usually working closely with other people in an occupation such as that of salesman

or shop-keeper. Membership in organizations is also expected to be reflected to a higher degree in the successful group of patients. It is expected that this ability to move out into the world and relate to other people will also be apparent in the patient's personality type.

Thimann[1] uses Sheldon's groupings of body types with corresponding personality traits or types as an aid in predicting success. Sheldon[2] has distinguished three types of individuals; The Endomorphs (fat, comfort-loving individuals), The Mesomorphs (active and vigorous people), and The Ectomorphs (slender, restrained, inclined to be rather schizoid). This latter group has been felt to have the least chance for success, while the Mesomorphic patients with their ability to compete with others are viewed more favorably. It should be remembered, however, that most patients are a mixture of characteristics of the three groups with usually one constellation of characteristics predominating. The patient's ability to complete treatment is another area which appears to be indicative of his general ego strength and probability for success.

Factors to be Explored

Factors which seemed to have promoted success in the past appeared to fall, upon closer examination, into two broad classifications; social class membership and personality. The question is posed as to whether it is the ego-strength of the patient which carries him through to success, or whether perhaps it is the social class to which he belongs which has

---

[1] Joseph Thimann, personal communication.

[2] William H. Sheldon, Modern Clinical Psychology, p. 241.

provided and will continue to provide the support the CRT patient needs for success in this special treatment program. Although these are alternative classifications, it may be that the successful patient is a combination of both.

Exploration of social class membership will include factors such as education, occupation, age of marriage, number of children, and membership in organizations.

Exploration of personality factors will include the CRT patients' personal interests, entrance evaluation by the psychiatrist, early history, sexual and marital adjustment, and the somatotype.

These are the factors which are felt to be most significant to the study. However, the study will include other areas of interest such as health, age, religion, age at which drinking became a problem, and other material relevant to the study.

CHAPTER VII

METHOD OF THE STUDY

Selection of the Sample

The year 1944 has been selected as a source of the sample for this study of Conditioned Reflex treatment patients. There are twenty-three patients in this sample and these represent the total number of Conditioned Reflex treatment patients treated that year. This is a small percentage of the total number of patients treated for alcoholism by other methods than Conditioned Reflex therapy. In the years since 1944 there have been a varying number of Conditioned Reflex treatment patients selected for treatment each year.

Of the twenty-three patients in this 1944 sample, thirteen have abstained; that is, since their treatment, all but one have maintained a continuous sobriety. The one exception did drink for a brief period of time and then made a successful comeback and has, therefore, been included in the Successful or Abstaining group. There were seven patients in the sample who relapsed, that is, drank and did not make a comeback. All relapses occurred within four years following treatment. There are three patients in the sample for whom outcome of treatment is unknown and who have lost all contact with the hospital. Two of these patients are entirely unknown to the hospital at the present time while one is known to have relapsed within eight to ten years of treatment. This is an unusual length of time to remain sober and it may be that this patient did maintain abstinence after this relapse. However, since nothing is known at this time

about his subsequent history, he cannot truly be classified as a Success, although one would be tempted to place him in that group.

Sources of Data

Case records were the primary source of data for this study. In the case record there were several sections in each record dealing with the various aspects of the patient's personality and physical condition as well as an environmental resume by both the psychiatrist and the social worker.

The case record, then, included a psychiatric evaluation, a medical report, interviews with the psychiatrist and often the social worker, knowledge of contacts with his family and sometimes employers, and letters to other institutions such as hospitals and social work agencies.

Interviews were also held with the Director of the hospital[1] who personally treated these patients and had much valuable information to add to the record material as well as knowledge of the current status of the patients, since most of the successful Conditioned Reflex (Response) Therapy patients are still attending the group-therapy meetings.

Interviews with the Director of the Social Work department[2] at the Washingtonian Hospital added to the general picture of the patient and his family.

It was possible to talk with some of the patients personally by attending the Conditioning Club. However, although a great deal of material came out of observing the group-therapy meeting in action, no specific

---

[1] Joseph Thimann, Medical Director of the Washingtonian Hospital, Boston, Massachusetts.

[2] Gladys M. Price, Director of the Social Work Department, Washingtonian Hospital, Boston, Massachusetts.

questions were put to any individual members because of the possible threat to the relationship.

During this study many letters came in from patients who were unable to attend the CRT club meetings. These letters were read at the group meeting and later added to the patients' records.

Method of Data Collection

A schedule was made up to include the sets of factors discussed earlier. Although the schedule itself set up eight sets of factors for exploration, it has been possible to arrange these data so that two broad general classifications emerge; that is, social class membership and personality. There is also included in separate sections a certain amount of descriptive and other information felt necessary for clarity.

There were many items making up each set of factors of the schedule so that the gathering of data was kept as objective as possible. Among these were such items as age, education, number of children, and age patient took his first drink. Some items such as the patient's description of his mother and his father (described as domineering, etc.) have been considered useful because of the uniformity of answers to a single question of this kind. The patients' answers were taken from the record, and the record indicates that these were adjectives used spontaneously by the patient and not yes and no replies to the therapist. Where a judgment such as Personality Type was required, the Director (psychiatrist) was consulted and gave his opinion after reviewing the record.

Limitations of the Study

Although the year 1944 represented a large sample (twenty-three) in comparison to the total number of Conditioned Reflex treatment patients

chosen per year in recent years, the sample is not considered large enough to do more than point the way and perhaps support to a certain degree the hypotheses formulated.

Since the group chosen for study is a selected Conditioned Reflex treatment group already screened for the Conditioned Reflex treatment, the differences within the CRT group itself will not be as widely divergent as might result in a comparative study of a Conditioned Reflex treatment group and a random group of alcoholics. The study is not representative of alcoholics in general.

Follow-up studies on the Unknown outcome group would have been desirable to round out the picture. There seems to be no question about the characteristics and success of the abstaining group who still maintain constant contact with the hospital, but little is known of the daily activities of the group not in regular contact with the hospital and still known to be drinking. Follow-up studies might reveal wide variances in the degree of drinking within the relapsing group itself.

CHAPTER VIII

PRESENTATION AND DISCUSSION OF STATISTICAL DATA

Introduction

In the treatment and observation of Conditioned Reflex (Response) Therapy groups over the years, several broad hypotheses have been considered. Among these attention has been called to several factors that repeatedly seem to be associated with the patient's success after the CRT treatment. Those patients who have successfully abstained appeared to have overall a higher educational level, a history of certain types of occupations or professions usually felt to be "white-collar" positions, have belonged to organizations of community value, have been predominantly of certain personality types, and have had an ego strength sufficient to sustain them in the reinforcement program after the initial treatment. Even though external pressures developed in the lives of some of these patients after their release from the hospital, their background and personality structure have seemed to carry them through to success. It is the hope of this study that by comparing the successful and relapsing groups, who received their initial treatment at the same time, some evidence can be provided to answer the questions posed. That is, whether a pattern emerges from the study of these special factors that can be used as a guide in the future selection of candidates for successful Conditioned Reflex treatment. This study will attempt to determine whether these factors point to membership in a certain social class or a specific personality type, or perhaps, a particular combination of factors in both of these classifications.

Definition of Abstaining and Relapsing Groups

A "successful" patient is considered to be one who has never relapsed since his initial treatment. Since this is a study of the 1944 group, complete abstinence from 1944 through 1958, is considered in the field of alcoholism to be a very impressive record. It is the intent of this statistical section to show that this did not happen by chance alone. One exception to total abstinence has been included, however, and this is the case of a CRT patient who relapsed after a period of time, but made a successful comeback. It is felt that he rightfully belongs to the Success group.

A patient designated as a "failure" is one who relapsed and never regained sobriety. This study will also attempt to show that there is the possibility that there are different specific categories of "relapsers" and that those who relapsed before two years may have slightly different personality structures or motivation than those who did not relapse for two to four years.

The Unknown group numbers only three patients and bears out the growing awareness that there may be special types of relapsers within the failure group since one of the Unknown patients remained sober for eight years before relapsing.

A fairly comprehensive analysis of data will be included to cover not only the areas in which we are posing questions, but to reveal any other significant areas which might lead to further hypotheses useful in predicting success of the CRT patient.

It is expected that there will be many characteristics in common in the CRT group, whether abstainers or relapsers, because of the nature of

the common problem, alcoholism. It should be remembered also that the differences between the two groups may not be widely divergent since the CRT group itself was a highly selected group from the larger community of alcoholics.

Discussion of the statistical data will be presented in six sections; Descriptive Information, Patient's Pattern of Drinking, Social Class Membership, Personality, Reinforcement Record, and Changes Following Treatment.

The first section, Descriptive Information, aids in establishing a well-rounded picture of the CRT patient, and is felt necessary to the study in order to clarify the characteristics of the CRT group as a whole. However, it does not deal directly with the dominant hypotheses in this study.

Descriptive Information

Religion

Catholic, Protestant, and the Jewish religions are represented in the CRT group. Although this is a small sample, it may be significant that of the six Catholics represented, five were successful, while only one failed.

There was a fairly even distribution of Protestant and Jewish in the F group.

Only the abstaining and relapsing groups will be used in tables throughout this study since the number of patients in the group in which outcome is unknown is too small for any significant comparison. Groups are designated S (success), and F (failure).

Table 1 indicates rather strikingly the very low percentage of Catholic failure in treatment:

TABLE 1

A COMPARISON OF SUCCESS AND FAILURE ACCORDING TO RELIGIOUS AFFILIATION

Religion	Number in S Group	Per Cent in S Group	Number in F Group	Per Cent in F Group	Total Number of Patients
Catholic	5	83.3	1	16.7	6
Protestant	6	54.5	5	45.5	11
Jewish	2	66.7	1	33.3	3
Total	13		7		20

These are percentages comparing the Successes and Failures within the religious group itself, not the CRT group total. Therefore, approximately eighty-three per cent of all Catholics taking the treatment succeeded. Although, again, the sample is small, it raises the question as to whether some elements of the Catholic religion may not help the Catholic CRT in his adjustment. Regularity of attendance and emphasis upon faith have been considered in relating follow-up treatment and success.

Birthplace

Most of the CRT patients had lived in the U.S.A. all their lives. Birthplaces of the parents were about evenly distributed between the U.S.A. and other countries. To find out if any particular cultural pattern influenced the success or failure of treatment, birthplaces have been broken down by country of parental origin.

There appeared to be no outstanding pattern setting the failures off from successes in the matter of countries of parental origin. Many parents in both groups seemed to come from Russia and Germany, but not exclusively.

Other factors must be taken into consideration in interpreting these particular data. The area in which the hospital is located is more or less at a cross-roads of cultural intermingling and there is a heavy influx of second-generation Irish admitted constantly for treatment. However, as this CRT study seems to indicate, Russian and German parental origins with Canada next seem to predominate in patients selected for CR treatment. Earlier it was brought out that the proportion of successes was greater among Catholics than among either Jewish or Protestant patients. Since most Irish in the neighborhood of the hospital (and this includes surrounding towns and cities) are Catholic, it suggests that the type of religious pattern involved in European Catholicism may be associated with the criteria upon which selection for CRT is based. This would apply to the common general characteristics of the CRT group rather than to differences between successes and failures.

Health

Patients in all groups had experienced the usual childhood diseases of measles, chicken-pox, mumps, and whooping cough. There were no unusual patterns in any group. This was also true of operations and serious illnesses. There seemed to be no predominance of psychosomatic disorders. The general health of patients in all groups seemed to be good.

Fathers of patients in the S and F groups appeared to die mostly from respiratory diseases, while mothers died from varying causes including childbirth, old age, heart disease, and cancer. All siblings were in good health in all groups.

The health of all CRT patients was considered good and was a prerequisite for CR treatment. Although many fathers died from respiratory

diseases, there is not enough evidence to point conclusively to a psychosomatic predisposition on the part of the fathers that might have influenced the later behavior pattern of the CRT patient. This is another area, then, in which there were no differences between the abstaining and relapsing groups.

Summary

In this descriptive information; religion, birthplace, and health, only religion gives any suggestion that there may be differences between the abstaining and relapsing groups. Of the six Catholics in the CRT group only one failed and this may be an area warranting further exploration. Neither the birthplace of the parents nor the health of the CRT patient and his parents brought out any significant differences in the two groups.

Pattern of Drinking

It was anticipated that there would be similarities in the patterns of drinking of all CRT patients since, as has been mentioned before, the study group is a select group of alcoholics and their characteristics in many ways will not be too divergent. However, slight variations in the drinking pattern did occur and these will be noted together with those characteristics which will help define the CRT group as a whole.

Type of Beverage

Since the type of beverages consumed by the patient varied from time to time, no accurate table could be presented. In all groups patients drank mostly hard liquor, that is, rye, scotch, gin, and vodka. When beer and wine were drunk it seemed not to indicate choice, but rather scarcity due to reduced finances.

TABLE 2

AGE WHEN PATIENT FIRST DRANK

Age	Number of Patients in the S Group	Per cent of Total	Number of Patients in the F Group	Per cent of Total
Before 20	0		2	28.6
20 - 24	9	69.2	2	28.6
25 - 29	1	7.7	2	28.6
30 - 34	1.	7.7	0	
35 - 39	0		0	
Unknown	2	15.4	1	14.2
Total	13	100.0	7	100.0

The average CRT patient seems to have started drinking in his early twenties with the S group showing the largest percentage, approximately sixty-nine per cent, between twenty and twenty-five years. The F group patients are more evenly distributed, but appear to have started drinking earlier than those in the abstaining group. In all groups drinking began twenty years or more before CR treatment and these patients would be considered to be addicted to alcohol by that time since they are classified as chronic periodic alcoholics. Consequently, motivation to undergo such a rigorous treatment which would mean giving up this gratification would be expected to take a great deal of strength.

Age When Drinking Became a Problem

The age at which the patient stated that he felt he had a problem with alcohol occurred between the ages of thirty and forty. Patients in

the S group averaged thirty-nine years, while those in the F group averaged thirty-one. The patients who failed to abstain seemed to feel that they had a problem with drinking somewhat earlier than the patients whose treatment was successful.

Longest Sober Period Prior to CR treatment

The longest sober period prior to treatment for patients in the successful group ranged from a few days to nine years. No one in the relapsing group ever remained sober for longer than one year. Although there were large numbers of unknowns in both groups, the following table may indicate a pattern.

TABLE 3

LONGEST SOBER PERIOD PRIOR TO CR TREATMENT

Patients in the S Group	Length of time Sober	Patients in the F Group	Length of time Sober
1	6 months	1	4 months
2	7 months	2	8 months
3	2 years	3	1 year
4	2 years	4	1 year
5	9 years		

Because of the small number of known sober periods for patients in the sample, this material cannot be considered to do more than add to the total picture of these two groups.

Age at Time of Treatment

The following table indicates the ages of the patients at the time of CR treatment.

TABLE 4

AGE AT WHICH PATIENT CAME FOR CR TREATMENT

Age	Number of Patients in S Group	Per cent of Total	Number of Patients in F Group	Per cent of Total
30 to 34	1	7.7	0	0
35 to 39	1	7.7	2	28.6
40 to 44	5	38.6	2	28.6
45 to 49	4	30.6	1	14.2
50 and over	2	15.4	2	28.6
Total	13	100.0	7	100.0

Although there are slight variations in the ages at which the two groups came to treatment, there is no really significant difference.

<u>Prior Admissions to Other Hospitals</u>

The number of previous admissions to other hospitals for alcoholism prior to CR treatment cannot be determined with any degree of accuracy since in the S group alone there were six patients whose records lacked information. In the F group all but one patient had been treated in a hospital for other than physical reasons before admission to the Washingtonian Hospital for CR treatment. Of the seven patients in the S group whose records are complete only one had received no previous hospital treatment, while three of the remaining six had previous admissions to the Washingtonian Hospital for the regular "drying-out" treatment. No patient in either group had remained abstinent after these other methods of treatment. This would seem to point again to the need of some patients for such a special treatment as CRT which combines removal of the addiction with

psychotherapy.

Summary

It appears that most CRT patients before admission drank hard liquor, were about twenty-one or twenty-two years old when they took their first drink (although the relapsing group started somewhat earlier), began to have problems with drinking between the ages of thirty and forty, coming for CR treatment in their mid-forties. Of those patients known to have received other types of treatment for alcoholism none remained abstinent although patients in the abstaining group averaged longer sober periods than those in the relapsing group.

Perhaps the most significant result of the material in this section has been to emphasize the two-fold task of treatment of the alcoholic; that is, the recognition of the long term addictive nature of the CRT group's problem with alcohol, and the necessity of recognizing that in the twenty years before CRT, drinking has become for these men a disease. Both the disease and the individual must be treated. The number of successful cures by this method supports the contention that the removal of the addiction itself with supplementary psychotherapy can succeed where other treatment methods have failed.

Social Class Membership

As indices of class membership, educational achievement, occupation, age at marriage, number of children, and membership in organizations have seemed significant areas for exploration in this study.

Education

In the S group approximately seventy per cent of the patients had had a high school or college education compared to only approximately forty

per cent of patients in the F group. Of the known education of these CRT patients, the abstaining group seem to have achieved a higher educational level. Patients in the abstaining group had averaged about two years of high school, while the majority of those in the relapsing group had achieved only a grammar school education, and more than one-half had not finished grammar school.

Occupation

Members of the S group held the following positions: hotel owner, transportation business owner, gas station manager, investment broker, traveling salesman, automobile sales manager, office employee for a railroad company, doctor, auditor for a State agency, representative salesman for a State agency, grocery store owner, radio repairman, and a shoe-factory worker. These positions represent the highest occupational level achieved by individuals in the abstaining group either before or after CRT.

Patients in the F group reached somewhat lower levels of occupational achievement. These positions were: candy maker, dipper in a paint factory, machinist, shipper in an apparel shop, druggist, bank teller, leather business foreman. The druggist moved from sheet-metal worker to druggist, while the bank teller moved to the position of attendant in a hospital.

The following table gives a clearer view of the occupational status of the two groups of patients.

It can be seen that there is a significant difference in the occupational status of patients in the two groups. In the abstaining group most patients were employed in professional, semi-professional or managerial jobs, while the majority of patients in the relapsing group held jobs

as laborers.

TABLE 5

PATIENTS' OCCUPATION AND OUTCOME OF TREATMENT

Type of Occupation	Number of Patients in S Group	Number of Patients in F Group
Professional	2	0
Semi-Professional	2	1
Business Management or ownership	5	0
White collar	2	1
Skilled laborer	2	3
Unskilled laborer	-	2
Total	13	7

Marriage

Of the study population of twenty patients there were sixteen married patients, or eighty per cent of all CRT patients. The remaining patients were equally divided as to separations, divorces, single status, and loss of spouse.

Of the sixteen married patients in the sample, twelve, or seventy-five per cent, were successful, while four did not remain abstinent. In the unmarried group of four patients, one was successful, while three, or seventy-five per cent, relapsed. From the record material it appeared that the cooperation of the wives of CRT patients played a large part in their recovery. Both wives and parents in the immediate environment were considered potential aids or deterrents to a patient's progress.

Although the sample is small this finding suggests that chances for

success for married patients are greater.

The average age at which the patient married in the S group was age twenty-six, while the F group averaged age twenty.

The following is a table of distribution of ages of both groups at the time of marriage:

TABLE 6

AGES AT WHICH CRT PATIENTS MARRIED

Age at which Patient Married	Number of Patients in S Group	Number of Patients in F Group
Before age 20	0	3
20 - 24	5	1
25 - 29	5	0
30 - 34	2	0
35 - 39	1	0
40 - 45	0	0
Unknown	0	2
Single	0	1
Totals	13	7

It appears that the abstaining group married somewhat later than the relapsing group. All of the known relapsing group married before age twenty-one, while the majority of the abstaining group married after age twenty-one. There was only one patient in the successful group who married at age twenty.

Number of Children

Patients in the S group averaged approximately two children per patient, while the families in the F group were somewhat larger with an

average of three children per patient. Although this difference is not large it appears consistent with our growing picture of the abstaining group as members of the middle class.

Membership in Organizations

One easily measurable indication of social class membership is an individual's membership in community organizations. There were very definite answers to this question in the records of almost all members in both groups. The following is a table of membership distribution:

TABLE 7

MEMBERSHIP IN ORGANIZATIONS

Membership in Community and Social Organizations	Number of Patients in S Group	Number of Patients in F Group
Membership	9	0
No Membership	3	6
Unknown	1	1
Totals	13	7

No percentages are needed to see that the relapsing group had no defined community interests. In the abstaining group it is interesting to note that there are three patients who did not join any organizations. Jobs held by these three patients were those of gasoline station manager, railroad employee, and traveling salesman for a State agency. The uncertainty and irregularity of their hours may have been a barrier to their joining any organization and attending with any regularity. Two of these patients had three years of high school, while the third had a grammar school

education. It would seem that conflicting work hours was the greatest deterrent in these instances. However, another element in the situation might have been the marital difficulties of two of these patients along with a certain degree of disharmony surrounding activities outside of business hours. Since this last factor relates more to personality adjustment it will be discussed in the next section.

Summary

In this section social class membership has been examined from the standpoint of education, occupation, age at marriage, number of children, and membership in organizations. It was found that educational achievement was significantly higher in the abstaining group than in the F group. Also, members of the abstaining group held more professional and managerial "white collar" jobs than those in the relapsing group. Patients in the S group married later on the average (at twenty-six) than those in the F group (at age twenty), and had fewer children than those in the F group. Most of the S group of patients moved out of the family circle and joined community-type organizations, while none of the patients in the relapsing group did this.

Occupation and membership in organizations seemed to be more associated with outcome than any other variable in this section of the study.

There has emerged a striking difference in the socio-economic status between members of the two groups which appears directly related to the probability of success in the Conditioned Reflex treatment.

Personality

In an earlier chapter the question was posed as to whether it is the successful CRT patient's membership in a certain social class which carries

him through to success, or whether perhaps it may not be personality factors which keep him in the abstaining group. In this chapter such personality factors as personal interests, entrance evaluation by the psychiatrist, sexual and marital adjustment, and somatotype will be discussed. It may be that there will emerge a combination of certain factors in each classification, social class membership and personality which will account for the continued abstinence of the S group.

Personal Interests

In interests of a personal nature the S group showed a higher ratio of interest in outdoor events, while the F group was evenly divided between indoor and outdoor interests.

Social Personality as Rated by the Psychiatrist

The original entrance evaluation by the psychiatrist showed that in this same area of personality the S and F groups were considered as follows:

TABLE 8

PSYCHIATRIST'S RATING OF SOCIAL PERSONALITY

Rating	Number of Patients in the S Group	Number of Patients in the F Group
Sociable	10	3
Restrained	3	0
Isolated	0	3
Unknown	0	1
Total	13	7

The percentage of patients classified as sociable is higher in the S group, and it is significant that all of the isolated patients were found in the F group.

Early History

In the early history of patients in all groups chosen for CR treatment there seemed to be no indication of juvenile delinquency, no severe sexual maladjustments, and no recorded psychotic disturbances. Whether this CRT group could be said to have had a normal youth cannot be determined from the information available. At least their behavior was not brought to the attention of the courts or other agencies.

In all patients there was a history of drinking in the immediate family. These were mostly fathers and brothers; no mothers were mentioned as being drinkers. There was no reference to mental illness in the families of patients in any of the groups.

The fathers of all patients were described as generally easy-going, liberal, and not stern. Only one father was described as domineering and this was one of the two drinking fathers.

The mothers of these CRT patients presented quite a different picture. They were described as "bossy", domineering, aggressive, and ambitious. One patient stated that ninety-five per cent of the discipline in his home was by his mother. However, three patients stated specifically that they were the favorite sons of these same domineering mothers.

Earlier, in the chapter on the theory of alcoholism, it was brought out that many advocates of the psychoanalytic approach feel that the alcoholic has never achieved genital primacy. The patient was considered to be latently heterosexual. It would seem that the parental relationships as described in this study of the CRT patients point to the likelihood of a certain confusion of identity due to the strong role of the mother in these families, and the relatively weak, passive role of the father. There

seemed to be no difference in any of the study groups in this area. This is one of the characteristics both the abstaining and relapsing groups have in common.

The patients' relationship with siblings is unknown. The impression from the record material is one of indifference since brothers and sisters are seldom mentioned. There was only one patient in the study who voiced any strong attachment to a sibling.

Sexual and Marital Adjustment

The record material yielded very little information concerning courtship data, that is sexual activity before marriage. Of the few replies recorded there seemed to be an absence of any real sexual interest. The patients gave answers such as "she was like a sister to me", "I never felt adequate sexually without liquor," and "no relations".

In the area of marital relationships there were only slight differences and such a variance between the patient's statement and that of his wife concerning their marital situation that it would seem that the motivation for the statement as well as the objective situation would have to be examined.

Patients in the S and F groups made replies as shown in Table 9.

As shown in Table 9, these answers given to the question of marital relationship represent the patient's own view of his situation. In one or two records there was evidence that when consulted, the patient's wife disagreed with the patient's statements feeling that the patient complained about the relationship saying to her that she was "too bossy". It would seem that the majority of patients either considered themselves to be happily married in spite of their wives' statements, or else had a need

to be seen by others as happily married man.

TABLE 9

STATEMENTS OF CRT PATIENTS CONCERNING THEIR SEXUAL RELATIONSHIPS

Patient	Statements of Patients in the S Group
1	"Happy"
2	"Good 50/50 relationship"
3	"Divorced wife because she drank"
4	"Very happy"
5	"Happy"
6	Unknown
7	"Wife drank and not too intelligent"
8	"Happy"
9	"Happy though can't function sexually without liquor"
10	"Very happy"
11	"Once very happy now in-law difficulties"
12	"Happy"
13	"Past two years arguments about drinking"

- - - - -

Patient	Statements of Patients in the F Group
1	"Dependent upon wife, would die without her"
2	"Very happy"
3	"Never cared much for girls"
4	"Happy with present wife though tells his troubles to his aunt"
5	"Wife is a 'good scout'"
6	"Difficulty with wife who doesn't like intercourse"
7	"Single with sexual relationships only occasionally"

Predominant Personality Type

One of the criteria which aids in selection of a candidate for Conditioned Reflex (Response) Therapy is the patient's personality type. This is not an inflexible criterion, but is considered helpful in considering the total picture. Three groups have been set up based on earlier studies by Sheldon and Kretschmer concerning the relationship between personality and body type. Thimann has used these concepts as representing a possibility for some degree of predictability in the selection of patients for CR treatment.[1]

Briefly, Sheldon believed that there were three somatic components represented in all individuals in varying degrees.[2] If an individual were predominantly one or the other he could be considered to be "endomorphic", "mesomorphic" or "ectomorphic". Each of these classifications has its own personality correlates.

In the group known as endomorph, the digestive viscera are massive and the somatic structures relatively weak. Endomorphs are usually fat people, although this is not always true. The personality correlation is the viscerotonic person who loves to be close to others, loves to eat, loves comfort, and is fond of relaxing. "The digestive tract is king."[3] Thimann has set this up as type I.

The mesomorph is a fairly sturdy individual. Bone, muscle, and connective tissue predominate. The mesomorph (personality correlation)

---

[1] Joseph Thimann, personal communication.

[2] William Sheldon, Modern Clinical Psychology, p. 242.

[3] Ibid.

is the somatotonic individual who is full of vigor and action. This is type II.

The ectomorph is rather frail and delicate with a long, slender muscular and bone structure. His personality grouping is cerebrotonic. These people appear inhibited and restrained and seldom like to call attention to themselves. These are the type III individuals.

The theory behind the formulation of these groups is that the endomorphs and mesomorphs are not so frail as the ectomorph and consequently not so exposed to their environment. It is felt that they have, therefore, a higher frustration threshold and a greater chance for success in treatment. In type III (slender, restrained) there is also found an "over-compensating" type individual who will force himself to overcome his inhibitions and in this way will succeed in treatment.

It should be remembered that everyone is a mixture of types in varying degrees, but that one may be able to make some prediction on the basis of the predominant typing.

The following is an outline form of the three types:

Type I: Endomorphic - viscerotonic: (traits of being overly relaxed, gluttonous, complacent, and socialized).

Type II: Mesomorphic - somatotonic: (traits of being aggressive, assertive, energetic, dominating, fond of risk, combative, ruthless, loud, hypomanic, and overly active).

Type III: Ectomorphic - cerebrotonic: (traits of being tense and restrained, overly sensitive, seclusive and inhibited, high-strung "schizoid").

The following table shows the distribution of somatotypes in the three types designated as type I, II, and III. In this table patients whose outcome is unknown have also been included as a possible guide in understanding why these patients drifted away from treatment and have lost all contact with the hospital.

TABLE 10

SOMATOTYPE DISTRIBUTION IN THE S, F, AND U GROUPS

Somatotypes	Number of Patients in the S Group	Number of Patients in the F Group	Number of Patients in the U Group	Totals
I Endomorphic	3	2	0	5
II Mesomorphic	6	2	0	8
III Ectomorphic	4	3	3	10

The results of the table give evidence that type III (ectomorphic) are most likely to be selected for CRT, and type I persons the least likely.

A type II person has the best chance of cure (three to one), and a type III person the least chance (two out of three) assuming that those who get lost also relapse.

A type I person has a slightly better than fifty-fifty chance of success.

The classifications of personality with somatotype component are helpful in predicting some behavior patterns, but cannot be used exclusive of other factors in the patient's internal structure or external environment. Since each person is a mixture of the various types, this does not

eliminate the possibility of success in any group. It is interesting to note that all persons who drifted away from treatment were of type III, while the greatest probability for success in the Conditioned Reflex treatment was found in type II.

Summary

Members of the abstaining group were found to enjoy outdoor events in pursuing their personal interests. In both groups the early history of the patient was considered fairly normal, and in all groups there was a history of drinking in the immediate family.

In both the abstaining and relapsing groups the fathers of the CRT patients were described as easy-going, while the mothers were considered to be domineering. In marital and sexual adjustment the CRT group, from the few answers given, seemed not to have achieved genital primacy.

Some of the most interesting results were found in the study of sociability factors and the somatotype of the patient. The S group had a markedly higher percentage of sociable individuals than did the F group, and patients rated as isolated were, without exception, found in the F group. In the study of somatotypes, type II (mesomorphic) had the greatest chance of being cured in the Conditioned Reflex treatment.

Reinforcement Record

Number of Treatments Completed

Some patients maintained contact with the hospital while others did not seem able to continue with the recommended program. The program consisted of "booster shots" to counteract any quantitative failure, weekly individual interviews during the first year, and attendance at the group therapy sessions. The following is a table showing the reinforcement

record of patients in both the abstaining and relapsing groups.

TABLE 11

NUMBER OF TREATMENTS COMPLETED BY PATIENTS IN THE S AND F GROUPS

Number of Treatments Completed	Number of Patients in the S Group	Number of Patients in the F Group
6 or more	7	0
5	1	0
4	3	4
3	1	0
2	0	1
1	1	2
0	0	0
Totals	13	7

No one in the relapsing group completed the full recommended treatment, while over fifty per cent of the abstaining group completed the full recommended treatment as scheduled.

It would seem that many factors influenced the success of the treatment since the table points up the fact that one patient did succeed with only one reinforcement. This patient's record is somewhat misleading insomuch as he is the patient who did relapse, but made a successful comeback after reinstituting treatment, so that actually he did take further treatment when he started the program over again. It was felt that he rightfully belonged in the abstaining group because except for this brief relapse he has abstained for the past eleven years. None of the other patients in the relapsing group made a comeback. In tracing other factors

concerning this patient he can be classed predominantly in type II, is listed as sociable, graduated from college, managed a business of his own, and belonged to three community-type organizations. This patient did reside out of the state and had marital difficulties which may have been contributing factors in his early relapse. However, his social class membership and his personality typing seemed to have had influence on his comeback.

The table also shows that there were eight patients who took three or four reinforcements, four of whom abstained, and four of whom relapsed. The question arises as to why some succeeded and some failed with the same number of reinforcements. An examination of other factors in the lives of the patients in the abstaining group reveals that one man suffered a heart attack and was not considered to be in any physical condition to undergo a reinforcement.

The second patient in the abstaining group was a traveling salesman who did not continue with reinforcements but involved himself deeply in the group-therapy part of the program sending frequent letters which were read at the regular Conditioning Club meetings as well as sending frequent financial donations to aid the work of the hospital. The third patient in the abstaining group was a member of the Jewish Civic League which seems to have had a strong influence culturally in his desire to be considered a part of the community. In fact, this patient's sister called to say that he had swung so far in the opposite direction that he was intolerant of others who drank.

The patient in the abstaining group with only three reinforcements lived in a state a considerable distance from the hospital. He was a college

man who held a responsible position in the United States Government as a minor official. He was considered sociable and was predominantly type II in personality typing.

In the relapsing group there were four patients who failed to return after four reinforcements. The first of these patients was in type III although considered to be an over-compensating type (a fighter). However, he was rated as an isolated person, attended only three years of grammar school, worked as a shipper, belonged to no organizations, and always considered himself lonely and frustrated. He was deserted by both parents at the age of seven.

The second patient in this relapsing group was rated as isolated and predominantly type III. He seemed to have a great need to "show off". In his environment after CR treatment he did encounter difficulties insomuch as his mother had paid for the treatment and his wife resented this very much. There was also combined with this his wife's fears that she was afraid of his attitude toward her when he was sober. His wife is described as "long-suffering," feeling that her husband is dependent upon her, and blaming his family for his troubles. It was during a vacation period in which the patient was redecorating the house that he relapsed.

The third patient who relapsed after four reinforcements had a grammar school education, worked at candy-making, but had followed seasonal harvests as a migrant worker, was predominantly type I, suffered from migraine headaches, and was considered isolated. This patient's wife was unable to have children because of surgery and considered the patient as her "baby".

The last patient in this group was predominantly type III, had one

year at a university, was considered sociable, belonged to no organizations, and worked in his family's business. It was felt upon examination of this patient's record that his environment defeated him since his mother was aggressive, domineering, and controlled the greatest interest in the family business where he worked each day. Although one brother was a periodic drinker, his other brother was considered to be "stern". This patient had felt very "let-down" after the death of his father, and overwhelmed by his mother's need to control.

Summary

The ability of the patient to complete his recommended treatment seems to relate directly to the various factors discussed as contributing to success and failure, that is, social class membership and personality.

Attendance at CRT Meetings

The following table illustrates strikingly the great variance in attendance of the abstaining and relapsing groups of CRT patients.

TABLE 12

CRT MEETING ATTENDANCE RECORD OF CRT PATIENTS

Attendance	Patients in the S Group	Patients in the F Group
Attended some meetings	13	0
Attended no meetings	0	7
Totals	13	7

Attendance of the S group was one hundred per cent, while no one in

the F group attended meetings. This would suggest that in addition to the factors discussed in relation to social class membership and personality, that removal of the addiction, either partial or complete, must be supplemented by appropriate and continued psychotherapy.

Changes Following Treatment

The abstaining group, except for the one patient who relapsed briefly and made a successful comeback, never drank again after their CR treatment. In the relapsing group, which is comprised of patients never making a comeback, there were found to be many different periods of time before the patient relapsed. The following is a table broken down into two year periods for the relapsing and unknown groups.

TABLE 13

ABSTINENCE RECORD OF THE RELAPSING AND UNKNOWN GROUPS OF CRT PATIENTS

Period of Relapse	Number of Patients in the F Group	Number of Patients in the U Group
0 - 2 years	6	0
2 - 3 years	1	0
4 - 5 years	0	0
6 - 7 years	0	0
8 - 10 years	0	1
Unknown	0	2
Totals	7	3

The relapser in the Unknown group, which has also been included in this table, had a certain degree of success, but there is no follow-up possible because of loss of contact with the hospital to determine if the

patient achieved any kind of comeback or if it were permanent.

The majority of relapsing patients seem to have done so within the zero to two year period. Many questions arise concerning the relapsing group. One of these is whether the term "relapsers" as is commonly used is appropriate to the study of the CRT group since technically speaking the patient cannot relapse from a treatment he never completed. This again would seem to relate to the original choice of patients wishing to take this special treatment. Factors previously discussed suggest that perhaps the type of person who can attend CRT meetings and follow through consistently with treatment are also those who can abstain successfully over long periods of time. The CRT relapsing categories following attempt to clarify some of the groups which have emerged:

1. Those patients who did not really complete treatment, that is, relapsed in the zero to two year period before completing the recommended reinforcement treatments. In addition to emotional and environmental difficulties in the lives of patients in this group, one must also consider this functional, or lack of reinforcement follow-up, as "quantitative failure" of the conditioning due to a gradual diminishing of the reflex before the optimal reflex was established. The question also arises as to whether these patients are true relapsers since they never actually completed the recommended treatment. They did relapse in the sense that they did not sustain contact with the hospital and thus were defeated before they really got started.

2. Those patients who did finish their reinforcements and later relapsed. There seem to be several sub-divisions in this group.

A. Patients who relapsed because they never really accepted the treatment.

B. Patients who had too great a sense of security feeling that they were cured forever and therefore could begin to drink moderately again.

C. Patients who were so insecure that they could not bear to be different from their friends feeling that to be different means to be inferior and weak. Although the environment of these patients accepted them as people who could not drink, they could not see this.

3. Patients who completed reinforcements and were in a relatively successful group of relapsers.

A. One-time relapsing patients who had faith in themselves and maintained sufficient contact so that the hospital and other CRT patients could reach out to them. There is some question as to whether this could not be called a successful patient.

B. Patients who relapsed after a successful record such as ten years abstinence and never made a comeback because they did not have faith in themselves or anyone else.

4. Patients who completed reinforcements but who were isolated in an environmental sense, that is, those patients with no roots, no strong family or work ties, who tended to drift because of a lack of individual loyalties binding them to a close relationship.

5. Patients who completed reinforcements, but who succumbed to their environment. Such a patient might have had a close marital tie, but of such a discordant quality that it kept the patient slightly off balance and undermined the effects of his treatment.

Although the differences between the abstaining and relapsing groups are significant for study as a guide to selection of candidates for the initial treatment, the emergence of such varied types of relapsers suggests that a future study might be undertaken based on a continuum with no sharp dividing line between abstaining and relapsing groups, but rather a study of the length of time the patient abstained and the reasons for his relapse.

CHAPTER IX

SUMMARY AND CONCLUSIONS

In the endless search for answers to the problem of alcoholism it is either disturbing or comforting, according to the individual viewpoint, to know that this search is not new. "Polybius, writing about 150 B.C. charges the Gauls with such brutal drunkenness that after a victory they would fall fighting and destroy themselves and their loot."[1] In the twentieth century new theories of alcoholism and new treatment methods promise more hope for the alcoholic bent on self-destruction.

Psychiatry has offered a frame of reference which continues to throw light on previously misunderstood motivations and behavior patterns of the alcoholic. Lolli has described the psychoanalytic viewpoint when he states: "The critical phases of human life - early infancy included- are highlighted by pleasurable and painful experiences. A normal proportion of both generally results in a satisfactory adult adjustment".[2] If the individual experiences excesses of these experiences, either pleasurable or painful, he may halt (become fixated) at that level of his development, and in late life when difficulties arise, he may react the same way that he did in this earlier period of his life. The individual who turns to alcohol discovers, that at least temporarily, alcohol satisfies some of

---

[1] Arthur A. McKinley, "Ancient Experience with Intoxicating Drinks: Non-Classical Peoples," Quarterly Journal of Studies on Alcohol, vol. 9 (December, 1948), p. 389.

[2] Giorgio Lolli, "The Addictive Drinker", Quarterly Journal of Studies on Alcohol, vol. 10 (December, 1949), p. 406.

these deep strivings. Lolli says:

> The satisfaction, however, is temporary and incomplete. Because of its chemical action on the central nervous system, with related psychological repercussions, alcohol only magnifies the addict's infantile longings, rendering attempts at their gratification increasingly unsuccessful.[3]

The Conditioned Reflex (Response) Therapy, as described in this thesis, is an attempt to answer some of these problems through the removal of the addiction itself by means of a special medical treatment combined with psychotherapy. The factors of concern in this study have been those relating to the probability of success in individuals undergoing this Conditioned Reflex treatment.

A sample of twenty-three Conditioned Reflex (Response) Therapy patients was chosen for study from the year 1944 at the Washingtonian Hospital in Boston, Massachusetts. Of the twenty-three patients in the sample, thirteen abstained from drinking from 1944 to the date of this study (1959), while seven patients relapsed.

Outcome is unknown for the remaining three patients because of loss of contact with the hospital. An abstaining patient is one who has maintained sobriety since the initial CR treatment. One exception was included in the abstaining group since this patient drank for a brief period of time and then made a successful comeback. The seven relapsing patients drank after CR treatment and never made a comeback. Case records were the primary source of data. These case records included psychiatric evaluation, medical information, contacts with other agencies, and supportive work done

---

[3] Ibid., p. 407.

by the social worker. The purpose of the study was to compare the characteristics of the abstaining and relapsing patients and to isolate those factors which aided the abstaining patients in successful treatment. The study also attempts to define some characteristics which both abstaining and relapsing patients have in common. Factors included in the study were education, occupation, age at marriage, number of children, membership in organizations, personal interests, sociability, early history, sexual adjustment, somatotype, religion, health, and drinking patterns.

The Conditioned Reflex (Response) Therapy patients included in this study are not representative of alcoholics in general since they are a small group chosen for this treatment from the larger community of alcoholics. Patients selected for this special Conditioned Reflex treatment have no evidence of psychosis, do not suffer from cardio-vascular diseases or other marked physical incapacities, are not addicted to drugs, have an I.Q. not below one hundred, have no evidence of constitutional psychopathy or any record of serious criminal offenses, are able to maintain themselves financially during their period of hospitalization, and must be well motivated toward treatment.

Characteristics Common to Both Abstaining and Relapsing Patients

Characteristics common to both the abstaining and relapsing patients were numerous. Most patients were in the fourth decade of life, this factor hopefully contributing to a greater degree of stability and maturity. Most CRT patients drank hard liquor and had begun drinking in their very early twenties. Patients in both groups acknowledged problems in drinking in their thirties, and came for treatment in their mid-forties. All were diagnosed upon admittance as chronic periodic alcoholics.

There was no evidence of any outstanding abnormal problems in youth in either the abstaining or relapsing patients.

There was some evidence of difficulties in pre-marital relationships in both groups of patients. Family members in their immediate environment drank heavily in many instances in both abstaining and relapsing patients.

The fathers of CRT patients were described as easy-going, not stern or "bossy". In both groups the mothers were predominantly described as ambitious, aggressive, and domineering. In spite of their domineering attitudes some patients considered themselves the favorite sons of these mothers. The attitude of the CRT patient toward siblings appeared to be one of indifference.

The health of all CRT patients was good and the history of family diseases was not unusual. There was no evidence in either group indicating a childhood marked by any physical incapacity.

Although some patients in both groups had been treated for alcoholism by other methods prior to CRT, no patient in either group remained abstinent after these other forms of treatment.

Characteristics Differentiating Abstaining and Relapsing Patients

Among the differences found between the abstaining and relapsing groups in this study was religion. Approximately eighty-three per cent of all Catholic CRT's remained abstinent, while only approximately fifty-five per cent of all Protestant patients succeeded.

Abstaining CRT's married somewhat later (average twenty-six) than the relapsing CRT's (average twenty), while the successes averaged two children per patient, the relapsers averaged three children per patient. In the area of personal interests, the abstaining group took a greater interest in

outdoor sports than the relapsing group which was more evenly distributed between indoor and outdoor activities.

The most significant differences between abstaining and relapsing patients emerged in the areas of socio-economic status and personality. In the area of socio-economic status the most positive signs predictive of success seemed to be the following:

1. An educational level of high school or better.
2. A professional, semi-professional, managerial or ownership type of job.
3. Membership in community organizations.

In the sets of factors dealing with personality the following seemed to be most positive:

4. A personality rated as "sociable".
5. A type II somatotype, (Mesomorph).

In the successful group of CRT patients seventy-five per cent had high school or college educations. Patients in the S group averaged two years of high school, while the majority in the F group had only a grammar school education and more than one-half had not finished grammar school.

Another area of significant difference was in occupation. Most of the abstainers held professional, semi-professional, and managerial jobs, while the majority of the relapsing group were employed as laborers.

Membership in organizations was the third significant indicator of difference between the two groups of abstaining and relapsing patients. No patient in the relapsing group belonged to a community-type organization, while almost seventy per cent of the S group were members.

Occupation and membership in community-type organizations seemed to

be more associated with outcome of treatment than any other variables in this area of socio-economic status.

Among personality traits which appeared to be conducive to successful CR treatment was the patient's social personality as rated by the psychiatrist. The percentage of patients rated as "sociable" was markedly higher in the abstaining group than in the relapsing, and it is perhaps significant that all patients rated as "isolated" were found in the relapsing group. Although personality type was not strongly related to success, it did appear that type II (mesomorph) had the greatest probability of success.

The reinforcement record of CRT patients seems to relate directly to outcome of CR treatment. Fifty per cent of the abstainers completed treatment as scheduled, while no one in the relapsing group of patients completed the recommended treatment. This held true also for attendance at meetings of the Conditioning Club. All of the abstainers attended meetings at some time during the course of treatment, while no one in the relapsing group ever attended any of the meetings.

These findings may be compared with those obtained by Voegtlin and Broz in their study at the Shadel Sanitorium in 1949. These authors found that the more highly skilled the patient was occupationally, the greater the probability of success, with the exception of attorneys, doctors, and dentists, who were found to be in the least successful category.[4] This

---

[4] Walter Voegtlin and William Broz, "The Conditioned Reflex Treatment of Alcoholism, "Annals of Internal Medicine, vol. 30 (March, 1949), p. 580.

contradicts the assumption of the present study that education and occupational status are positively correlated with successful outcome of CRT. Further research may bring out a status differential between the practitioner and his patient as a factor in success.

Such factors as the financial status of the patient, although not specifically noted in this study but inherent in the occupational status, was also found to be useful in prediction in the Voegtlin - Broz study. The status designated as "wealthy" had the highest percentage of abstainers.

Interest in abstinence clubs and the patient's reinforcement record also were similar in both studies, approximately eighty-seven per cent who abstained complied with the reinforcement schedule as set up at Shadel.

In conclusion, although it has been constantly emphasized that there are a multiplicity of variables, internal and external, which can "turn the tide" in treatment, it appears that an alcoholic candidate for the Conditioned Reflex (Response) Therapy would be most promising if he possessed a high percentage of the following five factors: an educational level of high school or better, a professional, semi-professional, managerial or ownership type of job, membership in a community organization, a personality rated as "sociable", and a type II (mesomorph) somatotype.

The average number of these factors present in patients in the abstaining group was 3.3 per cent, while the patients in the relapsing group had an average of only 1.4 per cent per person. Although this finding in no way precludes the possibility that an individual possessing none of these seemingly essential factors could not succeed in treatment, it does suggest that these factors can be strong assets in the successful recovery from alcoholism.

Accepted June 1959
Barbara Ayres

APPENDICES

Thesis: 1959

TITLE: CHARACTERISTICS OF THE ABSTAINING AND RELAPSING GROUPS OF CONDITIONED REFLEX THERAPY PATIENTS AT THE WASHINGTONIAN HOSPITAL.

POP: 23 CRT (Conditioned Reflex Therapy patients) of the year 1944. Includes Failures, Successes, and Unknown to 1958.

SCHEDULE: 8 Areas for Schedule:

- I Socio-Cultural Data
- II Patient's Pattern of Drinking
- III Personality Characteristics of the Patient
- IV Predominant Personality Type
- V Environmental Factors
- VI Health
- VII Description of the Treatment
- VIII Changes Following Treatment

Circle CAT. F S U

I. SOCIO-CULTURAL DATA

A. Age (at time of CRT) ________
B. Sex (check) Male ____ Female ____
C. Marital Status (circle one) S M W D Sep.
D. Religion (specify) ________
E. Length of residence in U.S.A. ________
F. Birthplace of Family (specify)
  1. Father ________
  2. Mother ________
  3. Spouse ________
  4. Mother-in-law ________
  5. Father-in-law ________
G. Birthplace of patient ________

II. PATIENT'S PATTERN OF DRINKING (before CRT).

A. Types of beverage and quantity:
  1. Hard liquor (check) ________
  2. Beer or Wine (check) Beer Wine Both
  3. Average amount per day (specify) ________

B. Before present drinking bout has patient been drinking (check)
  1. Regularly ________
  2. Periodically (at regular intervals) ________
  3. Not at all ________

C. How long has patient been abstinent prior to present bout.
  (Specify number of months or years) ________

D. Describe patient's behavior during present bout.
  1. ________

E. Patient's eating habits during present bout.
   1. Poor (generally not eating) ____________
   2. Fair (eating less or irregularly) ____________
   3. Normal (no change in dietary habits) ____________

F. Age at first drink (specify) ____________

G. Age when drinking became a problem (when patient felt he was unable to stop) ____________

H. Has patient ever had any psychotic episodes Yes ______ No ______

I. Longest sober period and reason if patient feels there is any.
   1. Sober period (specify) ____________
   2. Reason, if any given (describe) ____________

J. Any occasions when patient stopped drinking which seem to have significance (describe) ____________

K. Previous treatment and effectiveness.
   1. Type of treatment (describe) ____________
   2. Did patient stop drinking Yes ______ No ______
   3. How long abstinent after this (specify) ____________

L. Has patient ever been confined to a Hospital or other institution for drinking. Yes ______ No ______ If Yes, specify ______

M. Admitting diagnosis if patient came into Washingtonian.
   1. Diagnosis (write in) ____________

N. What seemed to precipitate present drinking bout ____________

III. PERSONALITY CHARACTERISTICS OF THE PATIENT

A. MENTAL STATUS

   1. Psychotic tendencies (check)
      a. none (oriented in all spheres) ____________
      b. mild (some misinterpretations) ____________
      c. hallucinations Yes ______ No ______

   2. Patient's General Information (check)
      a. good ____________
      b. poor ____________

   3. Patient's judgment and insight (describe) ____________
      ____

   4. Presence of compulsive phenomena Yes ______ No ______

III (continued)

B. OCCUPATIONAL HISTORY and EDUCATIONAL SUMMARY

1. Education. How far did patient go in school (specify) ________
____

2. At what jobs has patient worked. List (in order) ____________
____
____

3. Did patient have periods of unemployment Yes ______ No ______
   a. If unemployed, why ____________________
   b. Average duration of unemployment ____________

4. Did patient change employment frequently, give reason if yes.
   a. Yes ____________________
   b. No ____________________
   c. If yes, reason ____________________

5. At what jobs had patient worked longest (specify)____________
____

C. SEXUAL HISTORY (Indices of patient's heterosexual adjustment).

1. Early history, any problems in this area, if known.
   Specify ____________________
____

2. Age patient had first intercourse (specify) ____________

3. Married at what age (specify) ____________

3a. Pre-marital courtship relations ____________

4. Married more than once.
   a. No. of times married ____________
   b. Cause of divorce, etc. ____________

5. Number of children and ages
   a. No. ____________
   b. Ages ____________

6. Marital relationships, describe, telling who gave information (wife or husband) ____________

7. Patient's account of his own feelings ____________ (turn sheet over for write-in)

D. SOCIABILITY FACTORS

1. Does patient belong to groups outside his home and business. (specify number and kind) ____________
____

III (continued)

2. Does patient meet or work with other people on his job.

   a. Alone ______________________
   b. With others ______________________

3. Is patient generally considered to be: (check)
   a. Sociable ______________________
   b. Restrained ______________________
   c. Isolated ______________________
   d. Unfriendly ______________________

4. Interests. List ______________________

5. Close friends mentioned Yes ________ None ________

E. PATIENT'S SELF-IMAGE

Describe this in patient's own words, if available.

____

____

IV. PREDOMINANT PERSONALITY TYPE

A. Group I: (Traits of being overly relaxed, gluttonous, complacent, socialized and dependent upon people) ______________________

Group II: (Aggressive and assertive, energetic, dominating, fond of risk, combative, ruthless, loud, hypomanic, and overly active)

____

Group III: (Overly tense and restrained, overly sensitive, seclusive and inhibited, high-strung "schizoid") ______________________

____

B. Patient's capacity for self-destructive projectiveness. (patient feels he can't stop drinking, therefore, no one else can stop him) Describe ______________________

____

V. ENVIRONMENTAL FACTORS

A. Others in environment who urged patient to drink. Describe.
____
____

B. Others in environment who have urged patient to stop drinking. Describe.
____
____

C. Other pressures in the environment. Describe. ____________________
____

D-1. Is there a history of family drinking. Specify ____________________
____

D-2. Is there a history of family mental illness. Specify ________________
____

E. If known, what are patient's relationships with his parents (in childhood and now.) Describe and give source of information.

1. Rel. with Father ______________________________
2. Rel. with Mother ______________________________
3. Rel. with Siblings ______________________________
4. Other ______________________________

VI. HEALTH (excluding alcoholism)

A. Does impairment of any kind of functioning seem to effect drinking pattern Yes ______ No ______ No information ______

B. Childhood diseases (specify) ______________________________
____

C. Operations or serious illnesses (specify) ______________________
____

D. General health

1. Considered excellent ______
2. Considered good ______
3. Considered fair ______
4. Considered poor ______

E. Family Diseases (describe)

1. Father ______________________________
2. Mother ______________________________

VII. DESCRIPTION OF TREATMENT

A. Did patient pay for his CRT treatment himself.
  1. Yes ______________________________
  2. No (specify) ______________________

B. Reinforcement record.
  1. Did patient take recommended number of reinforcements according to hospital schedule Yes ______ No ______
  2. How many reinforcements did patient take ______________
  3. Did patient miss one or more (specify) ______________
  4. Did patient stop completely before required number of reinforcements Yes ______ No ______

C. Did patient attend meetings of the CRT group as scheduled (group therapy)
  1. Regularly ______________________
  2. Some __________________________
  3. None __________________________
  4. Geographically inconvenient __________
  5. Other reasons, write in ____________

VIII. CHANGES FOLLOWING CRT TREATMENT

A. Abstinence record.
  1. Did patient relapse at all Yes ______ No ______
  2. If patient relapsed, time before first relapse.
     1944 0 to 2 yrs. ______________
           2 to 4 yrs. ______________
           4 to 6 yrs. ______________
           6 to 8 yrs. ______________
           8 to 10 yrs. ______________
           10 to 12 yrs. ______________
     1958 12 to 14 yrs. ______________
  3. Longest period of abstention between 1944 and 1958 __________
  4. How many of these years did patient abstain (total)__________
  5. Total number of relapses ______________________
  6. Circumstances of first relapse ___________________

B. Occupation after CRT.
  1. Same __________________________
  2. Different, specify _______________
  3. Work record
     a. more consistent ______________
     b. less consistent ______________
  4. Has patient found his work more satisfying than before CRT.
     Yes ______ No ______ Describe, if necessary______________
  5. Unknown ________ Yes ________ No ________

C. Rehabilitation potential. (Other persons influencing situation).
  1. Write in role of others effecting abstinence ______________
     ____

D. Changes in Personality and attitudes of the patient toward himself and others. Write in____

E. Other changes not covered by above items ____________________

BIBLIOGRAPHY

BIBLIOGRAPHY

Books

Fenichel, Otto. The Psychoanalytic Theory of Neurosis, New York: W. W. Norton and Company, Inc., 1945.

Mann, Marty. Primer on Alcoholism, Philadelphia: Rinehart and Company, Inc., 1950.

Merck Manual of Diagnosis and Therapy, 9th ed. Rahway, N. J., 1956.

Noyes, Arthur P. Modern Clinical Psychiatry, Philadelphia: W. B. Saunders Company, 1948.

Richards, T. W. Modern Clinical Psychology, New York: McGraw - Hill Co. Inc., 1946.

Journal Articles

Bergler, Edmund. "Contributions to the Psychogenesis of Alcohol Addiction," Quarterly Journal of Studies on Alcohol, vol. 5 (December, 1944), pp. 434 - 449.

Carlson, Anton J. "The Conditioned - Reflex Therapy of Alcohol Addiction," Quarterly Journal of Studies on Alcohol, vol. 5 (September, 1944), pp. 212 - 215.

Carter, H. R. "Conditioned Reflex Treatment of Alcohol Addiction," Rocky Mountain Medical Journal, vol. 40 (May, 1943), pp. 318 - 321.

Edlin, J. V., Johnson, R.H., Hletko, P., and Heilbrun, C. "The Conditioned Aversion Treatment in Chronic Alcoholism," American Journal of Psychiatry, vol. 101 (May, 1945), pp. 806 - 809.

Gerard, Donald L. "Intoxication and Addiction. Psychiatric Observations on Alcoholism and Opiate Addiction," Quarterly Journal of Studies on Alcohol, vol. 16 (March, 1955), pp. 681 - 699.

Hoff, Ebbe C. "A Cultural View of Man's Drinking Habits," Inventory, (January, 1959), p. 29.

Kephart, William M. "Drinking and Marital Disruption," Quarterly Journal of Studies on Alcohol, vol. 15 (March, 1954), pp. 63 - 73.

Lemere, F., Voegtlin, W. L., Broz, W.R., and O'Halloran, P. "Conditioned Reflex Treatment of Chronic Alcoholism," Northwest Medicine, vol. 41 (March, 1942), pp. 88-89.

Journal Articles...continued

Lolli, Giorgio. "The Addictive Drinker," Quarterly Journal of Studies on Alcohol, vol. 10 (December, 1949), pp. 404 - 414.

McCarthy, Raymond G. "Group Therapy in Alcoholism. Transcription of a series of Sessions Recorded in an Outpatient Clinic. Eighth Session," Quarterly Journal of Studies on Alcohol, vol. 12 (March, 1951), pp. 103 - 117.

McKinlay, Arthur P. "Ancient Experience with Intoxicating Drinks: Non-Classical Peoples," Quarterly Journal of Studies on Alcohol, vol. 9 (December, 1948), pp. 388 - 414.

Osborn, Leslie A. "New Attitudes Toward Alcoholism," Quarterly Journal of Studies on Alcohol, vol. 12 (March, 1951), pp. 58 - 60.

Price, Gladys M. "Social Casework in Alcoholism," Quarterly Journal of Studies on Alcohol, vol. 19 (March, 1958), pp. 155 - 163.

Sapir, Jean V. "Relationship Factors in the Treatment of the Alcoholic," Social Casework, (July, 1953), pp. 277 - 292.

Schilder, Paul. "The Psychogenesis of Alcoholism," Quarterly Journal of Studies on Alcohol, vol. 11 (September, 1941) pp. 277 - 292.

Shadel, Charles A. "Aversion Treatment of Alcohol Addiction," Quarterly Journal of Studies on Alcohol, vol. 5 (September, 1944), pp. 216 - 228.

Stewart, David A. "Empathy in the Group Therapy of Alcoholics," Quarterly Journal of Studies on Alcohol, vol. 15 (March, 1954), pp. 74 - 110.

Thimann, Joseph. "Conditioned Reflex Treatment of Alcoholism," New England Medical Journal, vol. 241 (September, 1949), pp. 368 - 370.

Thimann, Joseph. "The Conditioned Reflex as a Treatment for Abnormal Drinking," New England Journal of Medicine, vol. 228 (March, 1943), pp. 333 - 335.

Thimann, Joseph. "Conditioned Reflex Treatment for Alcohol Addicts," Clinical Medicine, vol. 53 (August, 1946), pp. 220 - 222.

Thimann, Joseph. "Constructive Teamwork in the Treatment of Alcoholism," Quarterly Journal of Studies on Alcohol, vol. 8 (March, 1949), pp. 569 - 579.

Journal Articles...continued

Thimann, Joseph and Price, Gladys. "Modern Trends in the Treatment of Alcohol Addicts," Journal of Social Casework, (October, 1946), pp. 222 - 229.

Tiebout, Harry M. "The Role of Psychiatry in the Field of Alcoholism. With Comment on the Concept of Alcoholism as Symptom and as Disease," Quarterly Journal of Studies on Alcohol, vol. 12 (March, 1951), pp. 52 - 57.

Tiebout, Harry M. "Surrender versus Compliance in Therapy," Quarterly Journal of Studies on Alcohol, vol. 14 (March, 1953), pp. 58 - 68.

Voegtlin, Walter and Broz, William. "The Conditioned Reflex Treatment of Alcoholism," Annals of Internal Medicine, vol. 30 (March, 1949), pp. 580 - 597.

Vogel, Sidney. "An Interpretation of Medical and Psychiatric Approaches in the Treatment of Alcoholism," Quarterly Journal of Studies on Alcohol, vol. 14 (December, 1953), pp. 620 - 631.

Walcott, Esther P. and Straus, Robert. "Use of a Hospital Facility in Conjunction with Outpatient Clinics in the Treatment of Alcoholics," Quarterly Journal of Studies on Alcohol, vol. 13 (March, 1952), pp. 60 - 77.

Whalen, Thelma. "Wives of Alcoholics," Quarterly Journal of Studies on Alcohol, vol. 14 (December, 1953), pp. 632 - 641.

Pamphlets and Reports

Bacon, Seldon D. Inebriety, Social Integration and Marriage. New Haven, Conn.: Yale Center of Alcohol Studies, May, 1954.

Bacon, Seldon D. Sociology and the Problems of Alcohol. Foundations for a Sociological Study of Drinking Behavior. New Haven, Conn.: Yale Center of Alcohol Studies, March, 1954.

Unpublished Material

Cork, Margaret. "Problem Drinking and Social Workers." Paper presented before the Institute on Alcoholism at the Canadian Conference on Social Work, June, 1954. (Mimeo).

Johnson, Dorothy M. "The Initial Interview in the Intake Process with Alcoholic Patients and their Relatives." Paper presented at the Social Workers' Institute of the National States' Conference on Alcoholism, Miami Beach, Florida, October, 1955. (Mimeo).