THE MANAGEMENT OF ALCOHOLISM*

C. BICCARD JEPPE, M.B., B.CH., D.P.M.

Johannesburg

It is generally accepted that alcoholism is on the increase; and so, therefore, is interest in and research into the problem. It is not easy to estimate the number of alcoholics in any given population. Jellinek has developed a formula whereby he computes the number of alcoholics in America to be about 1% of the population. Various estimates of the figure for South Africa have been made; it seems likely that the number is in the region of 90,000. The significant figure which has emerged from a study of the statistics, however, is not so much the number of alcoholics, but the number of other people whose lives are affected. The effect on the family—wife, children, and so on—is obvious. In industry the effect of alcoholism has been of far-reaching consequence, and it has now been realized that it is *profitable* to treat the alcoholic rather than to discharge him and train another man in his place. This realization has had its impact on the Rand, where the gold-mining industry and the Johannesburg municipality have well-established schemes for the treatment of the alcoholic and are carrying out research into his problems, with consequent benefit both to the alcoholic and to the general policy of conservation of man-power.

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This is an important change in attitude, that the alcoholic should be considered a sick man and receive treatment as such, rather than as a weak, immoral or wilfully badly-behaved person, who should be treated with contempt. The circumstance which is largely responsible for this change in approach is the recent realization that there is a physical factor in the etiology of alcoholism. It appears that there develops in certain people a central idiosyncracy to the substance alcohol, which results in compulsive drinking. This mechanism is triggered off by alcohol, sometimes by a very small amount of it, (as, for example, in one of our cases, the brandy in the Christmas pudding), and the need for alcohol is then truly compulsive and quite outside the control of the patient. The alcohol in the body appears to create a craving which can only be satisfied by the substance which brought it about, as, of course, with other addictions. This physical need can naturally not be dealt with by persuasion or by threats. Medical and nursing care is essential during this phase, so that it can seldom be managed at home.

The cause of this change in the physical reaction to alcohol is not known. It has been postulated that there may be some intracranial lesion; the lowered tolerance to alcohol after head injuries is well known. But it is perhaps more likely that certain cells in the liver are destroyed, or in some way altered, so that they can no longer deal with alcohol as is done in the normal liver, that is, by breaking it down into acetic acid, water and so on, with the result that toxic acetaldehydes form and accumulate. It is these toxic substances which initiate and perpetuate the cycle of compulsive drinking. Typical indications that such a cycle has begun are a change in the drinking pattern; a small amount of alcohol has a far greater effect than previously and, specifically, the need for a *regmaker* arises.

Underlying these physical factors are the psychological needs for alcohol. Alcohol has the effect of minimizing self-criticism and easing tensions aroused by frustration, resentment or anxiety. As with other neuroses, the fundamental pattern is one of insecurity, and the feelings of guilt, unworthiness or rejection which are aroused by the attitude of society towards the alcoholic still further accentuate these tensions and so perpetuate the psychological need for reliance on alcohol. It is a disturbing thought that the attitude of society actually contributes towards the very condition it seeks to abolish by its condemnation.

TREATMENT OF THE ACUTE ATTACK

Treatment of the acute physical disturbance, as mentioned, is best managed in a nursing home. Rest, adequate nutrition and suitable sedation are the chief aims.

During a drinking bout, sleeping and eating are severely affected and it is often only because he feels so ill that the alcoholic can be brought to the realization that he does indeed require hospitalization. Massive doses of vitamins, particularly the B complex and C are given by mouth and by injection, as well as large amounts of fluids. We have not had such dramatic success with intravenous vitamin therapy as has been described elsewhere, but this obviously has its value. We prefer to give alcohol *ad lib.* for the first 24 hours and then to taper off over the next 2 days, for it appears to be a terrifying experience to the alcoholic to be deprived of alcohol until he feels that his craving is being blunted by some other means. We have found that Tolseram is of value in this respect but, because of the readiness with which the alcoholic becomes addicted to any form of sedation, this should not be continued for more than a few days. At Northlea beneficial results have followed the use of Hydergine and Bellafoline. Northlea is an institution for alcoholics maintained in Johannesburg by the Rand Aid Association. If there is evidence of severe damage to the liver, a high-protein, fat-free diet, with perhaps some protective substance such as methionine or Methischol, is advisable.

In the matter of sedation, paraldehyde is probably the drug of choice, though it has its dangers. Unless kept from contact with the atmosphere, oxidation tends to take place and aldehydes form, which may have a toxic effect. Hyoscine and the barbiturates are generally contraindicated.

In view of the possibility of epileptiform seizures, Epanutin is a useful routine for the first few days.

The development of delirium tremens is a distressing and often dangerous complication. Here Largactil by intramuscular injection has been proved to be of considerable value, often bringing about a deep sleep, from which the patient wakes in his right mind, as it were, even when large doses of paraldehyde or other narcotics have previously failed to touch him. Largactil, however, is of little value while the patient is taking much alcohol; in fact, it has a deleterious effect.

The 'drying-out' period is particularly uncomfortable and a sympathetic attitude on the part of the doctor will do much to form a basis for a good rapport when the more difficult stage of the treatment of the chronic phase is commenced.

MANAGEMENT OF THE CHRONIC PHASE: REHABILITATION

Treatment during the chronic phase must be continued for a long period, after the patient has returned to his home and his work, and is of necessity then on an out-patient basis. Individual psychotherapy is often essential, but group psychotherapy, such as is carried out at 'The Gables' (a Toc H organization in Johannesburg where out-patient facilities are available for the treatment of alcoholism) and Northlea, is of even greater value. It is of the utmost benefit to the alcoholic to feel that he is an accepted member of a group. Feeling, as he does, rejected by society, his awareness of his own inadequacies increases tenfold and so, consequently, does his need for reliance on alcohol; so that acceptance by a group comes as a tremendous relief to him and gives him a solid foundation on which to develop an understanding and the eventual management of his personality difficulties. The success of Alcoholics Anonymous is a good indication of the value of this aspect.

In the management of the chronic phase, the *attitude* of the therapist is again of paramount importance. It is essential to minimize, as far as possible, any of the moral significance which society places on excessive drinking.

In our culture, as indeed in many others, the use of alcohol has become almost a yardstick of manhood. The adolescent indicates, by indulging in a few beers, that he has now become a man. It is a matter for congratulation to be able to 'carry one's liquor like a man'. In certain literature, too, the 'hard-boiled' criminal investigator creates admiration by the way he is able to 'knock back' his whisky neat. It is for this reason that a man is most unwilling to make the admission that he is unable to manage his alcohol. It appears to him to be a confession of weakness, a slur on his manhood. It is of the utmost importance to make the point early in therapy that this difficulty is the result of a physical change occurring in a certain type of physical constitution. It is pointed out that difficulty with alcohol occurs particularly in a group of people who tend to have certain physical characteristics in common. For instance, 80% of alcoholics in South Africa have blue eyes (the average for the whole population is 49%). The majority too, have skins which are sensitive to the sun and burn easily. Most of them do not like sweet foods, puddings and so on; they prefer salty foods. Finally, the men, particularly, tell us that, even when they started drinking, they could take more than the average, their tolerance for alcohol being high; then, suddenly, after 5 or 10 or 15 years, their tolerance dropped and a small amount of alcohol had a large effect; the pattern of their drinking changed, an indication that some *change* had taken place in their physical reaction to alcohol.

These points, made in group, nearly always strike some chord amongst its members and the process of counteracting the effects of the 'morality' attitude to alcoholism has begun. Because the alcoholic is so sensitive to the emotional climate in which he lives, it is necessary to enlist the support and cooperation of those about him, and it is most helpful if wives or parents can attend the group discussions with the patients. Often a hostile or resentful wife can be turned into a useful ally, once she begins to understand more about the reasons for her husband's drinking.

Emphasis is at first laid on the changes in metabolism which bring about the sensitivity to alcohol. The fact that these changes are irrevocable and irreversible means, of course, that the alcoholic will always be sensitive to alcohol and that he will never be able to drink socially again. But this is not laboured in early discussions, because 'never' is a long time and it is by no means easy for the alcoholic to contemplate never drinking again for the rest of his life. He says he won't, but he doesn't really mean it. In fact, he has no right to say so; he does not fully realize all the implications. He has to learn for himself. As he is learning more about the problem, by the simple, painful process of experience, with the help of support, explanation and reassurance, he learns from his 'slips', 'skids' or bouts of drinking that in fact he cannot drink. It may take many bitter experiences before this simple fact is genuinely accepted but, once it is, he is well on the way to rehabilitation.

Antabus

It is never easy, however, to do without alcohol, if its use has been a necessary part of one's life-long pattern of reaction. It has been mentioned that alcohol has the effect of easing tension brought about by stress and, once this behaviour pattern of reliance on alcohol in time of stress has become established, there is a strong resistance to any interference with that pattern, no matter how clearly it is recognized that it is an unsatisfactory one. For this reason we have recently employed Antabus (tetra-ethyl thiuram disulphide) for its protective value in the treatment of alcoholism. Taking alcohol while one is on antabus cause the development of certain uncomfortable symptoms, which make it unpalatable to take enough alcohol to trigger off the mechanism of compulsive drinking. In advising the use of antabus, its *protective* value should be stressed and the parallel is drawn of the man living in a malarial area who protects himself from malaria by the use of quinine, or the diabetic who protects himself by the use of insulin; so the man who has had difficulty with alcohol protects himself against further difficulty in that respect with the help of antabus.

The primary value of antabus is obvious, to guard against further bouts of drinking and to halt the otherwise inevitable progress of the disease. The secondary effect, however, is even more valuable. On antabus, the alcoholic feels 'safe' and, what is more, his wife feels safe too and so does his employer and the other people about him. It is difficult for even the most sympathetic and well-meaning wife to avoid something of a suspicious or even a nagging attitude towards her husband in regard to alcoholism, and it is this very attitude which so often drives a man to have a drink and so start off the whole cycle of compulsive drinking. On antabus, the whole domestic climate is more favourable and the patient is free to give his full attention, in a clear field uncomplicated by anxieties about alcohol, to whatever psychological, social or domestic difficulties have been encumbering his life.

The usual dose of antabus is one tablet daily, taken morning or evening, whichever is more convenient. It is not always sufficient to rely on the patient to take the dose by himself; it is sometimes preferable to arrange for the wife to give it, and it may be wiser to have it crushed, in suspension in water, it has been known for the patient to conceal the tablet under his tongue and spit it out later. It is of the utmost importance, in any case, for the administration of antabus to be as unemotional and matter-of-fact as possible. There is inevitably some resistance to the idea of taking it, and threats, insistence, or making an issue of it, will increase that resistance to the point of blank refusal.

The contra-indications to the use of antabus are such conditions as cardiac disease, severe hypertension, renal damage and the like; but it should be borne in mind that possible danger from antabus may be a lesser evil than the certain danger of further alcohol. In the first few weeks of taking antabus there may be some side-effects, such as mild urticaria, frequency of micturition, or a generalized feeling of dullness or lethargy, but these effects are only temporary and eventually wear off completely, particularly if the dose of antabus is cut down for a few days. Impotence is sometimes complained of, also temporarily. Increased libido has also been reported. We have occasionally seen a severe neuritis, which may

have been due to antabus, but in any event cleared up eventually with massive doses of vitamin B_{12}. A rare complication is the development of a confusional state not unlike delirium tremens.

Antabus should not be given until 48 hours after the last drink, for fear of precipitating the antabus-alcohol reaction. It is rather slowly absorbed into the system and even more slowly excreted, so that one may take antabus for 3 months, then stop, and 4 days later have a drink and still have a reaction. This is fortunate protection in the case of a sudden impulse to stop antabus and take alcohol.

It is a necessary part of the regime for the patient to undergo an 'antabus test'. In this the patient, who has been on antabus for at least a week, is given a small amount (usually 4 drams) of alcohol, in order to produce the antabus reaction. This consists of flushing of the face, tachycardia and dyspnoea, all compensatory effects which follow the sudden drop in blood pressure brought about by the aldehydes produced during the reaction. Usually 2 such tests are given, with a fortnight's interval; the aim, apart from the obvious 'safety first' reason, is to demonstrate what happens when one takes alcohol on antabus and inculcate awareness of the fact that there is, with antabus, a protective mechanism against alcohol. In short, where the original mechanism was, in effect, '"alcohol" means "more alcohol"', it becomes '"alcohol" means "stop"'. It is unnecessary, even unwise, to produce a severe reaction with a test. When antabus was first used the aim was, apparently, to produce a very severe reaction indeed, in an attempt to frighten the patient out of drinking. This was found not to work; all that happened was that the patient was frightened out of using antabus. The point is that antabus should be looked on as a *friend*, not an enemy, as a means of protection from alcohol while one is learning to manage the other circumstances of one's life.

The protest has often been raised that it is a confession of weakness to use antabus—,Surely will-power is good enough?' The answer, of course, is that 'will-power' can play no possible part once the mechanism of compulsive drinking has been set in motion; it is completely outside control. Even against the first drink, it is of little help, for will-power simply does not work in reverse; the more one tries to force oneself *not* to do a thing, the stronger the urge to do it becomes. It is much less productive of tension and anxiety, in our view, to recognize one's problem, take appropriate protective action, and then forget about it.

Rehabilitation

It is, of course, not enough just to remove alcohol from a man's life and hope for the best. Without his crutch, he feels unsafe, insecure and exposed to hostile forces. He becomes tense, anxious, restless and irritable, and it is during this phase more than ever that he is in need of the support of the people about him, as well as the reassurance and guidance of psychotherapy, both individual and group. Alcoholics Anonymous can be of great assistance at this time and, in order to combat the habit factor, which is by no means inconsiderable, some alteration in the pattern of living will be necessary. Some men have said that, if they have a couple of cups of tea as soon as they get home from work, it breaks the urge for a sundowner. A new hobby, or a new circle of friends, may help considerably. Even such a small dodge as drinking iced ginger ale out of a champagne glass helps him not to feel 'out of it' at a party.

CONCLUSION

These comments and the general approach outlined above are based on work carried out by 'The Gables' and Northlea. The inadequacy of the facilities available is woefully apparent. We are only on the fringe of a proper understanding of the problem, let alone its management. Nevertheless, even in the light of our present knowledge, much can be done to help the alcoholic. He is seldom a sought-after patient; he causes much trouble and heartbreak to those who try to help him; he is often ungrateful and usually 'broke'. The problem is, however, a tragic and a devastating one; the approach to it must of necessity be many-sided—physical, psychological, social and religious; but it is surely the enlightened, understanding and sympathetic medical practitioner who is in a position to be of the greatest help to the patient and to his family.

If one has been able to contribute towards the achievement of a year's sobriety in an alcoholic, one has done much. As implied in the title of this paper, the aim must be not the *cure* of alcoholism so much as the *management* of alcoholism.