A PSYCHOLOGICAL APPROACH TO ALCOHOLISM*

ARNOLD A. LAZARUS, B.A. HONS. PSYCHOLOGY (RAND)

Johannesburg

Enlightened medical and psychological knowledge has done little to lessen the prejudice and discrimination directed against the alcoholic. In South Africa, only the skilled and trained personnel who work in the field are familiar with the 'disease factor' in alcoholism and its implications; there is still an urgent need for enlightenment of the public. Even among professional groups prejudices still exist. In the Southern Transvaal, for instance, the majority of hospital boards do not admit alcoholics as such for treatment. 'Hospitals,' they say, 'are designed for sick people and not for drunkards.' Consequently, where medical supervision is indicated the alcoholic is usually hospitalized for 'acute anxiety' or a 'liver complaint'. Alcoholism is still viewed in the light of 'bad character' and 'weak will-power', and the majority of alcoholics must still endure the pull-yourself-together doctrine with its concomitant emotional appeals, morality lectures, threats, promises, and the like.

The study of alcoholism has mainly developed under the interests represented by psychology, psychiatry, sociology, religion, and economics. These diverse influences have visibly contributed to the contradictory concepts and the fragmentary nature of theory in this field. Moreover the general urgency of the problem and the desire for rapid progress lend acceptance to technically faulty work that would not pass muster in other fields. While semantic difficulties seem almost inherent in the social sciences, the study of alcoholism has added to this confusion by introducing a myriad of terms—'chronic alcoholism,' 'acute alcoholism,' 'alcohol addiction,' 'pathologic alcoholism,' 'primary alcoholism,' 'secondary alcoholism,' 'toxic alcoholism,' to mention only a few—all varyingly defined and applied with neither consistency nor uniformity. An attempt to define these conditions operationally is the one measure that will reduce the amount of confusion and controversy which abounds in this field.

DISCUSSION OF A DEFINITION OF ALCOHOLISM

The term 'alcoholism' is itself a matter of dispute. In some circles the term 'problem drinking' is preferred,

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concluded that we cannot speak of a personality structure which is typical of the alcoholic, and that compulsive drinking seems to depend upon the total effect of environmental stress upon a particular individual who has a biological inability to cope with alcohol.

THERAPY

Turning now to the therapeutic procedures for combating alcoholism in South Africa, we must note that the reported percentages of 'cures' are at best disappointing. This is not surprising when we recall that the usual approach to the alcoholic in this country is to hospitalize him for a short time, during which he is kept off alcohol and given vitamin injections. While this is a useful means of preparing the patient for further treatment, all too often it is administered as a cure in itself. There are, however, several sanatoria, homes and clinics which provide far more extensive means of treatment for the alcoholic. But even the measures adopted there, when viewed in the light of the vicious circle previously outlined, are inadequate. The mere regime of physical rehabilitation coupled with occupational therapy and 'healthy living' (as provided by some of these specialized homes and clinics) is insufficient. Unfortunately, the expectation of a possible 'panacea approach' is still prevalent among many clinicians, so that the problem is generally tackled within a unitary, or at best a 'bimodal', frame of reference.

Each of the following curatives and therapies has made energetic attempts to hold the centre of the stage as *prima donna* but, unhappily, each in turn has been relegated to the chorus. They include: relaxation therapy, psycho-analysis, conditioned reflex therapy, vitamin therapy, hypnotherapy, and the various drug therapies. The fault lies not with the methods, but with the failure to combine the advantages offered by each. For instance, it is estimated that psychotherapies, as they are applied at present without many selective criteria, may have an average success of 25-30% in terms of 2-4 years of total abstinence,[1] whereas when combined with conditioned-reflex therapy, Cotlier lists cures ranging from 50-75%.[2]

On the basis of 32 alcoholic case studies and Thematic Apperception Test interpretations (TAT), we submit that the consequences of alcoholism usually require a series of active steps in order to break the compulsion, as well as substitutive treatment (the fostering of hobbies and other recreational and occupational pursuits) and other forms of environmental manipulation, which all form part of a wide and all-embracing re-educative programme. The final and complete dissolution of the aforementioned vicious circle can usually be achieved by applying the following fourfold plan.

1. *Active measures to break the compulsion.* The gradual weaning process is supplemented by large doses of vitamin preparations administered intramuscularly. When the patient has regained his physical well-being, certain steps are recommended to ensure his total abstinence from drink while undergoing psychotherapy. This is best achieved by either administering a course of conditioned-reflex therapy or else tetraethylthiuram disulphide (Antabuse). (1) The former procedure consists of repeated sessions in which the individual is given a dose of emetine or apomorphine and shortly after either sees, smells or drinks various alcoholic beverages. The emetine or apomorphine induces nausea and vomiting, and because this becomes associated with the alcohol, the patient develops an aversion to it. The unconditioned stimulus is concerned with the elicitation of nausea or vomiting, and various alcoholic beverages represent the conditioned stimulus. This, it must be stressed again, is not intended as 'a cure for alcoholism'. Experience has indicated that in many cases, this conditioned aversion to alcohol breaks down after a few months, even when the response is 'reinforced'.[6] But if the individual can be made to avoid the apparently inevitable 'slips' during therapy, a positive prognosis is greatly facilitated. (2) The use of tetraethylthiuram disulphide is less involved than the conditioned-reflex therapy. The patient takes the drug orally in tablet form every day (any attempt to administer it without the patient's knowledge is contra-indicated) and it creates a sensitivity to alcohol, so that the patient cannot take alcohol without experiencing disagreeable and often violent reactions. This, unless medically inadvisable, is a valuable aid in rendering the alcoholic more amenable to psychotherapy.

2. *Educative Procedures.* By attending group or individual discussions, the alcoholic must learn the nature of his condition. He must be led to realize that he is suffering from an incurable disease (in the sense that he can never drink socially again) and that complete abstinence from any alcoholic beverage whatsoever, is his only salvation.

3. *Psychotherapeutic Procedures.* Individual psychotherapy should consist of (i) diagnostic interviews, i.e. a psychological and social diagnosis—an evaluation of the interaction of the patient and his environment; and (ii) treatment, which is designed to help the patient to gain 'insight'. Insight into, say, the relation between A and B in the life situation is a function of an intellectual and an affective bond between the two. It is a matter of *knowing* and *feeling* into the situation. The ultimate aim of psychotherapy is to ensure that the alcoholic remains abstinent by way of favourable readjustments in his personality. This implies the use of techniques which are designed to uncover the true motives behind the addiction and to provide the patient with a basis for readjustment through insight into his motives.

4. *Socio-economic Procedures.* A specially-trained social worker should visit the home of the alcoholic with the primary purpose of explaining to his family the 'disease factor' in alcoholism. Furthermore, the alcoholic should receive advice and help in securing employment, the correction of faulty home-environment, associates, etc., and aid in smoothing out domestic and other incompatibilities.

We are not suggesting that this fourfold plan is *the* cure for alcoholism. Nor are we under the impression that it constitutes anything novel. What we are attempting to convey is simply that all too often, therapists are prone to overlook the importance of each of these steps in turn, and unless this wider therapeutic approach is widely adopted, few of the alleged 90,000 European

alcoholics in South Africa will escape the searing effects of their terrible affliction.

A most useful adjunct to psychotherapy is progressive relaxation, since repeated practice of relaxation inhibits the tensions which may lead to drink. In some circles, injections of adrenal cortical extract are lauded. The successes claimed by Alcoholics Anonymous range from 50 to 70%. We submit that their successes are due largely to an effective mobilization of emotional relationships and, hence, participation in this movement should be encouraged where the patient's personality is considered amenable to their teachings.

Finally, we should like to emphasize again that since alcoholics form a heterogenous population embracing different and even antagonistic personality-types, no one treatment or approach can prove beneficial to all abnormal drinkers.

SUMMARY

1. Despite the important strides which have recently been made in the scientific study of alcoholism, there is still an urgent need for widespread public enlightenment concerning the 'disease factor' and its implications.

2. Ill-defined and contradictory concepts lend general confusion to the field. The general orientation should lean towards operationism.

3. The following definition is submitted and amplified: Alcoholism is a psycho-biological malfunction which manifests itself in a compulsive and progressive craving for alcohol, as the result of a pattern of conditioning, habit formation, and a biological inability to cope with alcohol.

4. The many generalizations about alcoholics so prevalent in the literature are not borne out by controlled studies. The so-called 'typical alcoholic' is a myth.

5. The emphasis in the rehabilitation of the alcoholic must essentially be on a *synthesis*, which would embrace active measures combined with educative procedures and psychotherapeutic and socio-economic procedures, as well as innumerable adjunctive measures such as chemotherapy, drug therapy, vitamin therapy and the like.

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