THE PROGNOSIS AND TREATMENT OF ALCOHOLISM

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Attitudes to alcoholism have altered a great deal over the past 3 decades, e.g. from the view that misuse of alcohol is 'sinful' to the view that alcoholism is purely a cultural problem or that it is simply a symptom of a psychological illness.

As always, of course, the truth is probably composed of something of each point of view. Moral issues cannot be entirely excluded from the matter. It is not enough for the alcoholic to consider himself absolved from responsibility for his condition. He has a definite obligation to follow certain rules as far as his daily pattern of behaviour is concerned — just as the diabetic has to follow certain rules with regard to diet.

There is no doubt that cultural factors play a part in the aetiology of this condition, and it is clear, too, that alcoholism often begins as a result of the use of alcohol as a 'tranquillizer' to relieve the symptoms of psychological tension.

The only factor in the whole syndrome of alcoholism about which there now seems to be agreement, is that the alcoholic has developed some special physical idiosyncrasy to the substance alcohol, the effect of which is to cause a compulsive need for more alcohol. It is this effect which brings about the destructive sequelae of the condition — destructive with regard to his physical health as well as to his adjustment both at work and at home.

It is the other factors in the syndrome, however, that make the *prognosis* difficult. People are loath to admit their 'weakness' regarding alcohol, and this is one condition where patients are not often eager to seek treatment.

It is self-evident that a patent desire to be helped improves the prognosis, but this can be most misleading. When physically ill as a result of his drinking, the alcoholic is usually grateful for help, cooperates fully, and often feels well in a few days. But the objective, of course, is for him to *stay* well; and to achieve this, motivation is all-important. Some large industrial organizations have something of an 'either . . . or' approach to treatment which is more effective than one would expect. To cooperate with treatment or else lose your job seems to provide quite strong motivation — rather contrary to the old view that coercion of necessity tends to negate the value of treatment to the alcoholic.

Perhaps the single most important prognostic factor is the attitude of the alcoholic's wife, parents, or children. If the alcoholic dwells in a climate of strong disapproval, the prognosis is poor indeed.

Again, the original basis of his drinking pattern is of significance in assessing the prognosis. If his earlier drinking was symptomatic, as a method of relieving tensions, prognosis is less good, or, at least, much psychotherapy may be needed. If the social or habit factor was the more prominent, this is easier to alter.

There have been many attempts to describe the 'pre-alcoholic personality'. No agreement has been reached. Alcohol does affect the personality along certain lines, and similar characteristics are found in many alcoholics after the condition has been present for some time; but no consistent personality pattern, which could be of prognostic significance, has been found to be present before alcoholism begins (although most alcoholics are of the 'passive-aggressive' make-up, which may account for the 'Jekyll and Hyde' picture so often described by distraught wives).

Certain physical characteristics may be of significance. It is striking how many alcoholics agree that they never had a 'hangover' in their lives. Certainly their tolerance to alcohol appears to have been higher than average before the compulsive element set in. This seems to point to an innate physiological factor. The predominance of blue-eyed, sensitive-skinned types, too, suggests an inborn physical difference, which is confirmed when the question of heredity is examined. There appears to be a genetic pattern.

To summarize, then, the prognosis in alcoholism is problematical. In general, one-third do well, one-third do badly, and one-third tend to relapse from time to time — although these figures have certainly been bettered in certain controlled groups, such as that of the Chamber of Mines, with their Social Services Department; the Rand Aid Association at Northlea and Mount Collins; and Castle Carey in Pretoria, one of the treatment centres of the South African National Council on Alcoholism.

TREATMENT

Short-term Treatment

This is largely symptomatic. *Sedation* is perhaps the most important aspect. Large doses are often necessary and a combination of paraldehyde, e.g. 4 drams by mouth, with 50 - 100 mg. of chlorpromazine by intramuscular injection, or its equivalent, have been found to

be effective in most cases. A barbiturate could be used instead of the paraldehyde, but it is generally better to avoid barbiturates, at least to avoid prescribing them for more than a few days, because of the very real danger of addiction. Addiction to paraldehyde is by no means uncommon, and the administration of this drug should not be continued for more than 3 or 4 nights. In most cases, however, if the rest of the 'drying-out' process has been proceeding satisfactorily, the sleeping and eating rhythms will have returned almost to normal by then, and heavy sedation will no longer be necessary. No matter what hypnotic is used, it is essential that it is not one that is readily obtainable by the patient. 2, 4-dioxo-3, 3-diethyl-5-methyl-piperidine ('noludar') is a case in point; this drug seems to have a particularly deleterious effect on alcoholics.

There is some controversy about 'tapering off'. Some authorities advocate the 'cold turkey' technique, withdrawing alcohol entirely at the beginning of treatment. This has a certain punitive connotation somehow. It is felt that the existence of a 'chemical need' for alcohol can be better understood by the patient if it is gradually withdrawn and replaced by other substances, rather than if it is 'taken away' from him as if he had been 'naughty'.

This tapering off should not last longer than 3 or 4 days, and the amount of alcohol given can, in most cases, be decreased from a bottle a day to 6 drinks the first day, 3 the second and 2 the third. The drinks must be large drinks though, e.g. at least 2 ounces of brandy, and not too dilute. A small, watered-down drink is merely irritating. These drinks given before meals are likely to help the appetite return more rapidly.

The dreadful discomfort of the withdrawal phase can be relieved to quite a large extent by the chlorpromazine derivatives. We have found 2-chlor-9-(3-dimethylamino-propyliden)-thiaxanthen hydrochloride ('truxal'), 50 mg. t.d.s., useful; and 7-chloro-2-methylamino-5-phenyl-3H-1, 4-ben-zodiazepine 4-oxide ('librium') helps considerably with restlessness, and meprobamate with shakiness. Epanutin, gr. 1½ t.d.s., should always be given for fear of withdrawal seizures.

It goes without saying that fluids must be increased as well as vitamins, by mouth and parenterally, since nutrition is likely to be poor particularly if the bout has lasted more than a week or so.

Delirium tremens. This serious complication of the withdrawal phase is often precipitated by the shock of a fracture or some intercurrent infection. An antibiotic given as a routine is advisable as a prophylactic measure. If restlessness and confusion are very severe, heavy sedation and ACTH are necessary (40 units of the gel b.d. for a day or two, gradually reduced over the next 4 or 5 days).

Long-term Treatment

For this to succeed it is essential for the patient both to understand his problem and to be sufficiently strongly motivated. It is important for him to understand the 'chemical' aspect of his addiction, and the following simplified explanation is helpful:

"Certain important cells, brain cells and others, are considered to be in, say, 'Stage I', when they are able to function effectively in the absence of alcohol.

"In Stage II, they learn to function even in the presence of alcohol.

"In Stage III, the final stage, they can function *only* in the presence of alcohol. Alcohol has become necessary for their oxidation processes.

"For this reason, there is discomfort — the 'withdrawal symptoms' during 'drying out', while the cells are reverting to Stage I, learning to function once again *without* alcohol.

"Then — and this is the crucial point — if they are ever again introduced to even the smallest quantity of alcohol, they at once slip into Stage III, by-passing Stage II, and the process which ends in compulsive drinking has begun."

In fact, this last stage may take some time; the patient may 'nibble' at mild drinking for several months before the drinking becomes compulsive, often precipitated by an emotional crisis. It does, of course, not infrequently happen that the compulsion begins with the very first drink.

In any case, once the patient understands this basic mechanism of his condition, he is better able to understand to what extent his cooperation with treatment is necessary. Also, his wife better understands that her husband's drinking is not, once it has become compulsive, entirely within his control, so that she is less likely to consider his drinking as purely wilful, and more able to give him the support and encouragement he needs.

Also, it emphasizes the point that *total* sobriety is essential. Alcohol in any form or in any quantity is certain eventually to start again the process of compulsive drinking.

It is not easy for the alcoholic, who has come to rely on alcohol to relieve his tensions, who requires its support on social occasions, or who has merely developed a strong habit pattern, to abstain completely from drinking.

'Antabuse.' It is for this reason that antabuse (tetraethylthiuram disulphide or TETD) has been found to be of considerable value. This tablet must be taken regularly, daily, for not less than 6 months. If alcohol is taken during this time, there is an uncomfortable physical reaction — flushing of the face, pounding of the heart and difficulty in breathing — and the desire for another drink diminishes, so that not enough alcohol is taken to set off the compulsive mechanism. By doing something *positive* in this way to protect himself against difficulties with alcohol, the alcoholic is free to devote his energies to more constructive activities, using the antabuse as a crutch, as it were, until he can walk well again.

Antabuse can cause certain side-effects. A skin-rash and frequency of micturition are uncommon. Headaches and drowsiness occur more frequently, but also disappear in time — more readily if the dose is decreased for a week or two. Impotence and a temporary confusional state have been reported. It must, however, be borne in mind that these side-effects are a small price to pay for the protection afforded by antabuse. Not only does the patient feel 'safe', but his wife does and his employer does, and the atmosphere of watchfulness and suspicion and mistrust which had contributed to so much of his tension, and, therefore, to his drinking, falls away.

Contraindications are few, although it might perhaps be better to avoid antabuse in cases of hypertension, heart disease or severe liver or kidney damage. The possible harm that may follow an antabuse reaction, however,

must be weighed up against the certain harm that will follow continued drinking.

It has been said that antabuse permits the alcoholic to devote his attention to more constructive channels. This is the crux of long-term treatment. He has to develop a different pattern of reaction to stress, a different way of life, and environmental manipulation of one kind or another may well be the most effective technique here. Group or individual psychotherapy on a supportive or a deeper level, is a *sine qua non* in some cases, particularly where a well-marked anxiety or obsessional state is revealed once the 'insulation' of alcohol is removed.

Certainly the support and encouragement of the family practitioner, the wife or parents and, where appropriate, the employer, is an integral and essential part of the rehabilitation of the alcoholic.

Such support is by no means easy to supply, because of the alcoholic's remarkable *penchant* for arousing disapproval by his behaviour — a characteristic which arises directly out of his strong feelings of insecurity and inferiority. He derives, it seems, a sort of back-handed satisfaction out of provoking an attitude of rejection in those about him, as if trying to prove that he is unwanted — a fact which he has suspected all along.

In fact, treatment of the alcoholic, as everyone knows, is fraught with disappointment. It is a most challenging problem, exacting the utmost resources of therapist and family alike, but exceedingly gratifying when success is achieved, even if only for short intervals at first, but, with the achievement of increased understanding by all involved, for gradually increasing periods of time.

The continually expanding activities of the S.A. National Council on Alcoholism, with treatment centres in Pretoria, on the East Rand, and in Durban; the remarkable results being achieved by the Social Services Department of the Chamber of Mines and by the Rand Aid Association; and the enlightened and positive attitude being adopted by Provincial Hospitals in various centres are all helping to bring relief and hope to many thousands of sufferers throughout the country.