METHODS FOR BRIDGING THE GAP BETWEEN ALCOHOLIC ADDICTION AND REHABILITATION

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The public has awakened to the far-reaching extent to which alcoholism permeates the educational, economic and social structure on an international scale. Instead of being considered a moral problem of depravity, as in the past, it is now viewed as a health problem, mental and physical.

Most notable of the intensive and critical scientific researches is being done by a group of Yale University psychiatrists, psychologists, and physiologists, under the direction of Dr. Howard W. Haggard and Dr. E. M. Jellinek, whose work is published in the Yale Quarterly Journal of Studies on Alcohol.

Yale also leads educationally in this field through the establishment of Yale Plan Clinics, and the Yale Summer Seminars open to lay therapists as well as professionals. The clergy, Social Service and law enforcement agencies, judges, economists, educators, members of Alcoholics Anonymous and others are free to avail themselves of these educational opportunities.

The concepts formerly held, that alcoholism was the result of a congenital weakness, lack of will power, or moral degeneracy, have been supplanted by the concept that alcoholism is a psychogenic disturbance, and that the alcoholic is psychologically sick, through maladjustment to his life situations. The unequivocal prognosis of "moral badness' has been replaced with concern for diagnosis and therapy.

More recent thinking has delineated his problem as an "illness", a "sickness", resulting from his abnormal use of the sedative properties of alcohol to allay psychic pain. By an attack upon the dynamics of his internal stresses the structure of his susceptibility can be exposed.

The prevailing hypothesis at present is that the addiction of an alcoholic can be arrested psychologically, through supportive measures, while the patient learns to redirect his energies. The evidence is adduced from the observed rehabilitated cases. If this hypothesis is correct, the same changes might be expected in those persons yet actively engaged in the excessive use of alcohol.

Concise experimental data, relevant to this hypothesis, is lacking, but it is steadily being compiled. There is indirect evidence that there are addicts who do not want sobriety. They only want to learn to control their drinking and stop the physical and psychical pain. In their desperate, but futile, fight against a demoralizing addiction, many do not know it is possible to live without intoxicants.

This hypothesis, that the alcoholic addiction can be arrested psychologically, is contingent upon the method of: first, the patient's receptiveness; second, his insight that his plight is not hopeless; third, his ability to mobilize suffcient incentive; and fourth, upon a cooperative willingness to appraise the exact nature of his difficulties with patience and persistence.

This frame of reference does not yield a typical "alcoholic personality", but rather a picture of emotional immaturity, strong dependent cravings, and suppressed aggression with a paranoidal taint. His reactions to conflictual experiences are met neither realistically, nor in an adult manner. Oral dependent patterns of a compulsive character, from the psychoanalytic viewpoint, delimit broad boundaries of personality terrain indicating a predisposition to adopt mechanisms of escape. Some equivalent neuroticism is likely to appear if the alcoholism, which is but the symptom, is diverted without the correction of the underlying motivation for escape.

This is substantiated by the ineffectual attempts—running the gamut of pleas, prayers, pledges, exhortations, institutions and jails—reported by former addicts who have finally achieved sobriety. Involuntary cessation achieved under duress, or by withdrawal by force, or through the enforced abstinence of penal institution life, has no lasting benefits. The alcoholic must formulate the desire to stop drinking himself. Otherwise, the discontinuance becomes the precipitating agent for resentments, aggressions, and infantile retaliation patterns of behavior, manifested in orgies of extreme drunken violence and destruction.

The termination of the mere motor response of the drinking act is not sufficient. The deep-seated neurotic character formations must be resolved, and there must be a redistribution of energy toward gratification and fulfillment of basic needs and drives. The choice of this type of flight or withdrawal resulted when the alcoholic was confronted with conflicts he could not handle or live with in harmony.

First, the alcoholic addict must contrast his present stupifying and incongruous physical manifestations to his original drinking reactions. Originally, alcohol accomplished such things as quiescence of anxiety, desire for social ease, and relief from feelings of inadequacy. He enjoyed transitory freedom from his tensions, and was able to function at a less inhibited level than when blocked by his frustrations, but not to maximum efficiency if these were removed clinically.

As total consumption increased, these original benefits were lost, tissue tolerance was raised, reality became untenable, and compulsive addiction was operative. When this degree of alcoholic dependence was reached, the narcotic effects, nullifying problem solving ability on a mature plane, offered only regression to a more immature level with its inadequate solutions.

The alcoholic must come to realize that his drinking is causing his behavior to become a problem to him; that while drinking he is evidencing marked personality changes. He is confronted with two equally potent, and equally unacceptable factors—he cannot face reality without the crutch of alcohol, and he cannot stop drinking through his own efforts.

When the alcoholic has reached this phase, he must make a choice. No therapy can be instituted until there is a cessation of drinking. In the case of the addict cessation may result in convulsions or delirium tremens, making his decision to be abstinent difficult to an extreme degree.

Dr. Robert V. Seliger, Instructor of Psychiatry at Johns Hopkins University Medical School, and Medical Director of The Farm for Alcoholic Patients, Howard County, Maryland, says that the alcoholic must be convinced from his own experience that his reaction to alcohol is so abnormal that any indulgence for him constitutes a totally undesirable and impossible way of life.

Sooner or later, he must fact the reality of his cyclic existence if he hopes to regain his health, his sanity, his self-respect, and his place in society. The decision to stop drinking must be for his personal happiness, for his individual and selfish satisfaction, and not to placate or mollify his employer, his family, his church, or his community.

Dr. Charles H. Durfee, a clinical psychologist, and Director, Rocky Meadows Farm, Wakefield, Rhode Island, has found in a clinical situation that once the alcoholic has accomplished the second phase—the decision to abstain—and is in contact with others fighting the same problem from whom he can gain incentive, he will voluntarily cease drinking within about three days.

The alcoholic must be brought to realize there is no magic formula for his problem. Reorientation cannot be achieved over-night since he did not acquire his addiction overnight. He has *learned* this pattern of reaction, and now he must *unlearn* the habituation. He must learn to forego immediate gains for long-term rewards.

Thus far his decision to abstain has been for relief, and he has been but vaguely conscious of a need for a more substantial incentive, which introduces the crucial third phase, leading to rehabilitation.

With the return of normal functioning of the higher thought processes the alcoholic is possessed by bitterness, shame and remorse because of his drinking escapades. Unless he is steadied by the reassuring and confident attitude of the therapist and other alcoholics in more advanced stages of rehabilitation, his first inclination will be to anesthetize his psychic pain with the easily available oblivion of alcohol. In a thoughtfully planned program of desensitization, during a temporary period of guidance and initial supportive treatment, the patient will be able to gather strength enough to adjust, to accept these memories, and to live with them.

Admittedly, he faces an ugly prospect, and the longer the retrospective drinking career, the more unsavory the prospect is; for as his drinking has increased, his concomitant troubles have increased proportionally. If, however, in this third phase—of gaining incentive—he sees others, similarly afflicted, making progress, he is powerfully motivated to try. In this phase members of Alcoholics Anonymous are very helpful. It has been found practical to put alcoholic patients together where they can share common experiences, a mutual incentive, exchange of suggestions through comparison of their successes, failures, and their progress.

During this time the therapist will guide the alcoholic to discover and interpret his inner drives, his qualities of temperament, his hopes, his fears, and his feelings of inferiority. Mere summation of his problems, weaknesses, and attitudes is sufficient to undermine his new intention to remain sober unless counterbalanced by a warm and understanding emphasis on commendable qualities.

The fourth phase, that of positive reeducation, finds the alcoholic sober but with a tremulous hesitancy and uncertainty. During this time the therapist in the hospital or institution, or on a farm, or the "sponsor" in Alcoholics Anonymous, can assign the alcoholic small tasks minutely progressive in difficulty, and carrying the merest suggestion of responsibility. It is not the perfection of the task, *per se*, but the learning to attack and accomplish small tasks that is of therapeutic importance. It is how he approaches the job, how he plans it, how he sticks to it despite obstacles, and how he accepts criticism, that counts. It is his attitude toward the assignment, the sustained interest and effort, that indicates emotional growth.

In this final phase of reeducation, the alcoholic must come to know himself and the abilities and potentials with which he has to work. He must acknowledge the manner in which he meets life situations, his reactions to things, places, situations, and people. If his past experience has taught him these have not gained him his goal, or if they have actually gotten him into trouble, he must recognize them as spurious. They must be deleted and replaced with more workable responses.

He must understand that within reasonable limits mutually contradictory impulses of hostility *vs.* fear, sexual pleasure *vs.* guilt, are normal. There are acceptable outlets for aggressiveness, compensations for feelings of inferiority and fears, and moderate dependence and reliance. To a degree, defense mechanisms can be healthy.

His self-critical attitude must be curtailed and often inverted, and the energy invested in a positive project. He must be brought to appraise his environment and himself; to reassess his values, his philosophy of life, his goals and ambitions, and directed toward a useful application of his assets. Some of these are outdated, some lack mature perspective, and some are laudable.

A reaffirmation of a spiritual concept of life has been found highly beneficial in many cases, but at no time should it be urged, or forced upon him. This, too, will develop in proportion to his emotional growth. As an adult, he is having to learn the youthful lessons of moderation, patience, tolerance, and acceptance. He must learn the difference between real achievement and alcoholic phantasy, between his conquests and his limitations.

The reeducation process is slow, tedious and often discouraging. For these reasons a survey of the literature seems to indicate optimum results have been achieved in a non-prohibitive atmosphere of freedom, and suggests a farm for alcoholics. Here, on a small scale and in reduced and simplified situations the individual's pattern of failure can be observed by his reactions to group and work situations. A farm offers a wealth of natural sources for application of the psychotherapeutic techniques of occupational therapy.

Dr. Durfee, of Rocky Meadows Farm, feels it should be a real working farm, with small tasks to be performed, where everyone has a real and honest job *needing* to be done. The idea is not to make of the individual an expert farmer or a handy man, but a mature, well-adjusted adult, who in learning to take small responsibilities for digging a ditch, keeping a watchful eye over a broad of young ducks, etc., learns new work-attitudes. He learns to persevere when things are not to his liking, and to know through experience the meaning of self-discipline. It is not the productivity of the truck garden, but the spirit that went into it.

In such a situation alcohol is not artificially removed. The alcoholic is not taught to remember to abstain, but is taught to forget to drink when thwarted and frustrated. Abnormal and excessive drinking is habit. It is a learned, inadequate way of responding to life difficulties. He must learn to relinquish this inadequate way, and learn new ways, carrying greater gratification and reward. To learn this he needs practice in surroundings free from conflictual tensions, and drinking associations of his environmental and familial life.

In work-situations, diversion, or entertainment, the alcoholic's contact with other patients, or with members of Alcoholics Anonymous, reveals faulty habit responses in human relationships, but these also provide an opportunity to participate and practice social adaptation in a favorable, non-competitive, non-critical atmosphere.

The interaction of the group serves as a constructive therapeutic medium. The greatest asset of this arrangement is to be found probably in working out his problem among others who have the same problem. Under the guidance of the therapist there is an exchange of ideas, suggestions, understanding, and a community spirit of helpfulness. All are striving for the same end.

In summary, first, the alcoholics come to see the importance of a desire for sobriety; second, they come to feel that the situation is not hopeless, that they can be salvaged; third, they gain incentive that sobriety can be won, and is being won; and, last, they come to find the patience for slow, but rewarding recovery.