Psychotherapy with Alcoholics

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Psychotherapy with Alcoholics

Introduction

Psychiatry has in general not been very effective in treating alcoholics. Most psychiatrists have little interest or experience in this field. Since most psychiatric residencies at the present time do not offer clinical training in the addictive disorders, psychiatrists are ill equipped to diagnose and treat alcoholism. Therefore, with a few exceptions, psychiatry has left the field of alcoholism largely to Alcoholics Anonymous, a few interested internists and general practitioners, and paraprofessional alcoholism counselors. However, psychiatry with its understanding of psychodynamics and the sociopsychological factors relating to human behavior can make important contributions to this field.

It is generally accepted that psychological factors alone are not sufficient to produce alcoholism in an individual. Sociocultural and physiological factors (possibly of genetic origin) along with psychological mechanisms are the *necessary* and *sufficient contributors* that produce the clinical state of alcoholism. Flow these factors interrelate to produce alcoholism in a particular individual is unknown. In some individuals one of the three factors may predominate. However, alcoholism shares with many other mental health related disorders a lack of etiological knowledge along with some fairly effective treatment approaches.

This chapter will present a psychiatrist's understanding of sociopsychological factors relating to alcoholism and the approaches for successful psychotherapy of this condition in a significant number of alcoholics. The experience and views presented are based on the author's work with many alcoholics in urban ghetto alcoholism programs, in a suburban community

mental health center, and in private psychiatric practice. There will also be a discussion of results obtained in the treatment of alcoholics during a two-year period in the author's private psychiatric practice.

Psychodynamics of the Primary Alcoholic

There is considerable literature on psychoanalytic theories of alcoholism. Much of this literature was reviewed by Blum (1). Blum indicates that psychoanalytic concepts can be applied to the psychodynamic understanding of alcoholism and that oral fixation is the arrested stage of development for the primary alcoholic. This fixation accounts for the infantile and dependent characteristics noted in alcoholics, including excessive narcissism, demanding behavior, passivity, and dependence. This fixation occurred in the development of the primary alcoholic due to a significant degree of deprivation during early childhood development. Other types of alcoholics are described as being fixated at the anal level or the phallic oedipal stage. There is considerable evidence to support the view that alcoholics had been exposed to rejection by one or both parents and that dependency needs are among the major psychological factors that contribute along with other etiologic factors to the development of alcoholism (2, 3, 4, 5, 6).

The dependency needs of many of the alcoholics the author has treated have been profoundly repressed and there was often little evidence of overt passivity or dependent traits when the patients were sober. Such dependent and passive traits were apparent, however, when they were under the influence of alcohol. Alcoholics who were sober in many cases had obsessive-compulsive personality traits. They were often perfectionistic and in need of maintaining control over their feelings and their lives, and were often completely unaware of the most intense feelings, particularly anger. Therefore, it is not appropriate to look for or to characterize an "alcoholic personality." The psychological conflict that is discussed below forms a psychodynamic constellation which is the key psychological factor in alcoholism and is the core conflict that must be dealt with

in therapy. This psychodynamic constellation is a common problem among alcoholics, but does *not* produce a common personality.

The psychodynamic conflict that the author found in the alcoholics he has treated has been lack of self esteem, feelings of worthlessness, and inadequacy. These feelings are denied and repressed and lead to unconscious needs to be taken care of and accepted (dependent needs). Since these dependent needs cannot be met in reality to compensate for the profound feelings of worthlessness, they lead to anxiety and compensatory needs for control, power, and achievement. These excessive needs are often doomed to failure, resulting in the use of alcohol which tranquilizes the anxiety felt in the face of failure and, more importantly, produces, pharmacologically, feelings of power, omnipotence, invulnerability. When the alcoholic wakes up after a drinking episode, he is full of guilt and despair because he hasn't achieved anything more than before he drank and his problems remain. Thus, his feelings of worthlessness are intensified and the conflict continues in a vicious circle fashion, often with a progressive downward spiral.

McClelland et al. (7) conducted extensive research with male alcoholics on the effects of alcohol on feelings and imagery. They noted that alcohol produces "ego-enhancing" effects and thoughts of power and strength. They hypothesized that "drinking serves to increase power fantasies and that heavy liquor drinking characterizes those whose personal power needs are strong and whose level of inhibition is low." They rejected the theory that alcoholism is related to dependent needs since they were unable to demonstrate increased fantasies regarding warmth and dependency during drinking. Similar studies conducted among women alcoholics by Wilsnack (8) suggest that alcohol enhances feelings of womanliness.

The psychological mechanisms presented above are basically not in conflict with McClelland's or Wilsnack's theories, since the male alcoholic can be viewed as striving for power and control consciously and the woman alcoholic as striving

for womanliness as compensations for unconscious feelings of worthlessness, a poor self image, and the need to be nurtured. Alcohol provides an artificial feeling state of power and control in men and increased feelings of womanliness in women that cannot be achieved in reality for very long. The very act of producing such feeling states at will feeds the alcoholic's conscious grandiose self image. This intense need for grandiosity can be called a *reactive grandiosity*.

McCord and McCord (9) conducted longitudinal studies of families. Some of the boys in the families under study later became alcoholics. They noted that alcoholics were often raised in homes that could be characterized as conflict-ridden, and in which there was an extremely erratic, unstable mother and a rejecting, punitive father. They noted the alcoholics had evidence of heightened dependency needs which were unacceptable and had feelings of being victimized by society and compensatory feelings of grandiosity. Feelings of fearlessness, self-sufficiency and aggression that were noted in prealcoholic boys were felt to be a facade erected in place of feelings of rejection and a heightened desire for dependency.

The observation that the core psychodynamic problem in the treatment of alcoholism is *reactive grandiosity* and a need to feel omnipotent was discussed in Tiebout's paper describing the psychological process by which an alcoholic becomes involved in Alcoholics Anonymous (10). The conversion process was described as occurring in four steps: 1) the need to hit bottom; 2) the need to be humble; 3) the need to surrender; and 4) the need for ego reduction. These steps were based on Tiebout's observation of an excessive amount of narcissism in the alcoholic's ego which gives rise to feelings of omnipotence. The steps in the conversion process are necessary to produce a reduction in this narcissism which perpetrates the self-destructive drinking behavior and the coexisting denial of this behavior. Tiebout did not indicate in this paper what happens to the excessive narcissism of the alcoholic's ego. Clearly, the narcissism is sublimated toward the goal of A.A. to rescue other alcoholics. Thus, the grandiosity becomes fulfilled and socially useful in the rescuing of other alcoholics. A.A. members

recognize that their help of other alcoholics is a way that they keep themselves sober. The first step in the 12 steps of A.A. is the recognition of the alcoholic's inability to control alcohol. With this recognition, there is also the beginning of recognition of one's inability to control other aspects of one's life. Thus, the beginnings of humility appear in an alcoholic, with a crack developing in the wall of denial built by the need for omnipotence as the alcoholic becomes involved in A.A.

Therefore, the central problem in rehabilitating an alcoholic is breaking through the *reactive grandiosity* that produces the massive denial of profound feelings of inferiority and dependency and perpetuates the pattern of self-destructive and family destructive drinking. The alcoholic not only destroys himself but his loved ones as well, without really perceiving his lack of control of this behavior pattern. The typical response of an alcoholic without insight into this behavior is, "I can stop drinking any time I want to." This occurs in spite of overwhelming evidence to the contrary. This self-deception must be penetrated if rehabilitation is to succeed.

Sociopsychological Factors Affecting Treatment

In addition to recognizing the psychodynamics of the alcoholic in treatment, one must recognize the social circumstances of the alcoholic. It is necessary to evaluate the family and marital relationships that exist or existed in the past, as well as the employment situation. In addition, information should be obtained regarding the cultural attitudes toward drinking and drunkenness that existed in the individual's family while he was growing up and how he integrated these attitudes into his present drinking behavior.

There must be a determination as to how the individual has handled crises and stress, and whether he has been able to modify or stop destructive drinking behavior spontaneously in the past, and for how long. One must determine at what level the individual is psychologically, socially, and developmentally and

how he reached these levels historically.

The social, family, and cultural contexts in which problem drinking occurs are significant factors in determining what treatment approaches can be most effective with the individual, and to determine what influences can be brought to bear to convince the alcoholic of his need for help. Coercion is often necessary because of the massive denial and self- deception that exist. Industrial alcoholism programs often use the implied threat of losing one's job unless the individual enters a treatment program for his alcoholism. Such programs report relatively high rates of success in rehabilitating their alcoholic employees. Such coercion can be viewed as *therapeutic leverage* in which a small degree of self-awareness is forced upon the alcoholic. Such therapeutic leverage can be useful; however, it cannot in and of itself produce recovery, which can occur only in the treatment process which will be described below. Therefore, looking for possible sources of therapeutic leverage should be a part of the initial evaluation of an alcoholic.

All alcoholics are not the same, even though most share the common psychodynamic conflict with dependency and the need for compensatory power and control. Alcoholics exist in differing age groups, socioeconomic circumstances, and cultural groups. Approaches with the skid-row homeless alcoholic cannot be the same as with the so-called "high-bottom" executive, or with the individual living in poverty in an urban ghetto. The skid-row homeless person is at the bottom of the barrel socially. He reached this depth after a prolonged history of alcoholism and has developed an adaptation, although a very tenuous one, to this state. The social, physical, and psychological consequences of this state require differing approaches aimed at physical, social, and vocational rehabilitation requiring years to accomplish. The executive who is still employed requires approaches dealing with his drinking, education about alcoholism, and psychotherapy and/or involvement in A.A., since social, vocational, and physical deterioration have not progressed to a severe degree.

One must make a distinction among various populations of alcoholics—for

example, people living in poverty. In this case drinking problems are often a reaction to the depression and stress of poverty. Alcoholism treatment for this group is necessary, but not sufficient to produce recovery. Socioeconomic incentives are needed to provide a motivating force to remain sober once sobriety has been produced through treatment (11).

It has been noted by several studies that different subpopulations of alcoholics respond differentially to various treatment modalities (12, 13, 14). Varying social and psychological factors in the alcoholic subpopulation will affect outcome. Therefore, programs that offer the widest range of treatment alternatives will have the greatest success for mixed populations, as well as those programs that provide the most effective specific approaches to a relatively homogeneous subpopulation.

The elderly alcoholic facing the stress of aging uses alcohol to cope with these problems (15). Treatment in such cases can be effective by dealing with the depression and social isolation of the individual with socialization activities and antidepressant medication best carried out in a setting serving the elderly.

Therefore, treatment approaches must be based on knowledge of the sociocultural norms, attitudes and needs of the patients under treatment. Sociocultural influences are often major contributing factors in the etiology of alcoholism, and such influences must be understood if the alcoholism is to be successfully treated.

It should be noted that alcoholism does not occur as an all or none phenomenon, but rather as a degree which will vary in severity from time to time in the same individual. Table 1 shows a scale (16) which approximately defines varying levels of severity of alcohol abuse from no problem to the skid-row alcoholic at level six. Improvement in treatment can be determined by movement upward in this scale, although the goal of abstinence with improvement in social functioning and greater awareness of and insight into one’s behavior should be the end point of rehabilitation.

Table 1
Alcohol Abuse Scale

Level	Characteristics
1. None	Drinks only on occasion, if at all.
2. Minimal	Drinking is not conspicuous, occasional intoxications (up to 4 per year). No social, family, occupational, health, or legal problems related to drinking.
3. Mild	Intoxication occurring up to once a month, although generally limited to evening or weekends, and/or some impairment in social, family relations, or occupational functioning related to drinking. No physical or legal problems related to drinking.
4. Moderate	Frequent intoxications, up to one or two times per week and/or significant impairment in social, family or occupational functioning. Some suggestive evidence of physical impairment related to drinking, such as tremors, frequent accidents, epigastric distress, loss of appetite at times. No history of delirium tremens, cirrhosis, nutritional deficiency, hospitalizations or arrests related to drinking.
5. Severe	Almost constantly drinking (practically every day). History of delirium tremens, liver cirrhosis, chronic brain syndrome, neuritis, nutritional deficiency, or severe disruption in social or family relations. Unable to hold a steady job but able to maintain himself on public assistance. One or more arrests related to drinking (drunk and disorderly).
6. Extreme	All the characteristics of severe impairment plus homelessness and/or inability to maintain himself on public assistance.

The Treatment Process

The treatment of the alcoholic is a long-term process. Alcoholism is a chronic illness with a high potential for relapse. As in other such chronic disorders, continuous care is required in some cases for the duration of the individuals' lives. Alcoholics Anonymous is particularly well suited to provide this supportive treatment for an indefinite duration. All an individual has to do is to attend meetings and follow through with their "12 Step'' procedures. However, professional intervention during the beginning stages of treatment is necessary to provide detoxification from alcohol and a thorough psychosocial evaluation. The psychotherapeutic process described is best suited for middle-class alcoholics who have family ties and a reasonable amount of socioeconomic resources.

Directive counseling during the process of detoxification can enhance the motivation of an alcoholic to continue the treatment after detoxification has been

completed. Detoxification from alcohol can be accomplished in many cases on an ambulatory basis (17) using diazepam (Valium) 5 mg. 3-4 times a day progressively reduced over 1-2 weeks. Patients are seen in the office 2-3 times per week during the detoxification, but not maintained on Valium after detoxification. Patients who cannot be detoxified on an ambulatory basis should be hospitalized.

Counseling or more intensive psychotherapeutic approaches are often necessary after detoxification has been accomplished. Acquainting the alcoholic with the physical effects of alcohol on his body and the effects on his ability to perform his necessary functions should be part of this effort. The use of disulfiram (Antabuse) in maintenance doses of 250 mg. per day to produce a deterrent effect in regard to drinking is also an effective approach.

Several principles are important in the treatment of an alcoholic individual. The first principle is that the drinking itself must be terminated if therapy is to be at all effective in achieving rehabilitation. A common mistake mental health professionals make is viewing alcoholism as a symptom of underlying psychopathology or personality disorder and attempting to treat the underlying disorder. This approach to alcoholism psychotherapy has resulted in many failures and a reluctance of psychiatrists to treat alcoholics in spite of an occasional paper describing some success with psychoanalytic psychotherapy of alcoholism (18).

Psychological conflict does exist as indicated, but efforts must first be directed to achieve sobriety for the patient through detoxification and the maintenance of sobriety through intensive directive psychotherapy, and the use of Antabuse. A patient who is continuing to drink will not be responsive to counseling or psychotherapeutic approaches and a power struggle often develops between the therapist and the drinking patient.

The second principle in treating the alcoholic is the understanding of the

transference the alcoholic will often establish with a therapist. This transference will be very intensive and be characterized by a great amount of dependence coupled with hostile, manipulating, and testing behavior. Thus, a great deal of ambivalence will be noted in the transference relationship. The alcoholic will be dependent, but at times act in a grandiose way, believing he can control his drinking as well as his life when the evidence is obviously to the contrary. Thus, massive denial is utilized by alcoholics to avoid facing their problems and their inability to handle alcohol. The therapist should encourage a dependent relationship with the patient by the use of support, acceptance, and directive counseling to permit the patient to change his dependence on alcohol, which can be considered an object relationship, to dependence on the therapist.

The third principle in the treatment of the alcoholic is understanding the countertransference that may develop in a therapist in response to the provocative behavior and drinking of the patient as testing of his continued interest. Because of this type of testing behavior, the treatment of an alcoholic can be felt to be frustrating and unrewarding. However, the therapist must recognize that he is not omnipotent in regard to the alcoholic's drinking. He cannot, nor can anyone, stop an alcoholic determined to drink. A therapist can only provide the means to assist the alcoholic in achieving sobriety and cannot force him for long into refraining from drinking. Only the patient's conscious efforts can achieve this for himself. Recognizing this reality, the therapist must impose limits on the behavior of the patient and conditions under which treatment can continue. If the patient cannot meet these conditions at a particular point in time, treatment should be discontinued. The door, however, should be left open to renew the efforts to achieve sobriety as the first step in the treatment process.

The treatment of an alcoholic has been observed to progress through several stages. Although the stages can be observed in group therapy, they are more apparent in individual therapy. The first stage involves the situation where the alcoholic "cannot drink." This situation exists when there is external pressure

on the patient to stop drinking, such as the threat of loss of job, or his wife leaving, or deteriorating physical health. In a sense, the alcoholic is forced to stop drinking, at least for a short time. Most alcoholics are pushed into treatment because of such external pressure. Attitudes toward drinking and the denial of drinking as a serious problem have not changed. The alcoholic has stopped drinking not because he sees it as necessary, but because someone else does. Often during this stage after the alcoholic has stopped drinking, he feels extremely confident about his newly acquired sobriety and experiences a "glow" of euphoria. This behavior is a reaction formation to his unconscious lack of control over his drinking which is now experienced as a certainty of control over his not drinking as well as control over the other aspects of his life. This situation is by its nature very unstable since there has been no significant change in his attitude about drinking or an ego reduction as described by Tiebout (10). It can easily lead to a return to drinking or can lead through psychotherapy and/or further Alcoholics Anonymous involvement to a second stage where the alcoholic "won't drink." The use of Antabuse as an external control over the impulse to drink is particularly valuable during the beginning stage of treatment. All patients should be encouraged to attend A.A. meetings as an adjunct to the psychotherapy. Not all patients will be willing to attend, but those who do will learn a great deal about alcoholism and obtain a considerable amount of hope and support for their own recovery. Involving the spouse in conjoint therapy and a referral to Al-Anon can also greatly enhance the therapeutic process by changing destructive attitudes and behavior in the spouse and tangibly demonstrating to the patient the spouse's active participation in the recovery effort.

The second stage is where the controls on the compulsion to drink have become internalized and there is no longer a serious conscious conflict about whether to drink or not. At this stage, the individual's attitude toward the necessity of drinking and the deleterious consequences in resuming drinking are apparent. He has experienced a considerable attitudinal change toward drinking.

The conflict about drinking is still present, but at an unconscious level. Evidence of the continued existence of this conflict is present in terms of fantasies of the patient and in dreams. This stage is the level many Alcoholics Anonymous members have achieved. It is a reasonably good stage of recovery and is fairly stable, only occasionally leading to a “slip” after years of sobriety. This stage requires at least six months to one year of treatment and sobriety to achieve. A decision regarding the stopping of Antabuse can be considered at this time because there has been established a good set of internalized controls over the impulse to drink.

During the first two stages of therapy, most of the defenses of the alcoholic should not be analyzed but redirected, particularly the grandiosity, through A.A. involvement. Patients who do not attend A.A. but are able to achieve sobriety have the grandiosity turned into an ego enhancing feeling of being able to control a problem that was extremely difficult. A paper by Wallace (19) discusses in detail how defenses of alcoholics can be redirected rather than removed to facilitate the therapeutic process.

The third stage of recovery involves the situation where the alcoholic “does not have to drink.” This stage can only be achieved through insight into the individual’s personality problems and conflicts and their resolution to a major degree. The habitual use of alcohol at this stage can be understood as a way of dealing with the individual’s conflicts and as a reaction to stress. With the resolution of the conflicts, the individual can achieve more adaptive ways of coping with problems, internal and external. This stage can be achieved only through psychotherapy and self understanding. It is a stable stage so long as the alcoholic refrains from drinking. The ability to refrain from drinking is relatively easy to maintain at this stage.

The fourth stage of recovery is a theoretical stage and involves the situation where “I can return to social drinking.” Probably a small percentage of alcoholics can achieve this stage (20), but at our present level of knowledge, it is impossible

to predict which alcoholic this might be. All alcoholics believe during the initial stages of recovery that they can return to controlled drinking. Therefore, for all practical purposes *abstinence* should be a necessary goal in the treatment of all alcoholics. Alcohol is not necessary to life and it is quite possible to live and even be happy without consuming alcohol. This fact should be part of the attitudinal change an alcoholic experiences during the process of recovery.

The termination of treatment with an alcoholic is a critical point. If the treatment process has been successful, the alcoholic will have established a dependent, trusting relationship with the therapist and, therefore, termination will produce anxiety and the possibility of return to drinking. This termination should be based on mutual agreement between the therapist and patient, a termination date in the future determined, and the final months of therapy involved with the issue of termination.

Termination can occur at stage II or III since both are relatively stable stages regarding control of drinking. A decision has to be made, however, when a patient reaches stage II as to whether further treatment to achieve insight into the psychological conflict related to his drinking problem and, therefore, moving to reach stage III are considered important to the patient. As far as control of drinking is concerned, it is not essential to reach stage III in treatment. Therefore, this option should be left to the patient.

Regardless of whether the patient terminates in stage II or III, the door to return to therapy at any time should be left open. A patient who stops treatment after stage II may determine after a while that not drinking is not enough to help him deal with his feelings and conflicts and, therefore, might wish to return to treatment to try to achieve insight into his personality conflicts. A patient terminated after stage III may have a slip; therefore, a return to treatment should be available. However, this slip should not be viewed as a treatment failure, but as part of a rehabilitation process that is not yet complete. Patients who slip in stages II and III generally do not return to continuous uncontrolled drinking

because their awareness of their problem and control mechanisms are such that controls can be quickly reinstated. The slip can be analyzed as a psychological maladaptation to conflict and anxiety or as a transference reaction.

Report of an Outcome Study

The author analyzed data on 23 alcoholic patients treated in individual psychotherapy during a two-year period in a private psychiatric office setting where the methods described above were utilized. The patients were seen in most cases on a once-a-week basis. In some cases where marital problems were major aspects of the patient's difficulties, joint sessions were held periodically. All patients received a physical examination and laboratory studies from an internist.

The data obtained for this study came from a review of the charts kept on the patients and follow-up telephone calls to patients who were no longer in treatment.

The results of the study can be seen in Table 2. This table indicates that 14 of the 23 patients treated (61%) were successes. An outcome was considered successful when there was at least 1 year of abstinence from alcohol with functional improvement in other aspects of their lives. Of the 14 patients who achieved a successful outcome, 10 patients achieved a stage II level of recovery (internalized controls over the impulse to drink) and 4 achieved a stage III level of recovery (conflict resolution).

Table 2
Characteristics of Treated Patients

		Successes* 14*** (61%)	Early** Drop-Outs 5 (22%)	Failures 4 (17%)
A.	Sex			
	Male	8	4	2
	Female	6	1	2
B.	Age			
	Average	43	38	41
	Range	33-54	22-52	30-51
C.	Religion			
	Catholic	3	1	1
	Protestant	6	2	3
	Jewish	4	1	0
	Other	1	1	0
D.	Marital Status			
	Married	7	3	1
	Divorced	3	1	1
	Single	3	1	1
	Separated	0	0	1
	Widowed	1	0	0
E.	Employment			
	Employed	11	5	3
	Student	1	0	0
	Housewife	2	0	1
F.	Social Class			
	Lower Middle	1	2	1
	Middle	7	1	1
	Upper Middle	6	2	2
G.	Duration of Alcohol Abuse (Years)			
	Average	7	6	5
	Range	3-17	2-12	2-10
H.	Level of Alcohol Abuse			

4	8	3	2
5	6	2	2
I. Use of Antabuse			
Yes	13	2	4
No	1	3	0
Complications	2	0	0
J. Type of Detoxification			
Hospital	3	0	1
Ambulatory	9	5	3
None	2	0	0
K. Use of Alcoholics Anonymous			
Yes	10	2	1
No	4	3	3
L. Previous Treatment			
None	6	3	2
Psychiatric	7	2	2
Alcoholism	1	0	0

* One year or more of abstinence with improvement in other aspects of their lives.
**Six sessions or less.
***Stage II–10; Stage III–4.

In the study, 5 (22%) patients dropped out of therapy early (6 sessions or less) and 4 (17%) were failures. If we consider the outcome of the 18 patients who remained in therapy, 14 (78%) had successful results.

There were 14 males and 9 females. The average age was 44 with a range of 22-54. The average duration of their alcoholism was 8 years with a range of 2-17 years. The severity of their alcoholism placed 13 of the patients at level 4 of the Alcohol Abuse Scale (see Table 1) and 10 at level 5,

Additional demographic characteristics of this treatment population indicated that 11 patients were married, 6 divorced or separated, 5 single and 1 widowed; 5 were Catholic, 11 Protestant, 5 Jewish, 1 Moslem, and another with

no religious affiliation; all of the patients were middle-class individuals, with 19 employed, 1 student and 3 housewives.

History of the treatment population indicated that 11 had no previous treatment for their alcoholism, 11 had previous psychiatric treatment which was unsuccessful, and 1 had previous alcoholism treatment which was unsuccessful.

When first seen for treatment, most of the patients required detoxification from alcohol, with only 2 being sober on initial contact. Of the 21 requiring detoxification, 17 (81%) were successfully detoxified on an ambulatory basis; 4 (19%) required in-hospital detoxification after failure of ambulatory detoxification.

Regarding Alcoholics Anonymous attendance, 13 participated in A.A. and 10 did not. Among the 14 patients who had successful outcomes, 10 used A.A. and 4 did not. Among the patients who dropped out and those who failed in therapy, 3 used A.A. and 6 did not. Although the numbers are too small to determine statistical significance, it is suggested that attendance at A.A. is associated with a successful outcome.

Antabuse was used with 19 of the 23 patients and with 13 of the 14 patients who had successful outcomes. There were 2 patients who had complications from the use of Antabuse which required its discontinuation. One patient developed a toxic hepatitis and another developed an organic brain syndrome. These conditions cleared up after the Antabuse was stopped.

Case Reports

Case 1

Patient is a 44-year-old married, Jewish lawyer. He had a 17-year history of alcoholism with several hospitalizations, an episode of delirium tremens about 10 years ago and several attempts at alcoholism treatment including A.A.

attendance, Antabuse, group therapy with a psychiatrist who specialized in alcoholism treatment, and most recently an internist who specialized in alcoholism treatment.

In recent years his drinking pattern had changed from daily drinking to abstinence of 1-2 months' duration and then going on binges of several days' to a week's duration. He came into treatment at a point when he appeared to be losing control of his periods of abstinence and his binges were becoming more frequent. He always planned his drinking to occur at times when it would least interfere with his work, but his more frequent binges were beginning to affect his work performance and create marital problems.

The patient was started in individual psychotherapy, Antabuse, and referred to A.A. He refused to go to A.A., however.

During the beginning stages of treatment he would stop taking Antabuse, wait a few days, and start a binge. This continued for several months until he was told he couldn't continue in treatment if he continued to drink. He came to one session drunk, at which time he was extremely depressed and full of anger at his father.

Prior to this session, the patient had denied any feelings about his father or, in fact, any disturbing feelings or thoughts of any kind. A joint session with his wife after this session confirmed his depression when he was drunk and his angry feelings at his father. He realized for the first time that he drank not only because he wanted to do so, but also as a way of coping with a great deal of emotional conflict.

The author's acceptance of him when he was drunk and the beginning awareness of his having repressed a great deal of feelings that were liberated by intoxication enabled him to accept the need for sobriety. He took the Antabuse on a regular basis and began attending A.A. meetings. He was able to identify with some of the members for the first time. He went on to achieve continuous

sobriety.

The use of the dependent relationship he had established with the author in the transference was threatened by the possibility of discontinuing therapy and was enhanced by his being accepted when he came to a session drunk. This represents a breakthrough in the treatment. The transference was not interpreted. He achieved a stage II recovery level because once his drinking ceased, his defenses in relation to his underlying conflicts were strongly reinstituted. He was able to achieve more than a year of continuous sobriety.

Case 2

Patient is a 44-year-old divorced, Protestant man who was the controller and treasurer of a financial corporation. He had a 4-year history of alcoholism which had contributed to his recent divorce.

He came to treatment just before his divorce was finalized because his wife had indicated that his drinking was the major reason for her leaving him. He was started on individual psychotherapy, but at first refused to take Antabuse or attend A.A., saying that he could stop drinking on his own. He was told that if he had a drinking episode it would prove that he couldn’t abstain without help and at that time Antabuse would be necessary for his continued treatment. He agreed to this suggestion.

After about 3 weeks of sobriety he began drinking heavily again. He said he really wanted to drink socially and that he wasn’t an alcoholic. When reminded of the agreement, he reluctantly agreed to take Antabuse. He also went to an A.A. meeting. He continued taking Antabuse for several months; at that time he was told that he was going to lose his job because of an economy move of his company. He became very upset and would have begun drinking again except that he was still taking the Antabuse. He realized that without the Antabuse he couldn’t control his impulse to drink.

His problem with his loss of his job was worked through and he began looking for another job. He had begun attending A.A. meetings and found them helpful. After about 6 months of therapy, he began to develop signs of organic mental impairment. The Antabuse was discontinued and his organic mental symptoms cleared up. He had changed his attitude significantly about the need to drink and he was able to maintain his sobriety when the Antabuse was discontinued.

He was referred to an organization called Parents Without Partners to help him meet women since he had problems making such social contacts. He met a woman whom he fell in love with and after 6 months of seeing each other they became engaged.

He was given a year to find another job by his present company. He had obtained some good prospects of another job and after about 14 months of treatment, with 1 year of sobriety, he was discharged from therapy.

Summary

The approach to psychotherapy of alcoholics that has been presented in terms of stages of progression of treatment in relation to varying levels of ability to control the impulse to drink provides a framework that structures a complex and often amorphous treatment process. It provides a goal-directed approach to achievable levels of improvement. Complex therapeutic decisions regarding involvement of the family in treatment, starting or stopping of Antabuse, attendance at A.A. meetings, use of uncovering techniques, discontinuation of therapy, and others can be considered in relationship to these fairly predictable stages in the recovery process. It is possible to make predictions of outcome of therapeutic intervention or lack of intervention based on knowledge of the stage of recovery the patient has entered. Therefore, such an awareness can make the complex psychotherapeutic process with alcoholics potentially understandable and subject to a certain degree of predictability.

Data have been presented that analyzed the results of private psychiatric office treatment of alcoholics according to the approaches described in this chapter. A significant number of the 23 patients treated improved (61%). Patients who remained in therapy beyond 6 visits had a 78% successful outcome. Such results suggest that alcoholism can be successfully treated with individual psychotherapy with the modified approaches indicated.

Although group therapy had been considered the treatment of choice by many specialists in alcoholism, the author’s experience with individual therapy suggests that it can be quite useful in the treatment of alcoholism. Individual therapy facilitates a profound transference relationship which, if effectively managed, can lead even very resistant alcoholics to recovery.

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