A Treatment Program for Alcoholics in a Mental Hospital

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BETWEEN September 1959 and June 1961 a treatment program for alcoholics was developed at the Saskatchewan Hospital in Weyburn (a 1500-bed mental hospital serving southern Saskatchewan) based largely on the principles of Alcoholics Anonymous. It included two weekly sessions of group therapy, three weekly A.A. meetings, work therapy in which the patients participated as a group, bimonthly movies with discussions, and a minimum of individual psychotherapy.

As an integral part of the program, most patients were also treated with *d*-lysergic acid diethylamide (LSD-25) following the principles established by Hoffer, Osmond, Smith, Chwelos and Blewett (1, 2, 3). The main emphasis of the program was directed at the symptom of inebriety. It was recognized and stressed in group therapy, however, that permanent sobriety (i.e., abstinence) could hardly be achieved unless the basic emotional problems were dealt with.

The Theoretical Basis

The treatment program was based on the principle that the patient in his group relationships not only becomes willing to accept the idea of sobriety but virtually must do so if he wants to feel accepted. Generally the alcoholic comes to the hospital against his own wishes. He has signed a voluntary application for admission but only under strong persuasion. Guilt feelings tend to make him regard his hospitalization as punishment rather than treatment; at the same time, however, there is an element of ambivalence for he is glad to find relief from the physical discomfort caused by withdrawal of alcohol.

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He is almost equally prepared to feel antagonistic and grateful. The latter emotion is nurtured by the sympathetic concern of the staff and by the assurance of the other alcoholic patients that he will find his stay worth while. He feels indebted to cooperate with those who have relieved his distress. There is also a sense of relief in surrendering to authority figures. Moreover, the attitude of the group is hostile unless he accepts "the program" and the alcoholic is more likely to be influenced by group sanctions than the average individual. The new patient therefore soon decides to comply—at least outwardly—in order to gain acceptance and privileges. In a short time, however, partly because of unconscious memory displacements, partly because he has thus committed himself outwardly, he becomes unable to distinguish between his original beliefs, simulated beliefs and group consensus, gradually accepting group opinions as his own. This process is reinforced as the patient becomes a spokesman for the group in the face of newer arrivals.

Concomitantly, and as a result of group meetings, the alcoholic becomes increasingly adept at analyzing behavior in terms of the A.A. program. Constant exposure to the group's "interpretations" breaks down his earlier defenses and he comes to view drinking as a weakness, as an easy way out, no longer as a proof of masculinity.

The final breakdown of defenses and the final commitment to a new way of life come in the course of LSD therapy during which a transcendental or spiritual experience may further aid in establishing self-acceptance. The patient is then able to renounce his former role as alcoholic without losing face, and the knowledge that he can gain recognition, more friends and more pleasure in his new role as an A.A. member reinforces his newly found strength.

Milieu Therapy

Treatment is carried out on the male admission ward, hence the 10 alcoholic patients constantly on the ward constitute a group within a group of 40 acutely psychotic, nonalcoholic men. The alcoholics have their own dormitory, which is not locked during the daytime; it therefore serves also as a clubroom. The dayroom, kitchen, bathroom, dining and recreational facilities are shared by all.

When a new alcoholic patient is admitted he undergoes a physical examination. If he is suffering from delirium tremens or another medical complication he is transferred to the sick ward. Otherwise,

he is introduced to the other alcoholic patients and started on an admission routine of tranquilizers and vitamins. If intoxicated, he is kept in bed for a few days.

Contrary to some therapists, I prefer to receive the patient in a state of intoxication. If the aim is merely to sober him he should be treated in a general hospital; but if the aim is intensive psychiatric treatment, he should be received when his need is greatest. As is well known to members of A.A., during the state of detoxication the alcoholic's motivation to accept help is at a high peak; by the time this phase is over, the therapist can have established a sufficiently strong therapeutic relationship to sustain his motivation.

Some of the difficulties encountered in treating alcoholics may stem from the classical psychiatric attitude of dispassionate objectivity. As Chafetz (4) and others have pointed out, an objective warm relationship must be established as rapidly as possible. Doing tangible things for the patient is no longer tabu. In the words of Ruth Fox, "You give him both hands and let go finger by finger."[2] Any use of aggression or force is contraindicated since most alcoholics have a problem about accepting authority. Similarly it is important to refrain from arguing with the patient.

Group Psychotherapy

The treatment program includes three weekly A.A. meetings. The patients are strongly encouraged, but not forced, to attend. There are also 2 hours of group psychotherapy, in the course of which those who are not already familiar with the A.A. program are indoctrinated mainly by the other patients' discussion. Basic facts about alcoholism are also taken up in those group sessions, while the patient's individual problems are dealt with mainly in individual psychotherapy. Because of the fairly short time available, the group therapy is superfical in nature and principally educational.

The alcoholic patients are encouraged to work together as a group, and in this capacity they have taken the psychotic patients out for walks, and have attended physical exercises and occupational therapy. Of these activities, occupational therapy was the least popular, being often referred to as "women's stuff." There were very few complaints, however, after carpentry was offered.

[2] Fox, R. Trends in Treatment of Alcoholism. [Lecture delivered at University of North Dakota, 7 June 1960.]

The LSD Experience

Toward the end of hospitalization (which averaged 2 months), the patients were given an LSD experience. They routinely received 200 gamma of the drug, a dosage which usually produces a fairly intense reaction in the nonalcoholic person; however, alcoholics are relatively resistant to this drug. The therapeutic interaction during the LSD session was based on the pioneering work of Chwelos and Blewett (1, 2), MacLean et al. (5), and Chandler and Hartman (6). These authors agree that it is absolutely essential for the therapist to have personally experienced the LSD reaction, since it is not just a matter of giving a drug but of using it to facilitate psychotherapeutic interaction unlike any conventional type.

Patients preparing for the LSD experience are told that it will not prevent them from drinking but will rather make them understand why they drink and what they can do about it. As Sandison (7) and Eisner and Cohen (8) have stated, one of the most important determinants of a favorable result from the experience is motivation —a genuine desire to get well. Since this desire is often lacking at the time of admission, it is the prime purpose of the pre-LSD treatment period to establish this motivation along the lines which have been indicated.

During the session the therapist remains with the patient constantly for 7 to 8 hours. Patients are encouraged to bring their own records and family photographs which have maximal emotional significance; if they fail to do so, however, the hospital collection is used. This material, skillfully used, is likely to bring up repressed memories, sometimes in the form of an abreaction, a reliving of the past, but occasionally in the form of a "movie" which the patient recognizes as unreal although at the same time he is impressed by its emotional significance for him. Other patients may experience emotions with no connection to specific events in the past. In that case it is probably advisable (as Chandler and Hartman suggest) to tell the patient to close his eyes and go with the experience in order to accomplish a more complete abreaction. A mirror has also been used as an aid in working out problems connected with self-concept and body image. In LSD therapy, even more than in ordinary psychotherapy, it is of the greatest importance to be constantly aware of the nature of the patient's experience in order to be able to deal with the conflict material as it comes up.

Results

The results attained with this program will be published as part of an over-all evaluation of treatment with LSD. The following statistics should therefore be regarded as a preliminary evaluation.

Of 58 patients who experienced the full program, including LSD, and were followed up for 6 to 18 months, 34 had remained totally abstinent since discharge or had been abstinent following a short experimental bout immediately after discharge; 7 were considered improved, i.e., were drinking definitely less than before; 13 were unimproved; and 4 broke contact.

Of 35 patients who received group therapy without LSD, 4 were abstinent, 4 were improved, 9 were unimproved and 18 were lost to follow-up. This group, however, was composed of patients who left the hospital early, who were considered unfit for LSD therapy for physical reasons, or who refused this treatment.

Of 45 controls, consisting of patients admitted to the hospital during the same period who received individual treatment by other psychiatrists, 7 were abstinent, 3 improved, 12 unimproved and 23 lost to follow-up. The difference in the proportion lost to follow-up between the two groups illustrates how the treated patients tended to form a dependent relationship and to keep in contact with the therapist. By chi-square test, significantly more of the alcoholics treated with LSD were abstinent or improved at the time of follow-up than of those who received group therapy alone or of the controls.

Termination of Therapy

The problem of optimal number of LSD sessions in each case is still unsettled. Patients who derive little benefit from their first session, often because of overwhelming anxiety, are sometimes helped by a second or third session. In a number of cases, however, patients apparently deliberately became intoxicated in order to receive more LSD. It was thereafter made clear to all patients that they could have a second trial without going on a spree. It is essential in each case to assess the motivation, the degree of benefit derived from the first experience, and the nature and degree of conflict material to be dealt with in the next session. Whatever the decision, it is essential that the patient leaves not only with a verbal understanding but with a genuine feeling that he may return to the therapist for further guidance and counsel at any time the need arises. While

it is widely agreed that off-hour emergency calls are not therapeutically justified for psychoneurotics, in the case of alcoholics a nightly phone call can often make the difference between intoxication and sobriety (9).

Summary

A pilot project for treating alcoholics on the admission ward of a mental hospital has been described. A program of group therapy was developed on the principles laid down by Alcoholics Anonymous, including work therapy, two weekly sessions of group therapy, three weekly A.A. meetings, bimonthly movies with discussion, and a minimum of individual phychotherapy. Most of the patients also received LSD-25 and the technique of this form of treatment is discussed in detail. Of 58 patients followed up between 6 and 18 months after discharge, 38 remained totally abstinent or had been abstinent except for a short bout immediately after discharge, another 7 had improved, 13 were unimproved and 7 were lost to follow-up. Of 35 patients who were treated by the same program but without LSD, 4 were abstinent, 4 improved, 9 unimproved, and 18 lost to follow-up. Of 45 controls treated at the same time by individual psychotherapy, 7 were abstinent, 3 improved, 12 unimproved and 23 lost to follow-up.

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