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THE FORMS
OF ALCOHOLISM
AND THEIR TREATMENT

HUGH WINGFIELD

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**THE FORMS OF ALCOHOLISM AND
THEIR TREATMENT**

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THE
FORMS OF ALCOHOLISM
AND THEIR TREATMENT

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LONDON

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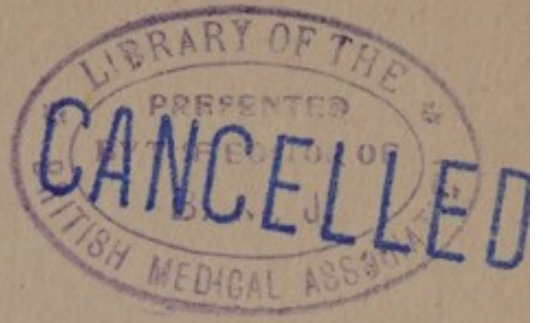
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PREFACE

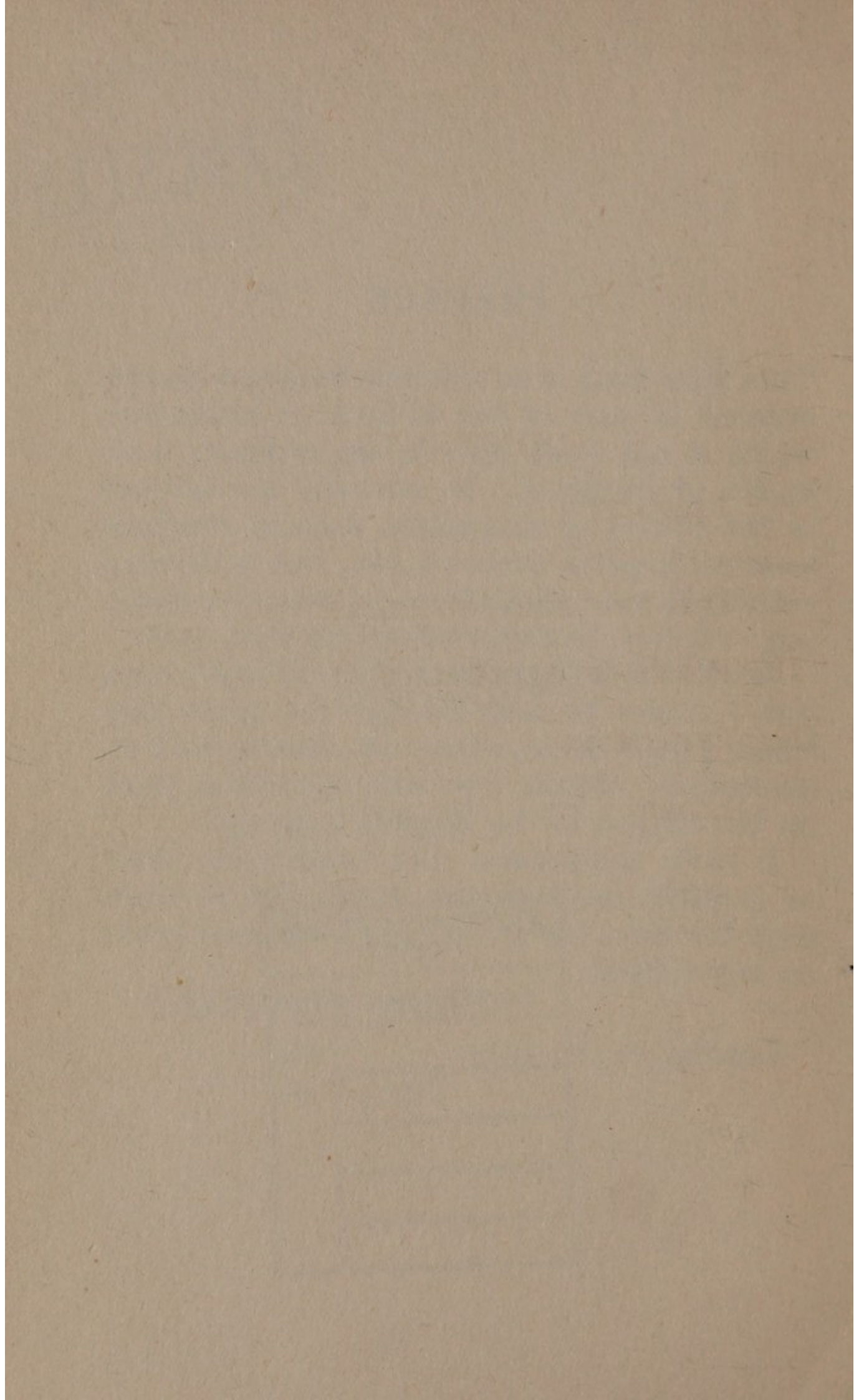
THIS little book is an attempt to give a concise account of part of the subject of alcoholism which is not dealt with in the ordinary text-books of medicine. It contains no account of the results of alcoholism, such as alcoholic neuritis, hepatic cirrhosis, etc., but is devoted entirely to the various forms of excessive drinking, and their nature, causes, and treatment.

Much of it is drawn from my own experience, but I desire to acknowledge the great help which I have derived from Dr. Hare's work on alcoholism, almost the only practical work on the subject in the English language.

I have compressed the matter as much as possible, perhaps too much, for in these days few have leisure to read ponderous books on any subject.

HUGH WINGFIELD.

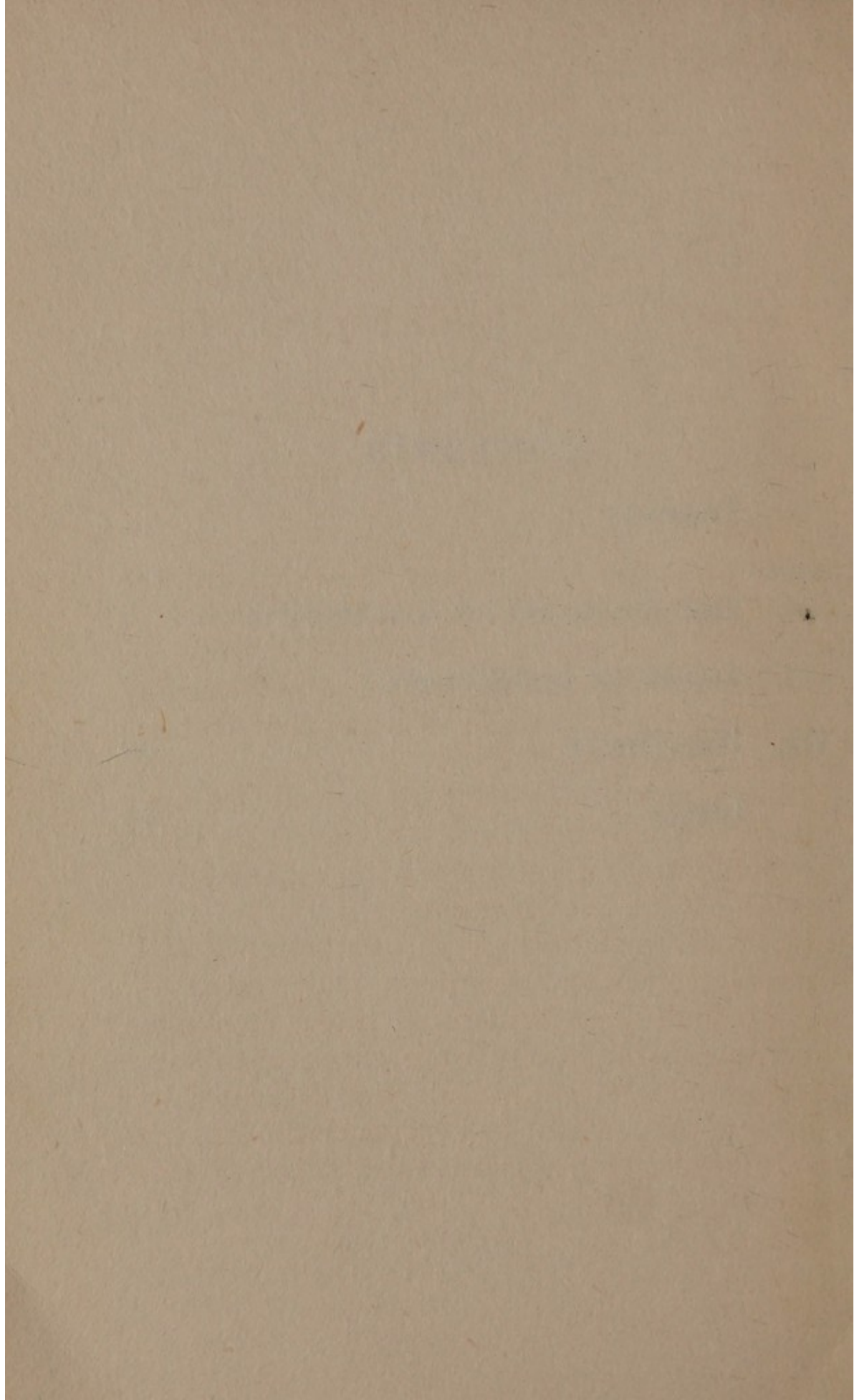
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THE FORMS OF ALCOHOLISM AND THEIR TREATMENT

CHAPTER I

THE PROBLEMS OF ALCOHOLISM

I

THE drunkard is generally regarded by the public as purely vicious, by the churches as guilty of heinous sin, and by the law as criminal; and, frequently, as the Saturday night orgy shows, these views appear to have some justification.

But, apart from voluntary backsliders, very many people appear never to be able to drink in moderation if they drink at all, and it is beginning to be recognised by the more thoughtful members of the community that these unfortunate weaklings may, after all, be the victims of something more than mere vice, and perhaps owe their excesses to some kind of compulsion. That this is really the case is a proved fact to everyone who has had to deal with any appreciable number of alcoholic patients.

We are at once faced with the problem : "Why are these people compelled to drink in excess if they drink at all ?" But that is only one of the very many problems which confront us if we study the nature of this strange condition.

Thus, in a large proportion of cases the tendency to alcoholism has been inherited. Yet (unless we accept the Lamarckian view) acquired characteristics cannot be inherited. Again, we find that the condition of inability to drink in moderation, once it has set in, is absolutely permanent, and lasts throughout the whole of the victim's life. Moreover, the condition can be acquired only by the taking of alcohol. Sometimes, as in certain of the primitive races, a single glass may be sufficient. In the more civilised races of Europe a comparatively long period of habitual drinking is required to induce it.

If we look at the condition of the various races of mankind, we are faced with still another problem, which has been handled with great ability by Dr. Archdall Reid in his works on "Heredity."

Of the native races of Africa, those on the West Coast, who have from time immemorial been accustomed to alcohol, in the shape of palm wine, are remarkably sober, nor has

their sobriety been appreciably diminished by the introduction of the stronger alcoholic drinks of Europe. But in other parts of Africa where the natives are not accustomed to alcohol, its introduction is followed by a tremendous outburst of inebriety, lasting as long as the stimulant can be obtained. Practically every one of these savages drinks to excess if he drinks at all, and can obtain the means of doing so; and even the first glass which ever passes his lips may create an irresistible impulse to take more.

The same tendency holds good with regard to other races in whose history alcohol had never played a part, until it was introduced to them by their European benefactors. The American Indians and the Australian aborigines are good examples. So terrible has been the effect of alcohol on these two races that, had not the Government intervened to render alcohol unobtainable, it seems probable that they would have been completely wiped out by its ravages.

On the other hand, we find in races long used to alcohol, as in our own country, an absolutely different state of affairs. If the native tribes just mentioned had discovered one of their members who could drink in moderation, they might reasonably have asked :

“How is it that this man can drink in moderation, since practically no one else amongst us can do so?” In our own country, if we come across a victim of alcoholism, the natural question would be: “How is it that he cannot drink in moderation, seeing that the vast majority can and do?”

It appears to be a law to which there is no exception that, provided an unlimited supply of alcohol is obtainable, the races who have been longest inured to it are the most sober, and those who have had the shortest experience of it, the most drunken.

Dr. Reid offers what appears to be as yet the only satisfactory answer to the problem propounded. He believes that the aboriginal man was always liable to the particular effect of alcohol which results in excessive drinking, and that practically none were exempt. After the introduction of alcohol, evolution, probably by eliminating those most liable to its injurious effects by natural selection, so changed the race that it gradually became less and less liable to be affected. Many would probably be eliminated by death; and, considering how frequently alcoholism causes impotence in the male, I have sometimes thought that this may also have been a considerable factor in the reduction of the number of those most

liable to violent intoxication. But, as is often the case with characteristics lost by natural selection, instances of atavism are bound occasionally to occur, and the alcoholic is in effect an individual who, as regards alcohol, has returned more or less to the condition of his remote ancestors.

Not only does this theory explain why alcoholism is so often hereditary, but it also shows why the condition, once acquired, is so permanent and unalterable. It is clear, on this hypothesis, that it is only by continued facilities for obtaining alcohol that the race defends itself against a return to the primeval condition of extreme susceptibility to its effects.

Dr. Reid points out that, if his theory be true, some of the more drastic proposals for dealing with the drink question may in the long run more than defeat their object. Of these the most drastic of all is Prohibition. Yet it seems likely that, if any such measure became law, the result in course of time would be that the nation, as a whole, would lose the immunity won by the sufferings of countless generations; and, if the law were eventually relaxed, alcohol would find a race ready for destruction, as the American-Indians now are. We should become dependent for our freedom from alcoholism, not on the evolved immunity

conferred by nature, but on purely artificial and moral restrictions. It seems safe to prophesy that against an agent of such tremendous power, this protection would be absolutely unavailing.

Dr. Reid boldly suggests that the only really effective measure would be one preventing the victims of alcoholism from propagating children inheriting their tendencies, and it seems clear that in this way the process of natural selection would be appreciably aided. Such a measure, however, for the present at any rate, seems quite outside the region of practical politics, besides becoming involved with the most vital controversies of Eugenics.

Reid's theory of immunity raises another interesting question. The effect of alcohol on the unimmunised native of the present day seems almost invariably to produce immediate craving and tremendous bouts of very excessive drinking—*i.e.*, the type of alcoholism induced is that known as pseudo-dipsomania. The fact that alcohol always produces such an excessive outburst of drinking is an effective barrier against the occurrence of chronic alcoholism—at any rate of the sober type. Chronic alcoholism, in fact, can occur only in an individual who is already immune to pseudo-dipsomania, and is therefore peculiar to races long

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acclimatised to alcohol. It seems probable therefore, that evolution first rendered mankind immune to the pseudo-dipsomania type of alcoholism, thus rendering chronic alcoholism possible, and that the task of eliminating chronic alcoholism could commence only when this immunity had been fairly established. How far evolution can or will eliminate chronic alcoholism, time alone will show.

The compulsion to continue drinking from which the chronic alcoholic suffers, seems to the writer so largely due to premonitory symptoms of delirium tremens induced by attempts at abstinence that one wonders whether the elimination of the chronic alcoholic would not really mean the elimination of those liable to delirium tremens; and this, at any rate, seems rather a tremendous task for even the process of natural selection.

II

Leaving the broad position as it affects the race, we come to the effects of alcohol on the individual.

We have to consider why the victims of alcoholism are unable to drink in moderation, why they find so much difficulty in remaining total abstainers, and what is the essential difference between them and the normal man.

As most of us know by experience, the effect of a moderate amount of alcohol is distinctly pleasurable. There is a feeling of increased cheerfulness, and a sensation of what is commonly termed being "bucked up." In excess, too, alcohol often induces pleasant feelings, though the after-effects may be the reverse. In the most typical alcoholic patients (the so-called pseudo-dipsomaniacs) the sensation induced by the taking of alcohol is not merely one of moderate enjoyment. The pleasure is magnified beyond all normal bounds, and may amount to almost ecstatic delight, so overwhelming that, for the time being, everything else pales into significance. A patient of mine once remarked to me: "I know of nothing so absolutely delightful as being drunk."

It is in this first of all, the increased strength of the euphoria, as the pleasurable feelings have been termed, that the alcoholic differs from the normal man. The euphoria is incomparably greater. Even in the milder forms of alcoholism, increased euphoria, though in a lesser degree, seems always present. Nor should we confine the term "euphoria" merely to the induction of pleasurable feelings to an excessive degree, for alcohol, in these patients, possesses the power of turning the

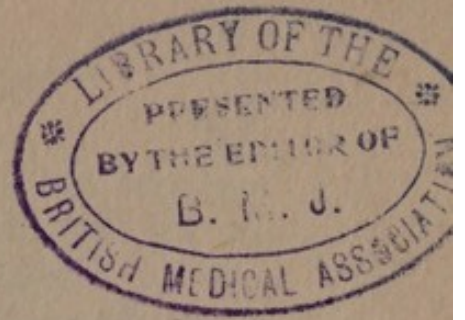
naturally depressed man into a temporarily happy one, and this to a markedly increased extent.

Coincidentally with the increased euphoria we find a considerable paralysis of inhibitory power—will-power, as it is commonly termed. Naturally the patient feels a desire to prolong and renew his euphoria—if it begins to fade away—and consequently desires more alcohol. This craving, were it not for his weakened will power, he might resist. But he is powerless: his only weapon of resistance, his will, is paralysed, and, for the time being, of no account. He has no other means of defence, and he succumbs without a struggle.

Once the patient has experienced the excessive euphoria of the alcoholic, the memory of it remains, ever ready to recur, and to stir up a desire to renew the former sensations of enjoyment; especially is this the case if any circumstances happen to worry and depress him. He remembers his old euphoria. In a moment of time he can, as he too well knows, exchange his depression for a real though temporary bliss. The temptation which assails him is unknown to the normal man, for he can never experience it. Is it any wonder that the struggle to abstain, with these unhappy beings, so often ends in defeat? Is it fair

that they should be judged, as they so often are, by the same standard as the normal man ?

I think one may fairly say that, if those who sit in judgment on them had half their temptation, the majority would yield, and would feel, as in my opinion they would have the right to feel, that they were deserving more of pity than of blame.



CHAPTER II

FORMS OF ALCOHOLISM

THERE are four principal forms of Alcoholism, which are generally quite readily distinguishable. Sometimes the same individual may suffer from more than one. They are as follows :—

1. *Pseudo-dipsomania*.—In this (which I believe represents the primitive type) craving is absent unless alcohol be first taken. If alcohol in sufficient amount be taken, irresistible craving is invariably excited ; and the patient drinks in great excess, until, owing to physical disability (usually due to gastric catarrh) he can take no more. The attacks usually last for a week more or less.
2. *Chronic Sober Alcoholism*.—The patient regularly drinks to excess, sometimes great excess, day after day for months, even years, together. Craving is only observed if alcohol is partially or completely cut off. The patient is never intoxicated unless by accident.
3. *Chronic Inebriate Alcoholism* resembles the above, but differs in that the patient is never sober ;

he may be only slightly intoxicated, or markedly so.

4. *True Dipsomania*.—There are several varieties of this comparatively uncommon form. The characteristic of them all is that craving occurs spontaneously, and does not require alcohol to excite it. These patients drink in bouts much like the pseudo-dipsomaniacs.

If patients of all these types be questioned, it will be found that they all present variations from the normal as regards certain definite factors.

So far as I have observed there appear to be four main factors:—

1. *Euphoria*.—By this is meant the pleasurable mental effect induced by the taking of alcohol, which may vary in degree from a mere feeling of being “bucked up” to almost ecstatic experiences.
2. *Dysphoria*.—By this I mean a condition the opposite of euphoria. If a pseudo-dipsomaniac, after taking his first glass, can get no more, the euphoria so induced is then followed by a secondary effect, which manifests itself as mental depression, and may be slight or severe. It is not the same thing as craving, since craving may be present with no real mental depression at all.
3. *Variations of Natural Tolerance*.—Everyone has a certain natural tolerance for alcohol, *i.e.* the amount of alcohol required to make him

intoxicated—or merely to get into his head—varies but little provided his environment as regards climate, intake of food, etc., is the same. In cases of alcoholism the natural tolerance may be either increased or diminished, and I think one must regard marked variation in either direction as purely pathological.

4. *Partial Paralysis of the Inhibitory Mental Functions.*—It is not merely with regard to the taking of alcohol that the diminution of will power shows itself. A man under the influence of alcohol will yield without a struggle to temptation of other kinds, which he would have no difficulty in resisting in his normal condition. This condition occurs in pseudo-dipsomania and appears within a few minutes after taking the first glass.

Besides these four factors there is, in the case of those who have been taking alcohol in excess for really long periods, a fifth. If suddenly cut off from alcohol they may become extremely ill, with symptoms of depression, tremors, etc., which may be the precursors of delirium tremens. One may, I think, fairly term these symptoms the premonitory symptoms of delirium tremens, even though the patients do not reach the stage of actual delirium.

The subjoined table gives the results which I have obtained by interrogating patients who

were sufferers from the first three forms. As regards true dipsomania, so many different varieties come under that heading that I have not succeeded in determining the factors in their case. But euphoria in excess seems to occur in all.

	Acute Pseudo-Dipsomania.	Mild Pseudo-Dipsomania.	Chronic Sober Alcoholism.	Chronic Inebriate Alcoholism.
<i>Euphoria</i>	Extreme.	Extreme	Present.	Marked.
<i>Dysphoria</i>	Marked.	Very slight or absent.	Absent	?
<i>Tolerance</i>	Often diminished.	Often diminished.	Normal, but increased during attack.	Normal, but increased during attack.
<i>Paralysis of Will which follows immediately the taking of alcohol.</i>	Very marked	Very marked.	Absent.	Absent.

As regards the results obtained when alcohol is cut off at the commencement of an attack, the above results have actually been observed by the writer, in a number of cases, except in the chronic inebriate kind. I have not had an opportunity of observing the results of the withdrawal of alcohol in the early days of an attack of chronic inebriety. In chronic sober alcoholism, however, I have had numerous

opportunities of observing the results of sudden abstinence within the first three days, and in none was there any trace of dysphoria.

It will be observed that a fall of natural tolerance and an increase of euphoria go together; and I imagine that they are really interdependent phenomena.

As is well known, in chronic alcoholism tolerance rises to an extreme degree; and falls again to normal if the patient manages to abstain for some considerable time. It is not uncommon for a patient, who has tried to cure himself of chronic alcoholism by repeated abstinence, followed by repeated failures, to develop pseudo-dipsomania. It seems possible that in these cases tolerance falls not merely to the normal, but below it, and this phenomenon certainly appeared to occur in three cases which I saw. The amount of whiskey required to induce inebriety in all three was far less than that required in the days before they became alcoholics.

The development of pseudo-dipsomania in a previously normal individual often begins, if one can trust the accounts given by patients themselves, with a gradually increasing loss of tolerance; sometimes also with signs of dysphoria, as a secondary result of the taking of alcohol. It is, of course, well known that

loss of tolerance—often very extreme—is one of the commonest results of head injury, however slight; and certainly these patients are peculiarly liable to the severest forms of pseudo-dipsomania. The same result not infrequently follows sunstroke.

If, however, alcohol be taken in excess for prolonged periods, tolerance is enormously increased, and this is certainly a pathological phenomenon.

That variations of tolerance occur in true dipsomaniacs is, I think, certain; but I have not seen a sufficient number of them from which to generalise. One striking point I noticed in two is that, at the onset of an attack, their tolerance has been diminished, while between the attacks it has been normal: but I do not know how far this is the rule. Hare mentions a case where the opposite occurred.

I have seen one case in which, for no apparent reason, tolerance was lost with absolute suddenness, and the patient became at once a hopeless pseudo-dipsomaniac, dying of pneumonia, accelerated by alcohol, a few months later.

I regard, therefore, loss of tolerance as a most important factor in the causation of alcoholism, as seen in the drinking bouts of pseudo-dipsomania.

In all the forms of alcoholism, and indeed in every form of narcomania, there is a strange and marked tendency to secretiveness and untruthfulness as regards the taking of the particular drug. A patient who may be absolutely truthful in his normal condition will be quite ready to swear that he has not touched a single drop of alcohol at a moment when he is obviously quite drunk. This curious phenomenon shows itself in the most striking way in certain cases of true dipsomania. These patients, though not actually drinking, are aware from their premonitory symptoms that an attack is impending, but they will vigorously repudiate any suggestion of the kind. This seems to be due to some definite mental change, and may perhaps be regarded, at least in the latter case, as due to a true insanity.

I.—Pseudo-Dipsomania.

Physically, the pseudo-dipsomaniac is in reality a perfectly healthy being, his failing not being one of bodily health, but a peculiar susceptibility to a particular form of alcoholic poisoning. In order to excite craving for alcohol it is essential that he should take a certain minimum amount of alcohol, and, unless he does this, he will never experience craving at all. The minimum required varies widely

in different cases. In some it is extremely small, especially when the dipsomania is a sequel to head injury. Half a wineglassful of lager beer may be sufficient to start an attack. The minimum dose may be so small that even the taking of the Wine at Communion may be sufficiently exciting. McBride states definitely that he had had such cases under his care, and that he once lost a friend who died within a week from an acute attack brought on by partaking of the consecrated Wine. Kerr gives an instance of an alcoholic who was seized with craving immediately after taking the Wine, though he was fortunately guarded by his friends until the paroxysm had passed. In the Roman Church the risk, of course, does not arise; and in the Church of England it can be avoided by the communicant partaking in one kind only, which, I am told by the best authority, is perfectly legitimate.

In this connection there is, besides the risk to the layman, which can be defeated, a very real danger to the priest if he happen to suffer from this form of alcoholism, and one which it is very difficult for him to escape. The priest, after the service is over, is directed by the rubric to call up members of the congregation to assist him to consume what remains of the consecrated elements, but the practice

has fallen into complete disuse, and in consequence he is compelled to drink the remaining wine himself. Hare, who draws attention to this point, states that he has had more than one clergyman admitted into Norwood Sanatorium from this cause. Perhaps one day the bishops may intervene to save some of their weaker brethren from this deadly peril. It seems most unfair that, by virtue of his sacred office, a man should be compelled to run such awful risk.

Some patients are attacked after a single glass of whiskey—some require two or more. Quite a number can take beer in moderation for a time. It seems certain too, that the amount of dilution of spirits has a marked influence on their result. It is, therefore, not surprising that I have known several pseudo-dipsomaniac patients who remained well for years, though they regularly drank beer with their meals, while in every case a single glass of whiskey ended their period of freedom from attack.

Cases differ largely in the severity of their attacks. As a rule, though not always, patients can be placed in two classes, either always severe or always mild. The fulminating attacks of a severe case in which the patient drinks to enormous excess, and becomes too ill in a

few days to take a single drop more, or, as I have seen, becomes comatose from acute alcoholic poisoning, are very different from the mild attacks to which others are subject. The latter drink to excess, but are moderate in comparison. And though, curiously enough, Hare states that he has never known a pseudo-dipsomaniac leave off drinking in the middle of an attack, I have come across several of the mild type who can and occasionally do.

Sometimes these mild cases may drink for a single day and then stop, though I have also known a severe case who was always too ill after a day's drinking to take more. Others go on drinking for such long periods that they pass into the condition of the chronic alcoholic, and cannot leave off without danger of delirium tremens. But they differ from the chronic alcoholic in that they experience craving from the very commencement of the attack. I have been much puzzled by these mild cases for years, and on inquiry into the mental effect which they derive from alcohol, I can find only that they experience little or no dysphoria, if they are suddenly cut off from drink during an outbreak.

The milder form is, however, quite rare, the vast majority of cases being of the severe type.

In every pseudo-dipsomaniac, alcohol produces also another effect of great importance which has already been mentioned. The inhibitory mental functions, which include what is commonly termed the will, are largely paralysed. This effect is extremely sudden; and may be seen after even the first glass.

Lastly, if alcohol be suddenly withdrawn during an acute attack, patients are seized, often in a few minutes, by depression and misery which may be so severe as to be intolerable, and which can be relieved only by renewed doses of alcohol. This, I think, may fairly be termed dysphoria, and may occur even after the first drink. It is not due to craving only, for craving may occur without any mental depression. The mechanism of an attack in a patient who is liable to euphoria, dysphoria, and will-paralysis is not difficult to understand. Having taken his first fatal glass, he immediately experiences an exaggerated euphoria, and his now paralysed will yields without a struggle to the temptation to prolong, and even increase it, by taking more. If, by any chance, he should try to check himself, or even if he does not absorb a sufficient amount, the resultant depression is an effective barrier against his struggle. He may find himself plunged into a veritable hell

by any attempt at abstinence ; while he knows that in a moment of time he can not only escape from his misery, but reach the height of bliss if he will but yield and take more. And the fires of hell are always too much for him, even if he could resist the allurements of his alcoholic heaven. Such cases—and they are far the commonest type of pseudo-dipsomania—never, I believe, succeed in checking themselves during an attack, but are compelled to continue to the bitter end.

On the other hand, the pseudo-dipsomaniac who suffers from no dysphoria is comparatively lucky. The lure of euphoria, and the reverie of will-paralysis, are the compelling forces in his case ; but the terrible compelling power of dysphoria does not lie in wait, ready to drive him back should he attempt to escape ; and the result is that these patients, whom I have classed as sufferers from mild pseudo-dipsomania, sometimes can and do leave off in the middle of an attack. Many drink as excessively as the sufferers from the acute form. Their attacks may be long lasting, though some may give way but a short time, owing to their greater power of checking themselves. But will-paralysis is, as a rule, very marked in the mild form. Hence on the whole, the comparative mildness of the attacks does not

improve the outlook so far as cure is concerned, as much as one might have hoped.

Some of these mild cases drink for such prolonged periods that they pass into the condition of the chronic alcoholic, and cannot desist suddenly without danger of delirium tremens.

I suspect that some patients who are believed to suffer alternately, now from pseudo-dipsomania, and now from chronic alcoholism, are in reality pseudo-dipsomaniacs of the milder type. I have certainly seen cases which might be supposed to suffer in this way, but they all proved to have experienced craving at the very commencement of their attacks, and were therefore clearly pseudo-dipsomaniacs, even though the attack was so prolonged as to amount to a condition of chronic alcoholism.

That true chronic alcoholists may eventually develop pseudo-dipsomania from repeated attempts at abstinence that succeed only temporarily is undoubtedly true, and, as I have said above, it suggests the induction of an altered degree of tolerance. In the few subjects from which I have been able to glean any information this appears to have been the case, for they showed a diminution of tolerance below their normal at the commencement of their attacks.

There is in almost all cases of pseudo-dipsomania a condition of actual inebriety from the very commencement of the attack. This naturally tends to destroy the small amount of will-power left, and helps to secure the continuance of excesses.

The intervals which elapse between the paroxysms vary greatly even in the same individual. Sometimes the exciting cause is one which arises at irregular intervals—sometimes at regular intervals. Thus a case which I saw had an attack about every quarter-day, financial difficulties in connection with paying his rent being the immediate cause of his taking his first glass. Hare mentions an exactly similar case.

But some persons have their attacks at quite short intervals, say, a week or two; whilst others may enjoy quite long periods of immunity. I believe the reason why so many have outbreaks separated by short intervals only, is a factor mentioned by Hare, viz., that the actual craving does not cease with the giving up of the alcohol. This shows itself in many instances in recurrent fits of mild craving for some time after the definite attack; and the patient in his weakened condition of will is often unable to resist. The craving is fortunately transient, as a rule, recurring at

intervals in a milder and milder form for not more than six weeks, and oftener for a much shorter period. It may last for a few minutes only, or for an hour or more, but if the patient takes no more alcohol, it occurs less and less frequently, and with steadily diminishing strength, whilst at the same time the will-paralysis, which, I am convinced, may remain for some weeks after a drinking bout, begins to vanish, and after six weeks, at any rate, the danger will have become reduced to its minimum. In fact, one must regard attacks as liable to last for about six weeks after all alcohol has been stopped ; and, to be on the safe side, that period should be taken as the average duration of an attack, though it may be very much less. With some of the more fortunate, indeed, the attack ends completely in a much shorter period, almost, I have thought, in a few cases, at once, or within forty-eight hours of the last dose of alcohol, and these cases have a far greater chance of remaining free for indefinitely long intervals.

The point is a very important one ; for, if not recognised and acted upon in treating patients, failure is almost certain with only too many.

I have used the term "craving"—and craving there certainly is—but it is always for

the mental effects of alcohol, and never for alcohol *per se*. It never occurs, and never can occur, in anyone unless he has on some previous occasion experienced the effects of the drug. The reason is obvious : the memory of euphoria is a pleasant one, and tempts the patient to take alcohol once more in order to obtain again the same agreeable results. In addition, it must be remembered that in these patients the exhilarating effect of alcohol is extraordinarily pronounced, and possesses an abnormal power of temporarily relieving feelings of depression, however produced ; hence even slight depression will remind him that alcohol offers a way of escape, and he will be tempted accordingly.

The memory of exaggerated euphoria is a source of temptation to which the normal man is not, and cannot be subject ; and this is only too often forgotten by those who are not similarly tempted, and who in consequence judge these unfortunates with harshness and injustice.

Even when such a patient feels well, the memory of euphoria may prove very strong, for he will often yield to the mere casual invitation to have a drink, and to take the first glass, so disastrous in its consequence. If one asks a patient who has acted thus foolishly

why he did so, the answer is a quite natural one. He took it because he felt sure he would take no more, and had no fear that it would lead to an attack. He felt that his will would be quite strong enough to resist a second glass; and the answer is not so absurd as it seems, for, if his will had remained as unimpaired after his first glass as it was before it, there is little doubt that he could have resisted the second quite easily. It is very difficult for a man to realise that a single glass of whiskey will change him, and destroy his whole moral strength so very suddenly.

The following is a good instance of the extraordinarily rapid onset of will-paralysis which follows in practically every case on the taking of alcohol by a pseudo-dipsomaniac.

Mr. X., a highly-educated man of considerable intellectual ability, had been under my care for severe pseudo-dipsomania, and I hoped all would be well. Some four months later, however, I received a telegram from his wife, asking me to secure a bed for him in a nursing home. He arrived towards the end of an acute attack. It transpired that he had told his wife that he was quite sure that I was wrong, that he was certain he could take just one glass of whiskey and no more, and that he was going to do so, and then write

to show me how mistaken I was. He had, he said, never before really tried to stop himself from taking a second glass; and was quite sure that if he made up his mind he could easily refuse it. He insisted on making the experiment with the above result. His account was that he had felt quite certain he could do it; but that, after taking his first glass, he could not even try to resist the next.

The non-recognition of the paralysing effects of alcohol on the inhibitory functions, or will, of such a patient, is often not so much his own fault as it is that of others. Again and again he has been told that if he could but exert his will, all would be well, and that his drinking to excess is due to weakness of character. Frequently, in accordance with this absurd idea, he has been advised to drink only with his meals, and never between them, his advisers being blissfully unconscious of the fact that he could almost as easily fly to the moon as follow their directions. Before all things, a man hates to think he is weak-willed, and the result is that he determines to conquer his failing, and by sheer will-power to drink in moderation. Total abstinence he regards as out of the question, for it amounts to a confession that he is too weak to drink in moderation. This is no fantastic idea of my

own. It is what many of these victims of well-meaning but mistaken advice have actually told me. Nothing, I believe, has done more mischief to these poor creatures than this mistaken insistence on their power to drink in moderation. It is true indeed that their salvation does depend on the exertion of their will—to abstain entirely. Beyond this they are absolutely powerless, for, just as they cannot by will prevent the onset of convulsions if they take an overdose of strychnine, so, in the case of alcohol, are they equally powerless by will to ward off the effects of the drug. Will is a poor weapon when used as an antidote to a powerful poison.

II.—Chronic Sober Alcoholism.

The history of the onset of chronic alcoholism is very different from that of pseudo-dipsomania.

The subject who is liable to this condition usually drinks at first quite in moderation, just like any normal man. He may take his three or four glasses of whiskey a day, but for a time—often a very long time—he does not increase his daily quantity. If he suddenly abstains during this period, though he may miss his euphoria, there is nothing like real craving,

nor are there any distressing symptoms, mental or physical.

Eventually, however, the onset of a state of chronic alcoholism will manifest itself in two ways. First he will begin gradually to increase his daily intake; and, secondly, sudden abstinence is succeeded by real and often intense craving and other symptoms.

Never drunk (except by accident) he keeps on drinking regularly, at first in moderation, then beginning to exceed, and gradually increasing his daily intake of alcohol until it reaches a point, which varies in different individuals, at which it remains permanently stationary.

In these cases there is no sudden attack. Often the patient has begun to drink in slight excess owing to circumstances, such as the conventional custom of always having a drink with anyone with whom he does business.

In the City, convention is, or was before the war, extremely strong with regard to drinking, and develops, as one would expect, a number of chronic alcoholics, a large proportion of whom remain in entire ignorance of their real condition. In fact, it is often only when the victim tries to give up his habit, or is by accident unable to obtain his whiskey, that he becomes aware that he is no longer a free agent in the matter.

The increase of his absorption is quite gradual and so insidious that he is probably unaware that he is taking more than he used to do, unless he happens to think of it, and compares the amount with what was his custom to consume. I have seen two cases in which, after long periods of steady drinking, the patients again began to increase the amount until they reached a stable point once more.

The chronic alcoholic, after he has been drinking for some considerable time, is unable to abstain, or even to diminish his intake to any appreciable extent without experiencing distressing symptoms. He dreads nothing so much as being unable to obtain his alcohol, and with good reason, for sudden abstinence may result, not merely in slight illness, but fatal delirium tremens.

The symptoms induced by abstinence include craving, often intense insomnia, extreme irritability, restlessness, tremors, etc., intense depression, epileptiform seizures, and delirium tremens.

The depression must not be confused with the transient dysphoria seen in the pseudo-dipsomaniac from whom alcohol, even after one single glass, has been withheld. Its origin is entirely different. In the pseudo-dipsomaniac it arises as a secondary effect of the

action of alcohol itself. It is not accompanied by symptoms pointing to delirium.

In the chronic alcoholic the symptoms may be justly regarded as premonitory symptoms of delirium, and as probably due to the same factor. It has been suggested that the cause of delirium tremens is in reality not the direct action of alcohol, but of an anti-alcohol toxin, gradually generated by prolonged indulgence which, on the withdrawal of its antidote—alcohol—acts as a powerful poison. It may certainly be caused by too sudden abstinence after long periods of drinking. Whether it is ever caused by excessive drinking without subsequent abstinence is a disputed point.

It is, or was, common after operation on alcoholic subjects, as one would expect, for it is generally accepted as an axiom that it is necessary to withdraw practically all alcohol before operating on a heavy drinker. The operation is generally blamed for the resulting delirium tremens, though probably it has but little connection with it.

As is well known, too sudden abstinence is also liable to cause epileptiform seizures, which are often a prelude to delirium tremens. Occasionally in true epileptics the taking of alcohol (not its withdrawal) is always followed by a fit. I have seen two such cases—one a girl

of ten, whose father was an epileptic. Her mother, who drank, used occasionally to force alcohol on her daughter, and a fit always followed within an hour. She is now insane. Another occurred in a man of forty-three, a dipsomaniac. After the first two or three glasses he likewise always had a fit.

The theory of an anti-alcoholic toxin, originally propounded by Jauregg to explain the facts of delirium tremens, whether true or not, is a valuable working theory, for it covers practically the whole of the phenomena connected with chronic alcoholism. It may be that the real difference between the ordinary man and the individual who is liable to chronic alcoholism consists in an abnormal power of producing the antitoxin possessed by the latter. In order to maintain his euphoria, a subject of this order is always compelled to take an amount of alcohol in excess of the antitoxin present ; and, as the latter increases in amount, he is obliged correspondingly to increase his intake, until the limit of his capacity for forming the antitoxin being reached, it remains stationary, and his intake at the same time ceases to increase. He is, in fact, always obliged to drink slightly ahead of his antitoxin. The theory explains why it is so very difficult for him to cease drinking, or even to

diminish his intake, how it is that careful diminishing is so effectual in averting the onset of delirium tremens; and why, if premonitory symptoms of delirium become pronounced, an extra amount of alcohol will so often render an attack abortive.

It is clear that the enormous though gradual augmentation of the intake implies a great increase in tolerance for alcohol, which can be explained by the action of the antitoxin. The patient may eventually take every day an amount that would certainly have proved fatal in his pre-alcoholic days. But if he becomes an abstainer his tolerance will gradually fall again to normal, or possibly below it. Hare cites the case of a chronic alcoholic who habitually took from one and a half to two bottles of whiskey every day. After treatment he abstained for six months. One night after this period had elapsed, he took some whiskey, certainly not more than his usual quota in his drinking days, and died comatose from acute alcoholic poisoning.

III.—Chronic Inebriate Alcoholism.

The chronic inebriate differs from the chronic sober alcoholic in that he is always, or practically always, more or less intoxicated. As in the case of the chronic alcoholic, his tolerance

gradually increases until at last he remains at a point where he maintains the same daily intake.

Wherein the real difference lies between the two, and why the chronic inebriate should be impelled to take amounts so excessive is uncertain. Comparatively few cases of this kind have come under my notice. Chronic inebriates are fairly common, but few in proportion seem to make any attempt at curing themselves.

As in other forms of alcoholism, euphoria in excess is present; and in the few cases which I have seen, it appeared to me that the distress caused by even careful tapering was greater than was noticeable in the sober alcoholic.

But I am not prepared to generalise without more facts at my disposal, and the condition remains an unsolved problem. Certainly, as far as I have seen, a cure for any long period is rare. In the few cases known to me, the condition of intoxication was reached very early in the attack, and was maintained throughout by increasing amounts of alcohol till the period of stability was reached.

IV.—True Dipsomania.

This, though the most uncommon of the four typical forms, is probably not so rare

as it appears to be. It includes a number of conditions, which may differ greatly in their nature; but all possessing one characteristic, viz., that alcohol does not initiate craving, which occurs quite spontaneously, and often without any discoverable cause.

A considerable proportion of true dipsomaniacs suffer from pseudo-dipsomania as well, but, unless this is the case, they can drink in moderation between their attacks, since alcohol then produces no craving.

In all cases of true dipsomania the craving is increased when it occurs, if alcohol be taken, and the attack is characterised by longing which may last for varying periods, usually between seven to fourteen days, and which sometimes ends quite suddenly. The patients in some cases have sufficient strength of will successfully to resist the craving from which they suffer. In some instances I have seen, it seemed to make no difference to the duration of the attack whether the patient drank or not.

In some of these patients who suffer from pseudo-dipsomania as well, one finds that, whilst the attack is begun in response to a spontaneously arising craving, it is continued with the violence characteristic of pseudo-dipsomania. In cases which do not suffer from pseudo-dipsomania, the craving never

appears to reach the same intensity, even after the taking of alcohol, though it is always increased.

With many the craving comes on at more or less regular intervals, in others quite irregularly. Dr. Hare mentions the case of a man who had what appeared to be a single attack which never recurred.

In the great majority there is a distinct premonitory period, and some regard this as invariably present. It may be so, but one comes very occasionally across a case in which it is impossible to find any indication of premonitory symptoms.

The commonest form is the periodic—the attacks occurring at fairly regular intervals. I have had for some years a case of this kind under observation—the attacks occurring almost invariably every twenty-ninth day. In this case it is always preceded by premonitory signs which last from three to six days, during which the patient becomes restless and irritable.

In one form, of which I have seen several examples, the premonitory sign is a slight feeling of general malaise which increases daily for a week or less, when craving comes on. The patients drink heavily for a week or more, and occasionally cease with extreme

suddenness, the termination being reached by a heavy discharge of urates. In one case which was under my care, the end of the attack was almost always accompanied by melæna. In two cases which came under notice—though not patients of my own—hæmaturia marked the end of the attacks.

In a certain number of cases, fortunately few, the attacks occur with extraordinary suddenness. One patient who was under my direction was liable to be attacked whilst walking in the street.

Another form is seen in some women at the menstrual periods. Curiously enough, the worst case of this kind I have ever seen, occurred in a woman who eventually had hysterectomy performed for uterine fibroids. The operation had no effect on the dipsomania, which remained as severe as ever whenever her periods, as indicated by pains in the back, etc., recurred.

There remains one form of dipsomania which perhaps ought to be classed by itself, viz., the dipsomania due to insomnia. These patients drink because they cannot sleep unless they do, and if, as may happen, the sleep so obtained is insufficient, they may drink heavily at all times of the day. They are interesting in two ways : first, because curing the insomnia

sometimes stops the taking of alcohol; and secondly, because in some cases (I have seen two myself) the result is a real cure, and the patient is afterwards able to take alcohol in moderation. I have come across no other cases of alcoholism in which this has proved possible.

One of the cases was a very striking one. The patient, a lady of fifty-four, had had persistent insomnia for years, and for seven years had been drinking regularly to great excess. Yet, even with drugs and alcohol combined, she rarely obtained more than two hours' sleep; and when I saw her she appeared utterly exhausted. While she was under light hypnosis I suggested that she would sleep nine hours that night, and fortunately the suggestion acted perfectly. She has slept well ever since—some five years—but though she still takes alcohol, it is in strict moderation, and all temptation to exceed appears to have vanished.

In another case of the same kind I obtained a similar result.

I have seen one case which I suppose to be one of true dipsomania, in which craving occurred every night between the hours of seven and nine, and at no other time. Probably the origin of the craving was a purely psychological one, but the case came under my notice a good many years ago, and before

the advance of psychological methods had made it possible to disentangle the cause of such a condition. Sometimes the origin of craving may be simply a repressed memory, as in the following instance :—

The patient, *æ*t. thirty-two, had for some ten years been worried by a constantly recurring craving for alcohol which, however, had always been successfully resisted. It lasted sometimes a day or two, sometimes a week or more, but was never absent for more than a few days at a time. Naturally I expected that this would turn out to be a case of true dipsomania, in which the craving was steadily conquered. Hoping, however, that it might be due to some repressed memory of childhood, I induced very light hypnosis, and in answer to a suggestion, the memory was recalled. The patient, when about three years old, had heard a story of a woman who had got drunk and murdered her own child. Such was the horror produced that the remembrance of the incident was completely repressed. The craving was not really a craving at all, but a fear that alcohol should be taken and some terrible results follow. The unearthing of the memory of the incident resulted in immediate amelioration of the condition, and the improvement has now persisted for about two years.

There is every reason to suppose that the origin of the craving in true dipsomania depends, as in every other form, on the memory of previously experienced euphoria. The real difficulty lies in determining the cause which rendered the temptation to euphoria so much greater at certain times. In the case of menstrual dipsomania, dipsomania due to insomnia, and that due to repressed memories the cause is fairly obvious. But it is less obvious in other forms. In those cases which terminate with excessive discharge of urates, it seems possible that it may be due to the accumulation of gouty poison in the system, and the results of treatment appear to me to corroborate this view. In the more common periodic cases the cause is at present quite unknown. When the craving suddenly occurs without warning, it appears as if the cause may be of the same nature as that of impulsive insanity.

One can only hope that, as time passes, careful and accurate observation may throw further light on the strange conditions of true dipsomania, and point out the way to its alleviation.

CHAPTER III

TREATMENT

UNTIL comparatively recent years, practically only one form of treatment for alcoholism—compulsory restraint in a retreat for long periods—was recognised at all. It was advocated by the late Dr. Norman Kerr, and such was his influence that it remained for many years unchallenged.

I have never understood the principle on which it was based. The ultimate end of all treatment must always be the same—to render the patient morally strong enough to remain a permanent total abstainer. Whatever treatment be adopted, the condition of the patient as regards the main trouble is unchanged and unchangeable. He is just as much unable to drink in moderation as he was before. It is clear that in only two ways can any help be given him. One is to make alcohol less tempting to him than before; the other, so to increase his moral strength as to enable him to resist such temptation as he must meet.

I am quite at a loss to understand how mere prolonged confinement, during which no physical or psychical effort is required to abstain, since alcohol is unobtainable, can help morally or otherwise, and the results of the treatment on patients whom I have seen, and their accounts of the effects on their fellow-sufferers, have convinced me that the value of mere confinement alone is, to say the least of it, extremely small. If, however, it be combined with powerful moral aids, as in Lady Henry Somerset's homes at Duxford, the results are far more satisfactory, and it is to the moral and religious side of the treatment that I ascribe her very real success.

I have seen a patient come out from one of these inactive homes after three years' confinement, and get dead drunk on the following day. Three whole years! And this was the result.

Of late years, fortunately, a more rational view of the subject has come into existence; and I look forward to the time, when, as a means of treatment, prolonged confinement will be a thing of the past, though it may perhaps be succeeded by a system of permanent confinement of the incurable cases, just as lunatics are interned now.

On the other hand, *voluntary* retirement in

a retreat for a limited period, where real systematic study of the alcoholic condition is carried out, is of immense value. Dr. Hare, who at present is in charge of Norwood Sanatorium, in his book on "Alcoholism," gives a striking account of the methods of treatment and results obtained there; and, if the reader happens to be acquainted with the methods in vogue a few years ago in those dismal cloisters in which patients were buried after signing away their liberty, he cannot fail to appreciate the enormous advance which the newer and more rational treatment, as carried out at Sydenham, presents. The usual residence lasts from six weeks to three months, as compared with the years of the old system; and the results in those who really wish to get well, are, considering the difficulty of devising any means to help these patients, exceedingly good.

The immediate treatment of the alcoholic patient resolves itself into two parts:—first, the cutting off of all alcohol, if he be actually drinking—a comparatively simple matter: secondly, taking such measures as are possible to induce him to attempt to remain a total abstainer, and to increase this power of self-denial.

As will have already been gathered, it is

quite impossible by any means to enable him to drink in moderation. His immunity to alcohol is lost ; and, even if he abstain for any length of time, whether it be for a few months or twenty years, his condition in that respect will never change. He can never during the whole of his life take alcohol without inevitably incurring the certainty of an attack. It is important to remember the real cause which tempts him to take his first glass. Excluding those who take it, not because they wish for it, but because they do not like to refuse it when offered, and those who take it for the sake of company, etc., the sole cause of the fall lies in the memory of previous euphoria, which excites in them a desire to renew it.

This we may combat in two ways. First, we may try by suggestion and moral encouragement to strengthen their will to enable them to resist ; and secondly, we may, by means of drugs, induce temporary feelings of disgust and loathing of alcohol, in order that the memory of disgust may supplant that of euphoria after the effect of the drug has passed away. Such at least I believe to be the rationale of successful drug treatment.

Besides these several lines of treatment, it is essential that each patient should be treated individually, and any special cause which

induces the first recourse to alcohol should be sought for, and, if possible, combated. Thus we may find symptoms due to heart affliction, asthma, and disorders of digestion, which the patient finds he can relieve by taking alcohol; insomnia may be another cause. Some women are tempted to take alcohol by the distress which they experience with menstruation, and I have found cases where recurrent neuralgia has been the starting point.

Mental causes are not uncommon. One of the most intractable is extreme shyness, which is temporarily relieved by alcohol. I have seen a prominent business man who, though frequently compelled to speak at board meetings, was quite unable to do so unless first primed with whiskey. In one case, sudden attacks of agoraphobia were the exciting cause. Depression, temperamental or otherwise, is another frequent cause; often mere boredom, and in addition the common and trifling annoyances of life are often of themselves sufficient to awaken the desire. I remember a patient who took his first glass simply because he had punctured his motor-tyre. Often, of course, the causes may be irremediable; but others may be lessened or removed by appropriate means, and very material aid may be thus rendered to the patient.

Having diagnosed as thoroughly as possible the acting cause or causes, the next step, and to my mind almost the most important, is to explain to the patient exactly what his condition is, and make him realise why it is that he must definitely make his choice between remaining a total abstainer, or drinking in excess. One can hardly expect anyone seriously to resolve on total abstinence unless he fully understands the necessity of doing so, and the chief obstacle generally encountered is the common, though mistaken belief I have before mentioned, that it is a mere question of will, and that if he does but exercise this a little more he can drink in moderation. It is therefore, I think, well, in explaining the position to the patient to insist on the fact that no amount of will can enable him to take alcohol in moderation, before he mentions this conviction, for it takes the wind out of the only sail which he can hoist.

Total abstinence is a *sine qua non*, not only in pseudo-dipsomania, but in chronic alcoholism and true dipsomania. It might be supposed that the chronic alcoholic might take alcohol occasionally without danger, but in practice the chronic alcoholic who touches alcohol at all nearly always relapses into his former habits. Finding that an occasional

glass does him no harm, and enjoying the euphoria induced thereby, he begins to think he can drink habitually in moderation. Experience, however, clearly shows this to be impossible ; I have never known one to succeed in doing so.

If, in spite of all one may say, the patient determines to try to drink in moderation, nothing can be done. One can only hope that further experience may convince him that he is attempting the impossible, and for the time being the case must be given up.

How important it is to get him to understand his own condition has on several occasions been brought home to me very forcibly by patients for whom no treatment was necessary, once they were convinced of the facts of the case.

One patient, a member of my own profession, exclaimed : " Why was I never told this before ? Why was I never taught it as a student ? " And, though he was an extremely severe case of pseudo-dipsomania, he at once made up his mind never to touch alcohol again, and now for five years has kept his resolve. It was this incident which made me resolve to try to write a short account of alcoholism, in the hope that sufferers might thereby be enabled to understand their own condition,

and so perchance be able to save themselves. The incident seems to cast a grave reflection on the teaching of our medical schools.

Every single student is bound in after life to meet with cases of alcoholism, and it is an astonishing fact that though he is rightly supposed to know something of many comparatively rare diseases, of this condition, one of the commonest, he is not expected to know anything at all. It is no wonder that the majority of medical men, when confronted by such cases, simply shrug their shoulders and pronounce them hopeless.

Once treatment has been decided on, it is essential that the condition under which it is to be carried out should be as favourable as possible, and to this end it is of great consequence that all forms of worry, especially from relations, should be avoided. Near relations can do much to help by encouragement, and much to injure by quite useless reproaches. The latter are, in fact, more than useless. So far from persuading him to make a real attempt to cure himself they almost invariably have just the opposite effect. Every outside worry should be kept away by every means in our power during the whole period whilst he is under treatment.

If the patient be actually drinking when first

seen one may make an attempt to cut off his alcohol. If he be a pseudo-dipsomaniac, this is not absolutely necessary, as the attack will end rapidly and spontaneously; but in chronic alcoholism it is essential.

Pseudo-Dipsomania.

The vast majority of those who first come for treatment between their attacks are naturally sufferers from pseudo-dipsomania, and sometimes from true dipsomania, whilst those who have been drinking for long periods to excess, the chronic alcoholics, practically always come under treatment whilst still drinking. The former can be immediately deprived of alcohol without evil consequences. It is simply cruelty to attempt to cut off the alcohol by degrees from a pseudo-dipsomaniac, since each dose induces fresh craving. In many instances it is a question whether it is not as well to allow the attack to terminate spontaneously, as it will in a few days, rather than attempt to end it by compulsion. Not infrequently the patient will settle the question himself, by deciding that he will not stop, and the mere fact that as a result he will go on drinking a day or two longer is not of serious consequence.

But, if he makes up his mind to stop, he

can be materially aided, though he suffers considerably. The first and most important point, in private practice at any rate, is that he must go to bed and remain quite at rest under the care of a competent nurse or attendant. So long as he is moving about, it is practically impossible for him to leave off; and, apart from this, it is almost impossible to exercise the necessary control over his actions. He is quite certain to experience craving, and to beg for alcohol; but if he be denied it from the commencement, this desire will subside spontaneously, and, in from twelve to thirty-six hours, will no longer worry him. In one case under my care the craving was intense, and lasted for nearly forty-eight hours.

Not only does the patient suffer from craving, but from insomnia, and often gastric troubles as well; thirst, too, is often present. I generally give him Vichy water *ad lib.*, partly because it helps to clear the blood of possible gouty impurities, and partly because its slightly pungent taste renders it agreeable to those accustomed to whiskey and soda. If the craving be unbearable, apomorphine given in small doses will provide immediate, though temporary relief. An injection of from three to five minims of a 1 in 200 solution of apo-

morphine hydrochlorate produces a feeling of nausea, quite transient, but sufficient to destroy the craving for the time. Doses of from 10-15 will produce vomiting, and may be given when this is desirable. The effect passes off in a few hours; but the smaller doses may be repeated at intervals when required, and the craving thus reduced and restrained to a bearable degree. Another advantage is that its administration is often followed almost immediately by sleep. So rapid is this effect that Hare recommends that the patient should settle down into a comfortable position ready to sleep before the injection is given, lest he should lose his chance by having to move at the moment the drug takes effect. The sleep so obtained is not of long duration.

For insomnia, which is almost invariably present, it is well to give one of the milder hypnotics (I generally give $7\frac{1}{2}$ grains of sod. veronal), make him settle down to sleep, and then inject 4 to 5 minims of apomorphine solution. The veronal helps to prolong the sleep induced by the apomorphine. Bromides, in 30 or 40 grain doses, or even more, three or four times a day are often given as routine treatment, and probably are of some real value.

But whatever treatment is adopted, the success on the first night usually leaves much

to be desired. The patient will probably have a restless night whatever drugs are given.

Some patients are highly dangerous to others during their attacks; some dangerous to themselves from intense depression after the attack is over. In cases of this kind morphia is indispensable. It must be given in sufficient doses to ensure its action. I generally give from $\frac{1}{4}$ to $\frac{1}{2}$ grain when it is necessary to use it—usually $\frac{1}{2}$ grain. It should not be given unless unavoidable. There are strong reasons against its use for alcoholic patients.

With regard to food, the stomach is often so deranged that the patient can take none; and for a time all food may have to be withheld. I have found Valentine's Extract useful, and, as the stomach recovers, milk, milk and soda, and beef tea may be tried. As a rule, the stomach recovers rapidly, and the catarrh induced by the alcohol may be treated on ordinary lines, and presents no special features. Albuminuria often occurs; but, as a rule, disappears rapidly. In some patients albuminuria occurs at once if they take some particular form of alcohol. I once had a patient (not an alcoholic) in whom even a single glass of sherry would always induce it, though he could take other forms of alcohol with apparent impunity.

As a rule, it is advisable to keep the patient in bed for a week at least after he has ceased drinking. Fortunately, he usually feels too ill for the first day or two to resent it. Unless he is in bed it is very difficult to exercise any real control over him. Once he is up and about, he should not be allowed to go out by himself; and, if it be possible, he should be persuaded to remain under control for at least a month. For these reasons it is much easier to treat a patient in a nursing home than in his own home. It is more easy still to treat him in a voluntary institution if he will consent to go to one and remain there; but many appear to have a rooted objection to submitting so far, lest some stigma should be attached to them in consequence.

Chronic Alcoholism.

Cases of chronic alcoholism practically always come for treatment whilst they are still drinking, and not a few after attempting to reduce the amount of alcohol which they have been accustomed to take, sometimes so rapidly as to risk real danger of delirium tremens. Such patients must be put under control if possible, though I have come across some who have had sufficient strength of will to carry out directions for diminishing their alcohol by themselves.

The patient who has unwisely attempted to leave off entirely on his own initiative before he seeks help is often so ill that it is absolutely necessary to put him to bed at once, and keep him there. Indeed, whilst in an institution it is a comparatively easy matter to treat patients who are still active, in private practice, whether the patient be treated at his own house or in a nursing home, it is far easier to treat him if he is in bed. At any rate, during the process of reduction of alcohol, it is essential in most cases that some one, whether it be a nurse or a relative, should be responsible for him. It is impossible without the gravest risk to cut off all his alcohol at once. This must be done gradually, by regularly diminishing his doses, and to this process the name "tapering" has been given. Albuminuria, if in excess, is an indication for very careful enquiry. It usually disappears when all alcohol is withdrawn.

The first thing is to ascertain as nearly as possible how much the patient has been taking on an average; and, secondly, whether he has reduced it, and if so, by how much, and how rapidly.

It is not so easy as it seems for a patient to give correct information on these points. He may have a rough idea, but as a rule he

thinks he has been taking less than he has, and he may quite honestly under estimate the amount by 10 ozs. or even more when the amount happens to be large.

If the patient shows none of the symptoms of too rapid withdrawal of alcohol, we must decide from the information he can give us, the amount of alcohol with which to commence. It is always safer to err by giving too much rather than too little. Thus, suppose we conclude that he has been taking on the average between 25 and 30 ozs. of whiskey a day, it is safer to start at 30 ozs. and this is the amount given on the first day. Each day the amount is reduced by about 3 ozs., any symptoms of too sudden withdrawal being carefully watched for, until at last he is taking none.

It may happen—as it happened to me—to observe these symptoms even on the first day, a sure sign that the amount has been under-estimated. In that event more alcohol must be given immediately, and a fresh start made. If at any time during the tapering process such symptoms arise, it is well to cease the lessening treatment for a day or two, and, even if the patient experience much craving, it is better to prolong the process than cause unnecessary suffering.

If the patient when first seen shows symptoms

of too rapid withdrawal, such as restlessness, tremor, etc., he has certainly diminished his intake too rapidly, and the remedy is immediately to give larger quantities of alcohol to make up for the loss. I have given 10 ozs. in $2\frac{1}{2}$ hours to a man who appeared to be on the verge of delirium, and the symptoms all subsided. Having checked the symptoms, tapering is now commenced, and carried out as above described.

If the diminished intake of alcohol be due to vomiting, or imperfect absorption from a disordered alimentary canal, it is extremely difficult to avert the onset of delirium. Dr. Hare suggested the inhalation of alcoholic vapour as a means of doing so. I have tried it in one case, but*the patient came too late for any kind of assistance, and delirium intervened; but I shall certainly try it in any suitable case in future.

Symptoms of too rapid abstinence are more likely to make their appearance during the first few days of tapering than towards the end, when the danger seems greatly lessened,—nor have I ever seen symptoms appear after the patient has taken his final dose. Most of the accompanying symptoms, especially gastric symptoms and insomnia, are caused by too rapid tapering, and it certainly saves time in

the end to prolong the process if circumstances appear to render this desirable rather than to insist that the patient shall cease to take alcohol at all after a certain specified time decided by mere rule of thumb.

With patients who have been drinking for many years it is well to be on one's guard against the possibility of fatty heart. Two such cases of my own bore even the most gradual tapering, diminishing by 1 oz. and at last by only $\frac{1}{2}$ oz. a day, extremely badly. In both the blood pressure fell greatly, and in one, mental symptoms appeared, due probably to cerebral anæmia. In each case, however, tr. strophanthi produced immediate improvement, though in one I was unable to cut off all alcohol even after a month, as doing so immediately resulted in signs of heart failure.

It is usual to give bromide during the process of tapering: Hare gives 40 grains combined with capsicum every eight, six or four hours. I usually give 30 grains three or four times a day. They probably help in securing sleep at night, and certainly tend to reduce restlessness during the day. I usually give sod. veronal for insomnia in $7\frac{1}{2}$ grain doses.

With the cutting off of alcohol the second stage of treatment begins. During the next few weeks the patient will be peculiarly liable

to relapse if he gets the chance of obtaining alcohol ; and he should, anyhow for a fortnight, not be allowed to go out by himself, lest he might be assailed by sudden temptation.

It is more especially during the second stage of "cure" that treatment aimed at rendering the patient safe, after he goes out into the world, should be attempted.

There are only two effective means which we can use : drugs and moral treatment, including suggestion.

Treatment by Drugs.

For the immediate though temporary abolition of craving, apomorphine, as already stated, is by far the most efficacious drug we can employ. The method of use has already been described. Such a drug, however, is of merely transient value ; and it is essential, if treatment by drugs is to be of any real value, to employ one which can exercise a most lasting influence. There is, I believe, only one drug, atropine, which is of any real value, and it is usual to give it in conjunction with strychnine. It is best given hypodermically three times a day. The treatment has been used in Norwood Sanatorium for many years ; first, I believe, by Dr. McBride, and now by his successor, Dr. Hare.

Here is the original treatment as advocated by Dr. McBride :

Two solutions are prepared—one containing 4 grains to the ounce of strychn. nitrate, and the other one grain to the ounce of atropine sulphate. The injections are given just after the three chief meals.

Commencing with a dose of 1 minim of each solution, the amount is increased during the week, the strychnine gradually until 1-30th of a grain is given at each injection, and the atropine until physiological effects, viz., dilated pupils and dry tongue make their appearance. Dr. McBride says that even better results are obtained if the drug be pushed to the extent of producing delirium, but for obvious reasons does not advocate this.

He allows his patients a certain amount of alcohol—sufficient to satisfy craving—but the amount is not large, only about four ounces in the twenty-four hours.

During the second week the injections are maintained at their maximum; and, if the result has been favourable, the atropine is rapidly diminished during the third week, and on the sixteenth day omitted altogether. Strychnine is injected up to the sixth week, when the dose is rapidly reduced to *nil*, the injections being given only twice a day.

Dr. McBride states that usually in three or four days the patient ceases to drink of his own accord, and by the end of the first week, eats and sleeps well. In many cases the effect is a lasting disgust for alcohol. In some, unfortunately, the disgust is only temporary; in a very few, the result is nil.

In cases who refuse to follow advice, or do not intend to be cured, he states that the following plan is sometimes successful. The atropine is increased rapidly until 1-50th grain is given three times a day, and the patient is then made to drink several heavy doses of alcohol. "He will probably be very sick, and nothing more is required."

From the psychological point of view it appears to the writer that this is the treatment most likely to be permanently successful.

But Dr. Hare found that there were certain disadvantages in the more drastic methods of treatment by strychnine and atropine, the chief being the occurrence of delirium, due sometimes to the atropine, and possibly sometimes to the too rapid reduction of alcohol, inducing delirium tremens.

In any case the danger of too rapid reduction of alcohol can be avoided by tapering when delirium is feared before commencing drug treatment. Dr. Hare does not commence it

at all until the patient has actually ceased to take any for at least a week, in order to avoid the possible inconvenient results, which are extremely difficult to deal with in an institution, as they may involve an enormous amount of extra work by the attendants.

But in private practice he advocates the more drastic methods, on the whole, and I certainly agree with him.

In my own practice, where I have used drug treatment, I have always tried tapering first, until the patient is taking four ounces, or sometimes only three ounces, a day. I have then given the atropine and strychnine until the physiological results are apparent, and dislike of alcohol sets in; but I always insist that, in spite of his disgust, the patient shall continue the alcohol for at least two days. If no disgust occurs, I have sometimes pushed the atropine up to 1-50th of a grain at each dose: beyond this amount I have not ventured, and it sometimes fails to produce the desired effect. It has in two cases caused mild delirium but delirium of a harmless character, lasting but a few hours, and the object—causing disgust—was obtained.

So far as I have observed, I have come to the conclusion that the taking of alcohol is essential to induce feelings of revolt. The

following is a case in point: Mr. A., at 34, a pseudo-dipsomaniac of four years, came to me a week after an attack. He was not drinking, and was treated at home by atropine and strychnine. On the fifth day the dryness of his tongue and dilation of his pupils was marked. The dose was maintained at the same point until the eighth day.

Knowing from his history that the minimum dose of alcohol required to start his attacks was at least three ounces of whiskey, I determined to give him an ounce in three ounces of soda water. Up till then he was quite unconscious of any dislike of alcohol; but he at once experienced extreme nausea and vomited freely. The loathing for alcohol continued for the succeeding month whilst he was under my observation, and when he was last heard of two years later, the dislike still persisted, and he had had no relapse.

McBride mentions a similar, but more striking, case, in which merely drinking water out of a glass which had previously contained whiskey and water produced a similar result in a patient who was quite unconscious of any repugnance to alcohol.

It is, I think, obvious that the feeling of disgust would never have arisen in these cases had not alcohol been taken to excite it. I

doubt much whether in private practice it is worth trying drug treatment at all, unless alcohol be given with it. The effect on the patient, after the immediate influence of the drug has departed, is at any rate very problematical, and it seems in the highest degree unlikely that the actual effect of the atropine can last very long after it has ceased to be given.

This lasting effect appears to the writer to be of purely mental origin, a persistent memory of nausea associated with the last occasion on which alcohol was taken. If this be so, it is clear that unless disgust be consciously excited, there can be no memory of it, and the treatment, therefore, can be of no permanent value. An instance of the taking of alcohol by a patient in whom disgust had persisted seems to me to point to this conclusion.

The patient, who had been treated by atropine ten months previously, had developed an intense disgust for alcohol. Unfortunately, he met with an accident, being knocked down by a taxi. A kindly bystander produced some brandy, and gave him some whilst he was still half conscious; but the brandy produced not disgust, but euphoria, and the incident was followed by a fresh attack of pseudo-dipso-mania.

Dr. Hare, who now uses the treatment only after all alcohol is stopped, remarks that the beneficial effects are not so obvious now as they were when the treatment was given from the very commencement. He gives, however, no indication of the results after patients have left the Sanatorium, as to whether they experience disgust or not.

It is, perhaps, not necessary to say that, in a case of pseudo-dipsomania, the patient should be cut off from all alcohol at once, so that the treatment must be carried out whilst he is not drinking. Unless his minimum dose is large enough to enable us to test with safety the efficacy of the drug treatment, we cannot form a conclusion. The treatment has a certain value in these cases, however, though possibly only a temporary one. It seems, on the whole, to diminish the danger of the patient's drinking whilst still under treatment—a very real danger if we are compelled to allow even a limited amount of freedom after the first weeks.

If it is inadvisable to make any test of its effects, I have sometimes adopted Dr. Hare's method of using the drug, but, instead of waiting until all alcohol has been withheld for a week, I begin treatment the moment all extreme craving has ceased. The chief differ-

ence is that, as most patients of this class will consent to be under treatment for only a limited time, I often increase the dose rather more rapidly than Dr. Hare advises. He continues the treatment for no less than six weeks, if possible, and so tides over the most dangerous period.

The scheme he gives is as follows, using the same solution as before mentioned :

- 1st week.*—Gradual rise to m5 of strychnine solution and m4 of atropine.
2nd week.—Dose of each, increased gradually by m2.
3rd week.—Dose maintained at m7 of strychnine solution and m6 atropine solution.
4th week.—Dose reduced by 1 minim each solution.
5th week.—Dose further reduced by 1 minim of each solution.
6th week.—Gradual diminution to m2 strychnine and m1 atropine solution.

As patients may have marked idiosyncrasies towards these drugs, they must be carefully watched, and the treatment modified accordingly.

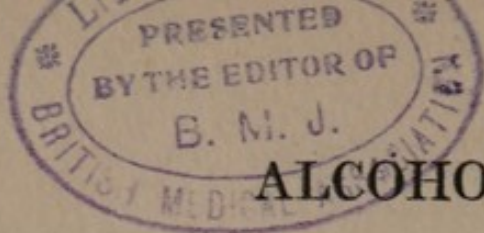
Hare states that the commoner undesirable symptoms due to atropine are cutaneous irritation, and sometimes temporary mental confusion and forgetfulness, and sometimes depression. I have observed the latter symp-

toms in two patients both over fifty years of age. Possibly they are more liable to unpleasant effects than children, who are generally more tolerant of belladonna than adults.

Besides the injections, Hare gives a tonic mixture containing cinchona, gentian, strychnine and atropine. I usually omit the strychnine and atropine, so long as the patient is already taking these hypodermically.

As I have said above, whilst this treatment is probably useful in combating craving during the danger period, it has so far as I can see but little or no effect on the after condition of the patient, unless he can actually take alcohol and experience disgust. Whilst the experiment can be safely tried with the chronic alcoholic, it is attended with risk in the pseudo-dipsomaniac, and the dipsomaniac also, if he suffers from pseudo-dipsomania as well. Unfortunately, it sometimes fails to induce marked dislike.

With regard to true dipsomania, in those rare cases who will come for aid when the premonitory symptoms first appear, and before drinking has actually commenced, a dose of apomorphine will sometimes work wonders. I had at one time a patient with quite regular attacks at two months' interval; and, though he would not come for treatment before the



craving set in, he came on three occasions the moment it did so. Apomorphine, repeated three or four times during the day, averted the attack on each occasion. He then remained free from attacks for four months, but unfortunately did not return when the craving again returned, and he has, I believe, relapsed to his original condition of periodical collapses. Treatment by atropine and strychnine is said to have succeeded in such cases, but I have no experience of it.

Sugar, especially in the form of chocolate, sometimes, though rarely, relieves the craving at the onset, provided that no alcohol has been taken; and is worth a trial.

Suggestion.

Suggestion, especially under light hypnosis, is, I believe, a valuable aid to treatment, and may be used alone, or better, in combination with drug treatment. Indeed, the combination of the two methods seems to be the best that can be given. The effects may persist for a very long time, and help to lessen the risk of relapse long after treatment is ended. Personally, I am of opinion that of the two methods of treatment, drugs and suggestion, suggestion is likely to secure the more permanent results.

It is quite unnecessary to induce deep hypnosis for this purpose, and the advantage of being rescued from drink far outweighs any theoretical disadvantage.

Many cases of pseudo-dipsomania come for treatment between their attacks, and either cannot or will not consent to undergo experience which interferes with their ordinary life, and for these, suggestion is almost the only possible line of treatment, and is often very successful.

One great advantage is that it can be continued, perhaps at only long intervals, for an indefinite time, and so constitutes almost the only practical mode of after-treatment.

I have known many patients before the war who would come up for possibly a single treatment at quite long intervals, six months, a year, and even more. They do so because they find by experience that they feel safer, and more certain of resisting their first temptation when the suggestion is occasionally renewed.

It is possible to create disgust by drugs, and then to maintain it to a great degree by suggestion. But the chief results which I have found produced by its means are: (1) a destruction or great diminution of haunting ideas of drink; (2) a means of making it impossible for the patient to deceive himself as

to the inevitable results of the first glass ; (3) a certain increase of the patient's will power, probably by calling out his full energy of resistance, in many instances ; (4) a bringing to light of some repressed memory, sometimes effecting a real cure thereby.

The results are often unexpected. A pseudo-dipsomaniac, a man of commanding intellect, remained quite well for over a year. Then, undergoing great overstrain, he deliberately determined to take alcohol to enable him to continue work, but found for nearly a month that he could not make up his mind to do so when it came to the point. Unfortunately, he eventually succeeded.

Whilst generally effective, this treatment—and, indeed, any treatment—is apt to fail in relapsed pseudo-dipsomaniacs.

In true dipsomania, when caused by menstrual troubles, I have found it often most effectual. In the periodic dipsomaniacs it has succeeded in several attacks in enabling the patient to resist the impulse to drink. Like every other form of treatment it is not a panacea. It only helps the patient to help himself ; and this, in alcoholism, is the most we can do by any treatment of whatsoever kind.

It is extremely easy to carry out. I usually

treat my patients every day for eight days, three times a week, in the following fortnight, and then twice during the next week. After this he is treated at longer intervals. He is urged always to come at the slightest sign that he is becoming less sure of himself, and to come at least once in four months if possible during the succeeding year. After this, it is well, if it be practicable, to see him two or three times every year for an indefinite period.

It is, as I have said above, frequent for patients to come, of their own accord, for treatment between their attacks of pseudo-dipsomania, when they are actually living their ordinary life. It seemed so improbable that suggestion alone could benefit a case under no sort of control that at first I tried it on such patients merely as an experiment, in the hope that it might do something to help them. But the result so far exceeded my expectations as to convince me that even in these unfavourable circumstances a great deal could be done, and I have seen many recover—as far as recovery is possible under treatment—and remain well for years without any other treatment whatever. Provided the patient is honestly determined to remain an abstainer, if he can do so, suggestion is always worth trying, even in the absence

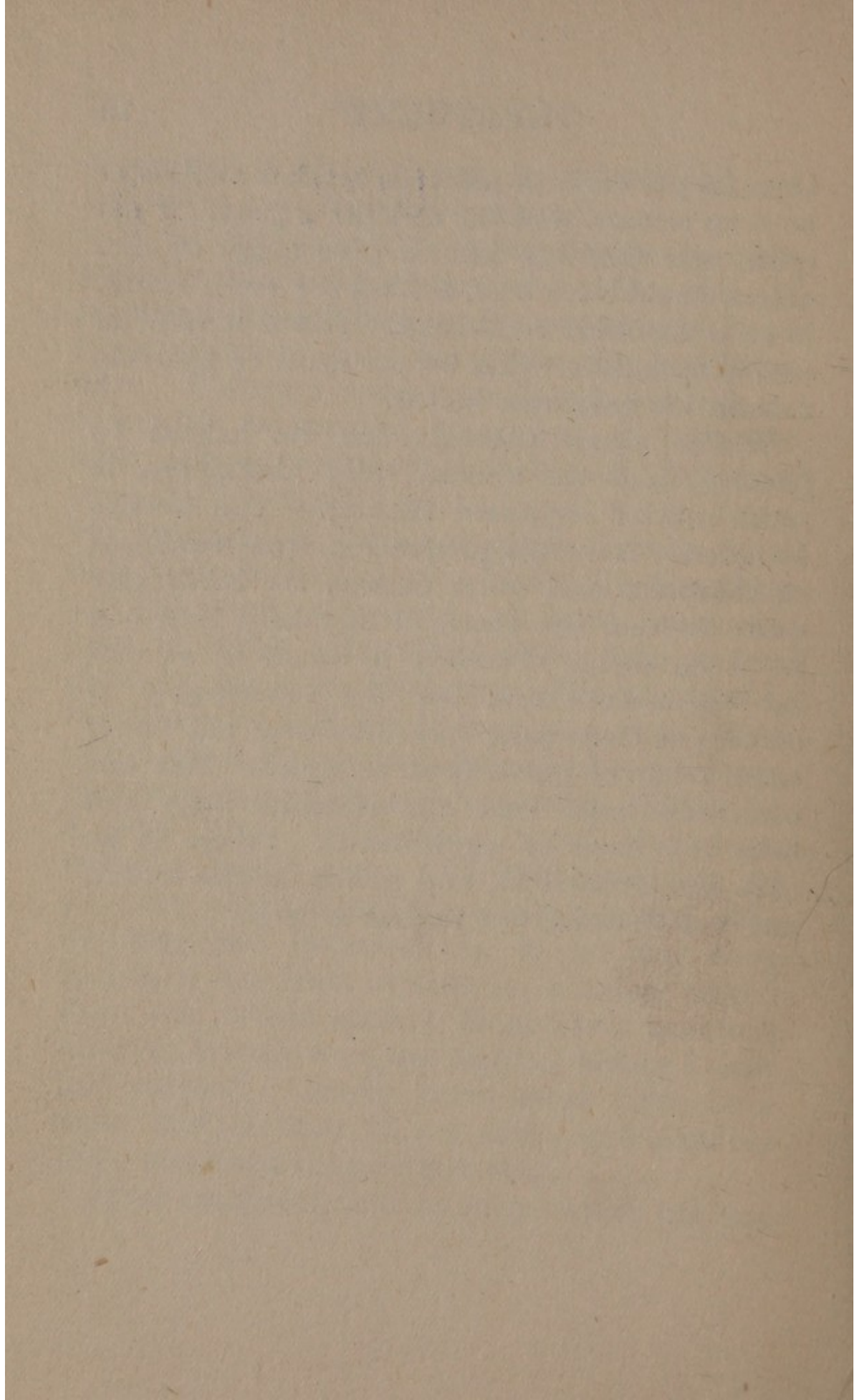
of control. If he is not so determined, no treatment is of the slightest avail.

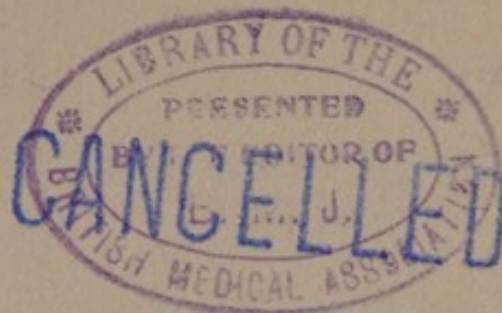
It is unfortunately impracticable to give statistics of results of any real value, since it is impossible to follow up the majority of cases for a sufficient time to obtain the necessary data. I always endeavour to get patients to come for subsequent treatment at intervals after active treatment has ceased, but less than half actually do so, and these form the majority of those of whom I have been able to track the history. Naturally, too, they are the most successful. I have, however, kept in touch with all of them (except five patients) for some little time after treatment, but less than half for as long as a year. Out of 311 cases, 22 per cent. failed before the lapse of one year, and 39 per cent. were still well a year after treatment; some had been well for many years. Of the remaining 39 per cent. all were well when last heard of. The majority had improved in so far that they had been free from attacks for a longer period than one would expect from their previous history; but all were lost sight of before a year had elapsed. Clearly there must have been more failures than 22 per cent., and possibly more successes than 39 per cent.

Hare concludes that he may expect not less

than 35 per cent. of patients treated at Sydenham to remain well for at least a year. I am quite sure that my known percentage of successes would have been several per cent. lower, but for the after treatment. But it is of little use to speculate when 39 per cent. of patients remain an unknown factor.

Whilst many patients can be helped to become, and do remain total abstainers, it must not be supposed that they can always be aided. A certain proportion, from weakness of character and other causes, are inherently quite beyond the reach of any help that can be given them. Possibly it would be as well for themselves and for the community if certain of these poor creatures were put under some form of permanent restraint. But one can only hope that the restraint may not take the form of punishment. Prison is no cure for alcoholism, and seems to the writer, not merely cruel, but useless as well.





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