Alcoholism
Author(s): Raymond G. McCarthy
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ALCOHOLISM—

A public health problem that has not received the amount of professional attention that it warrants.

Raymond G. McCarthy

THIS country has played a leading role in the development of public health programs. Notable accomplishments can be reported in research leading to treatment and prevention of diseases such as tuberculosis, diphtheria, the diseases of childhood, and conditions resulting from improper sanitation. Research into current major health problems such as polio, cancer, cardiac involvements, and arthritis is being conducted in our university and medical centers. A comprehensive program designed to reduce the incidence of mental illness has the support of governmental and private agencies.

Progress in public health has usually stemmed from the leadership of professional persons. When a condition becomes so prevalent that it threatens the welfare of a segment of a community, research is initiated which in time isolates the cause, identifies the host, and defines the syndrome which marks the disease. Treatment and prevention can then be built around knowledge of the established progression of the illness.

Alcoholism, however—while it, too, is a public health problem—has not received the professional attention accorded to the others. Contemporary concern about it has not arisen from professional groups but from those afflicted, their families and friends. Professional persons exhibit a mixed reaction toward alcoholism. This reaction ranges from lack of understanding of the nature of the condition, on the one hand, to indifference, rejection, and even some hostility on the other. The problem cries for understanding. Failure to understand the condition and to adopt suitable remedial measures inclines the professional person to project his failure to the patient himself.

Alcoholism, as a public health problem, presents certain unique characteristics. There is no recognized and specific cause. Although there are approximately 70,000,000 users of alcoholic beverages in the United States, the proportion developing the illness of alcoholism is small—about 5,015,000. That alcoholism does not develop without the use of alcohol is obvious. The converse of this proposition—that alcohol is the primary cause of alcoholism—is an oversimplification of the problem. There are wide differences in the prevalence of alcoholism among cultural groups. Some groups who use alcohol consistently show a low rate of uncontrolled drinking. Others have a fairly high rate. Some factor or factors in addition to the action of alcohol would appear to be a necessary condition for the development of the disorder.

The Facts About Alcoholism

Alcoholism is a complex individual and social disorder which cuts across many specialized areas. It impinges upon the fields of medicine, physiology, psychology, social welfare, religion, penology, education, politics, and economics. Because specialists in different fields tend to see the problem from one particular point of view, their biases have retarded attempts at solution.

Those who see the question as one of willful irresponsibility believe that some punitive action is necessary. Others who think that alcoholism arises from a constitutional hereditary defect contend that not much can be done about it. Those who see alcoholism primarily as a problem of tissue habituation are continually being frustrated by the failure of the patient to maintain a favorable response to medical treatment. They conclude that he does not wish to recover and that responsibility for his welfare no longer rests with the community. A program based upon these tenuous assumptions concerning the cause of alcoholism is certain to fail.

Many persons assume the alcoholic to be the derelict, the panhandler who drifts around the fringe of every large city. Society rejects him by relegating him to the back streets. On the other hand, the drunken comedian of stage and screen is accepted, and his antics are considered humorous. We tolerate the comedian, but the derelict is a threat to civic conscience.

A distinction must be made between drinking and alcoholism. The derelict and the comedian may or may not be alcoholics, although they exhibit drunken behavior. Between these two extremes, the stage comedian and the skid row outcast, people representing a complete cross section of American society exhibit the behavior called alcoholism. The ratio of men to women has been estimated at 5.5 to 1. It has become a cliché to say that alcoholism is no respecter of intelligence, of professional skill, or of individual prestige.

There is no generalization that will apply to the entire alcoholic population except possibly this: all suffer from a kind of discomfort, a severe discomfort that stems from some physiological or psychological cause, or more probably a combination of both. All have learned that alcohol relieves this discomfort. Once they begin to use alcohol for relief it has an appeal, a gratification, that leads them to continue using it repetitively. Eventually control is lost.

When a drinking episode begins, the terminal point is no longer determined by social custom or approval. Perhaps the only identifying criteria that can be applied to all alcoholics —except that they are not abstainers —are (1) the use of alcohol associated with a kind of discomfort, and (2) the inability to control the use, once it begins.

There is a purpose behind the use of alcohol as there is purpose in every action. It provides the ordinary drinker with a kind of relaxation, a mild sedative effect associated with low concentrations in the blood. I think it may be said that for the ordinary drinker, small amounts of alcohol furnish an increase in his satisfaction with reality. But the contact with reality is not lost nor is the loss sought. For the ordinary drinker there are no problems, no involvements, associated with his use of alcohol. Moreover, if he is advised that he must discontinue the use, he is able to do this without great difficulty.

The Drinker—or the Alcoholic?

By contrast, the alcoholic uses alcohol to achieve a change in reality, to make of reality something that it is not, something he can manipulate, control, adjust in terms of his fantasies. The alcoholic's drinking is always associated with some involvement such as disorganization of family life, physical complaints, or loss of job. Involvement is sometimes less obvious—a deepening sense of futility, of worthlessness, or of hopelessness.

An individual cannot control his life without help once alcoholism is well developed. This help must result in some emotional reorientation—a new relationship to an individual, an organization, some agency outside himself. It may be a physician, a clinic, the church, Alcoholics Anonymous, or some combination of these. But it is essentially a new relationship resulting from a shift in emotional tensions and pressures within the personality.

There is relatively little evidence of an alcoholic personality as such. Indeed there is no "alcoholic." Rather there are millions of people who display this pattern of behavior in varying degrees and for varying combinations of causes. If you consider the three criteria mentioned—motivation leading to modification of reality, involvement, and inability to control the intake of alcohol—then such factors as years of drinking, the quantity or type of beverage consumed, the number of arrests or divorces or institutionalizations become secondary.

Basically, we are concerned with an individual with a severe personality imbalance. We must ask, "What is this man attempting to get through this technique, this compensating mechanism, this defensive pattern of uncontrolled drinking? What is he attempting to get, and why does he feel that he needs it?"

Alcoholism is one expression of emotional dysfunction. It is a problem of feeling tone. Every alcoholic who has reached a crisis stage in his life has within his own experience every reason for never taking another drink. These are not necessarily the reasons given by his doctor, his clergyman, his wife, or his friends. They are reasons based on the evidence of his own deep inner experience which should be the most compelling evidence. Yet in most cases he is unable to act upon this evidence. Intelligence, logical argument, common sense falter and become submerged in a wave of rising emotional tension characterized by impulsiveness which precedes the taking of the initial drink.

Mr. McCarthy is associate professor of health education at Yale University and associate director of the Yale Summer School of Alcohol Studies. He is the author of three books concerned with this problem.

Obstacles to Treatment

Treatment of alcoholism is not a prestige field. Many psychiatrists and many physicians are unwilling to become identified with a relatively small segment of the total field of medical care. Among some of the professional groups there is reluctance to devote time to a disorder which past experience leads them to believe will be unproductive. The demands for psychiatric services—for psychiatrists, trained case workers, clinical psychologists, and nurses —greatly exceed the supply of competent personnel. The conspicious lack of adequate treatment resources in the community reinforces the stigma attached to the condition.

Clinicians generally recognize that an alcoholic can never again drink in controlled fashion. But abstinence is not the only goal in treatment. There must be some redistribution of emotional forces which will enable the individual to achieve a degree of satisfaction in sobriety which will compensate for the pseudosatisfactions which he has sought in drinking. Those assets in the personality which have been blocked and smothered by the complications of drinking are now released for constructive ends. Therapy is a long-term process, but once the patient has learned that he can live comfortably and that he can gain satisfactions without drinking, the effects are cumulative.

The Need for Research

Alcoholism, like other public health problems, confronts us with questions that need research. The clinic is the laboratory in which a considerable part of necessary research required for understanding of alcoholism must be carried out. Many questions need to be resolved. Are there personality characteristics which are specific for the alcoholic or for different groups of alcoholics? Are there some factors in metabolism, in body chemistry, in hormonal functioning, which distinguish the uncontrolled drinker from the millions of users of alcoholic beverages who do not go out of control? What determines the onset of alcoholism in one group and not in another?

One aspect of the work with alcoholics that is sometimes disconcerting is the fact that most persons consider themselves authorities on the subject, and their speculative assumptions are based on little objective evidence. We need research to evaluate some of the existing theories of the cause of alcoholism. We need to know more about the effectiveness of different types of treatment. Techniques must be developed to handle a large number of cases with a minimum expenditure of professional skills and of budget. Public funds now expended annually for treatment of alcoholism amount to only about one dollar per person reported to be suffering from the illness.

A substantial segment of the alco-

holic population, perhaps the most conspicious segment—the homeless man and the chronic court offender—has not responded to medical treatment or Alcoholics Anonymous. Evidence suggests that a large number of these persons are not alcoholics. How many of our skid row cases are alcoholics and how many are primarily borderline schizophrenics, morons, or psychopaths? What facilities are needed in order to alleviate this condition to the extent that it can be alleviated and thus reduce the pressure upon municipal welfare budgets and court and jail facilities?

No public health problem has ever been resolved in the clinic or through treatment of a series of individuals. There must be research—research which brings to bear on the problem the highly developed skills of a number of specialized disciplines. To date, there has been no comprehensive epidemiological research in the field of alcoholism. Unquestionably, this would be a difficult undertaking but it is no more difficult than similar projects in mental health, geriatrics, or in other mixed medical and social problems to which science is now directing attention.

The technical skills for developing a constructive approach to this public health problem of alcoholism are available. However, they need to be mobilized to reduce some of the misconceptions about the nature of the condition and to modify some of the existing attitudes which tend to block progress in determining etiology and effective methods of treatment.

Where the Nurse Fits In

The nurse is in a particularly advantageous position to make a constructive contribution. In a hospital situation, the alcoholic recovering from the effects of acute intoxication is usually amenable to suggestion. His defenses down, he is guilt-ridden, confused, and depressed. Because of his own self-recrimination, he needs acceptance in the community of the ailing. Acceptance can be expressed best by attitudes which emphasize the personal worth of the patient and thus to some degree compensate for the loss of self-respect which he has experienced. Unlike the physician, the clergyman, and some social workers, the nurse is not an authoritarian figure for the alcoholic. In her approach to the patient at this critical point, she is in a position to exhibit concern for his recovery. She can approach him without reflecting the criticism which he expects and with a suggestion for a definite plan of treatment, whether this be referral to a clinic, to Alcoholics Anonymous, or to some other community resource.

A medical approach to the acute effects of a drinking spree is only the first stage in treatment. There must be a sustained period after physical balance has been restored, during which the individual has an opportunity to re-evaluate himself in an accepting atmosphere. This will allow some of his resources to begin to operate in the direction of the emotional orientation referred to previously. Too often in the past, the period of hospitalization has been only an interlude between drinking episodes, an interlude which, for many individuals—especially members of the family—creates a false expectation which is then dashed to the ground in a tragic way by a relapse.

Family defensiveness and hostility increase as the alcoholic progresses along the pathway of uncontrolled drinking. Whatever degree of perspective existed in the family in the early stages becomes distorted and diluted as the disorder increases.

The nurse's role varies with the setting in which she works. The occupational health nurse is well aware of the number of men exhibiting Monday morning absences or seeking mild sedatives for the relief of hangover. She should not disregard the opportunity to focus attention on certain elements in the progression of alcoholism, to make available (in discreet fashion) literature which may have meaning for a number of men. Early diagnosis and treatment is imperative in alcoholism as in any illness.

The public health nurse occupies a crucial position in case finding and health education directed toward constructive action. When evidence of alcoholism appears in a family, her objectivity may mitigate the tension with direct benefit not only to the alcoholic, but also to his wife. Although the wife faces her husband's emotional condition on a 24-hour basis, an interpretation of the nature of alcoholism may help her. It may be possible, even imperative, for the nurse to encourage the wife to seek help in the community in order to bolster her own resources; and the nurse is in a position to refer not only the patient but also his wife.

Most alcoholics have had enough of intoxication and the consequence to themselves and to others. They are usually ready to give up drunkenness but are not able to visualize a life without drinking. That such a compromise is impossible for the alcoholic is well established; it is most difficult for him to understand this, however, because of past failures and because of his emotional needs. That the element of lack of control is a primary symptom of the illness is a new concept for many persons. By applying her professional skills and interpreting the nature of the condition, the public health nurse can frequently lead the family to accept help.

Gaps in Our Knowledge

A certain proportion of the alcoholic population exhibits a rather poor prognosis because of lack of personal assets. However, we do not hesitate to offer treatment in other disease conditions in which the prognosis may be extremely guarded—for instance, cancer and schizophrenia. If members of the healing professions acknowledge that alcoholism is a mixed medical and social problem, that it is an interrelated physical and emotional disability, that the medical treatment of the body alone is not sufficient to bring about recovery, that the community—along with the professions—has a responsibility to provide the kinds of resources that in time will reduce the prevalence of alcoholism, progress can be expected. The nursing profession occupies a crucial position in this field. In the final analysis, the nurse may serve as a catalyst to stimulate other staff members to accept full responsibility for this major public health problem.

Basically, any comprehensive treatment program is essentially a mental health program. As knowledge of the causative factors in alcoholism circulates, there will come a better popular understanding of the dynamics of personality. With the gaps in our present knowledge of the etiology of alcohol addiction, we must depend on the development of balanced personalities as a factor in prevention. As such, work in this field becomes allied with other fields of health and education. One will complement another.

This is a long-range project. Measurements of results can only be undertaken in the next generation. The forces with which we are dealing in seeking a solution to alcoholism are so fundamental to human endeavor and aspiration that they warrant the support of professional groups everywhere.

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