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- p 188 - 197 Clinic sample results (including AA)
- p 347 - 352 The Doctor's Dilemma: should we treat when there is no cure?
- p 358 - 360 AA is associated with positive results. Clinical treatment is ineffective, but does show some benefits.

Unofficial summary notes are added for convenience only.

investigators cannot forbid their subjects to seek treatment elsewhere. As Kendell and Staton (1966) first noted, if followed for more than a year or two alcoholics will get multiple treatments from multiple sources. Proof of therapeutic efficacy is not easy.

Thus, it is well to set forth some minimal ground rules that must be observed before we can regard treatment efficacy proven beyond a shadow of a doubt. First, since alcoholism is a chronic relapsing disease, follow-up must be prolonged—at least 5–15 years. Second, observations must occur at multiple different times. (To my knowledge, in the world literature there is no previously published study that has both followed an alcoholic clinic population for more than four years and also assessed their outcome at more than one time.) Third, in order to assess the effect of favorable admission variables upon outcome, the study must be prospective. Fourth, attrition must be minimal. Failure to observe this requirement has called several otherwise well-designed studies into question. Fifth, at outcome presence or absence of alcohol abuse must be correlated with multiple facets of social functioning. The goal of alcohol treatment is not to reduce an individual's annual alcohol consumption, but to improve the quality of his life. Sixth, posttreatment environmental variables should be controlled. To my knowledge, this has been carried out well only by Finney and colleagues (1980). Failure to observe this last requirement is a methodological defect in the Clinic study to be reported below.

In Table 3.8, the best outcomes were from untreated community samples of Goodwin, Ojesjo, and the Core City; the worst outcomes, if one includes deaths, were experienced by alcoholics who received inpatient treatment. Such alcoholics represented a more severely ill population with a poorer prognosis. It is useful to contrast, but unfair to equate, the natural histories of older alcoholics who attend alcohol clinics with younger alcoholics drawn from community samples. In this section I shall present a description of an eight-year follow-up of 100 alcoholics (the Clinic sample in Table 3.8) who sought hospital treatment for their illness, and I shall contrast their course with that of the Core City sample.

The Clinic sample comprised 110 consecutive admissions admitted for detoxification to an urban, municipal hospital (Cambridge Hospital) during the winter of 1971–72. Four patients who did not stay for 24 hours were excluded from the study, leaving 106 patients; 91 men and 15 women. At the time of admission, in anticipation of prospective follow-up, systematic data were gathered for all patients on previous employment, living arrangements, use of Alcoholics Anonymous, prison history, and so on. The criteria for

Summary:

An 8-year study of 100 severe alcoholics
(already with a history of abuse)

diagnosing physiological dependence upon alcohol were that the patients had either required 750 mg or more chlordiazepoxide (Librium) during detoxification or manifested severe withdrawal symptoms during previous detoxifications. Hospital stay ranged from 1 to 11 days with a mean of five days.

All patients received individual counseling and two to three hours of films and group discussions a day. An internist educated patients about medical issues on alcohol use and abuse. Alcoholics Anonymous meetings were required twice weekly. After discharge, all patients knew that they could return to the program as outpatients at no cost and without appointment. All patients were encouraged to attend the twice-weekly outpatient group meetings, which were designed to guide patients toward Alcoholics Anonymous.

The Cambridge and Somerville Program for Alcohol Rehabilitation (CASPAR) program blankets the entire cities of Cambridge and Somerville and includes halfway houses, drop-in centers, freestanding detoxification units, and integrated mental health facilities. Therefore, a majority of our sample, when they relapsed, continued to have multiple therapeutic contacts with our program. In addition, over the next eight years a special effort was made every 18 months to monitor the course of these 106 patients. If abstinent, the patient was personally interviewed; if the patient was abusing alcohol and not available for interview, a relative of the patient was interviewed or recent clinical charts were reviewed. The number of days in detoxification units and in halfway houses and the estimated number of AA visits were specifically recorded. Multiple informants were used, and the records of five halfway houses, four detoxification centers, and four alcohol counseling programs were reviewed. Over eight years, we could identify, for the average subject, 15 admissions for detoxification and at least as many visits to emergency rooms or counseling centers. At each interview an effort was made to assess not only the individual's use or abuse of alcohol but also the quality of the individual's social, medical, and occupational adjustment.

The last effort to contact these men and women was during the spring of 1980; and on the average, the course of each patient was reassessed at five different times. Over the eight-year period of follow-up, 6 Clinic patients were lost, but even these patients were followed for an average of three years each. At last contact, 1 of these lost patients had been abstinent for six months, 2 were using alcohol intermittently, and 3 were still experiencing severe, sustained alcoholism.

The following list shows the characteristics (at time of admission) of the 100 patients in the Clinic sample who were successfully followed for eight years.

Summary:

After detox, 1 – 11 days of inpatient treatment.

After discharge, outpatient treatment was available.

Outpatient meetings encouraged AA attendance.

During 8 year study, patients had access to local network of halfway houses, drop-in centres, detox units, and integrated mental health facilities.

Over 8 years, the average subject required detox 8 times.

Age	45±10
Male	87 percent
10+ years of alcohol abuse	87
Ever previously detoxified	80
Ever in jail	71
Straus-Bacon score 0 or 1	64
Lives alone or in street	50
Lives with spouse	35
Regular employment	27
Attended college	19
Stable psychosocial adjustment (1970–1971)	17

Table shows subjects' status before treatment.
Most had already been detoxed and in jail.

Premorbidly, all subjects were rated on the Straus-Bacon scale for social stability. The Straus-Bacon scale is a four-point scale that gives a point for each of the following: ¹if the subject had a steady job for the past three years, ²had a stable residence for the past two years, ³is currently not living alone, and ⁴is currently married or living with a spouse. Compared to the population of alcoholics attending private hospitals or industrial alcohol counseling programs, the Clinic sample was socially very unstable. For example, 64 percent of our sample received Straus-Bacon scores of 0 or 1; this was true of only 18 percent of the original sample from New Haven Alcohol Clinic on whom the scale was developed (Straus and Bacon 1951).

Premorbidly (1970–71) and at follow-up (1978–79) the men in the Clinic sample were also assessed for psychosocial adjustment, employment, marital stability, and number of detoxifications. The time frame was the preceding two years.

Psychosocial adjustment was assessed on a four-point scale. A score of one indicated a “skid row” adjustment—unemployed more than 80 percent of the time and living in a single room or institutionalized because of alcohol abuse. A score of two indicated a “marginal” existence—the individual might have *either* a regular job *or* a stable home situation but still manifested clear social instability attributable to alcohol. A score of three indicated a “fair” social adjustment that could not be directly blamed on alcohol abuse: such individuals might be chronically physically ill, socially isolated, or psychiatrically disabled. A score of four reflected “stable” social adjustment: the individual held a regular job or functioned effectively as a homemaker *and* enjoyed a regular residence *and* remained in contact with relevant family members *and* experienced no serious emotional or physical disability.

Half of the Clinic sample were living alone or in the streets; only a third

(premorbid = before onset of disorder)

lived with a spouse and only a quarter were regularly employed. Four-fifths of the Clinic sample were between 30 and 60; and four-fifths had begun abusing alcohol before age 30. Virtually all had experienced alcohol-related problems for more than a decade. Seventy-one percent had spent time in jail for public drunkenness, but only 5 had spent more than a month in jail. Although the average Clinic subject had experienced greater social damage from alcohol abuse than had the average Core City alcohol abuser, originally they had represented a less socially disadvantaged group. Of the Clinic sample, 61 percent had graduated from high school, and 28 percent of the Clinic patients currently classified as leading a skid-row existence had attended college.

Outcome measures for the Clinic sample were deliberately global and based on a time frame of years, not months. As dichotomously as possible, clinical outcomes were separated into categories of stable remission and chronic alcoholism. The category *stable remission* included the 29 individuals who for the past 36 months or for the three years preceding death (3 cases), had remained in the community without experiencing alcohol-related problems of any kind. Five such individuals had resumed asymptomatic drinking and 24 had been abstinent (no use of alcohol for 51+ weeks/year) for three or more years.

The category *chronic alcoholism* encompassed 47 individuals who for the last three years (or until death) had spent at least six months of the year symptomatically abusing alcohol, had manifested physiological dependence, and had required at least 1 detoxification. Over the eight-year period, all but 4 of the 47 chronic alcoholics had required at least four detoxifications, and two-thirds had been detoxified ten or more times.

The category *intermittent alcoholism* encompassed those 24 individuals who for the previous three years did not fit easily into either of the dichotomous categories described above. Many members of this category correspond to the "atypical" alcoholics described in Table 3.9. Intermittent alcoholics also included individuals who were institutionalized, who were currently abstinent for less than three years, or who managed to remain abstinent for long periods between binges.

Table 3.10 documents that not only were the categories of stable remission and chronic alcoholism dichotomous for alcohol abuse, they were nearly dichotomous for social adjustment. As a group, the chronic alcoholics were psychosocial cripples and the stable remissions were employed and were living in gratifying social environments.

Had a briefer time frame been employed, however, the course of most of

After 8 years, subjects were rated

- stable remission (29)
- intermittent alcoholism (24)
- chronic alcoholism (47).

Note this sentence: "As a group ..."

TABLE 3.10. Association between presence of alcoholism and social adjustment at outcome.

	<i>Clinical status (1979)</i>		
	<i>Stable remission (n = 29)</i>	<i>Intermittent alcoholism (n = 23)^a</i>	<i>Chronic alcoholism (n = 46)^a</i>
<i>Psychosocial adjustment (1980)</i>			
Stable	66%	35%	9%
Fair	31	26	9
Marginal	3	26	30
Skid row	0	13	52

a. Social adjustment of 2 cases could not be rated.

the Clinic patients could have been described as intermittent alcoholism. By this I mean that at some time after discharge from their first admission to the Cambridge Hospital detoxification unit, 95 of the 100 Clinic patients relapsed to alcohol dependence—a criterion often used to indicate clear failure of treatment. However, within the same eight-year period, 59 percent of the clinic sample achieved at least six months of abstinence—a criterion often used to indicate stable recovery. On the one hand, 6 of the 29 men eventually categorized as stable remissions required ten or more detoxifications. On the other hand, 15 of the 27 chronic alcoholics who survived the full eight years achieved at least four consecutive months of community abstinence. Under high magnification most blacks and whites appear gray.

Figure 3.7 depicts the clinical course of the Clinic sample alcoholics over eight years. The figure illustrates that once alcoholism is severe enough to require hospital detoxification it represents—in a cybernetic sense—a very unstable state. After one year, 81 percent of the Clinic patients continued to abuse alcohol; after eight years, the proportion had shrunk to 26 percent. Figure 3.7 corroborates both the pessimism of Lemere and the optimism of Drew. Stable remissions gradually rose to 34 percent, but 29 percent of the patients died. The data from the Core City sample in Figure 3.2 and for the Clinic sample in Figure 3.7 graphically reflect the point made in Table 3.8 that stable remission from alcoholism occurs in roughly 2–3 percent of active alcoholics per year. Perhaps 10 percent of alcoholics will achieve stable remission the first time they seek clinical intervention.

The death rate depicted in Figure 3.7 was roughly three times what would have been expected for nonalcoholic men and women of comparable age.

Treatment can be seen as a failure or partial success, depending on what criteria are used.

Fig 3.7 shows year-by-year progressions

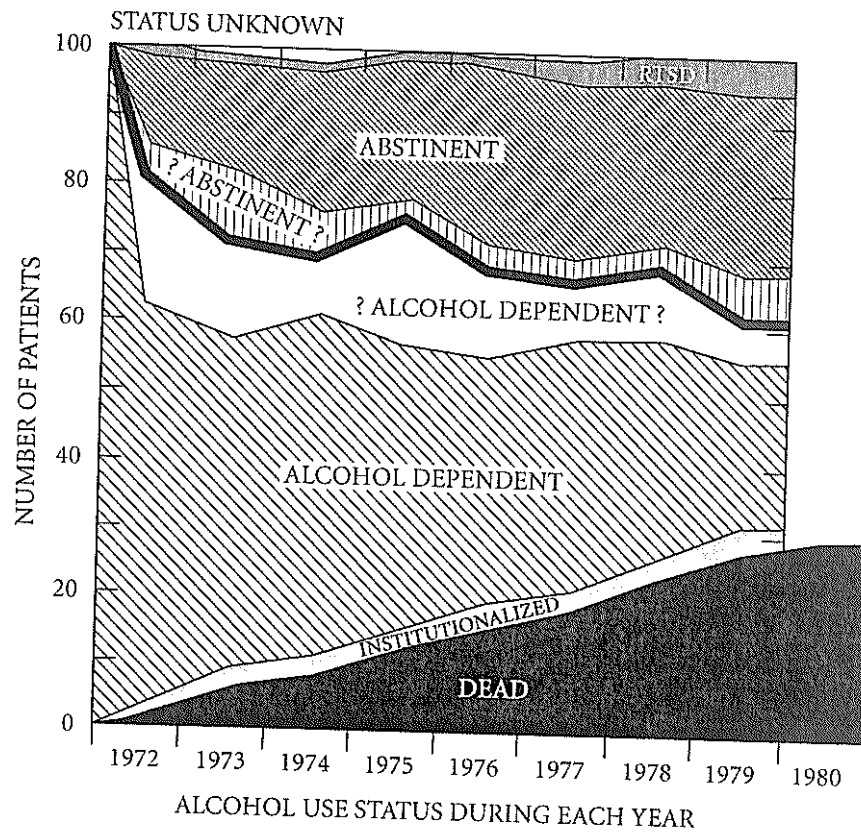


Figure 3.7 Composite posthospital alcohol use histories of the Clinic sample. Abstinent = no alcohol use for more than 51 weeks during a year (corroborated by more than one source). ?Abstinent = evidence for abstinence unreliable, or abstinent for 44–51 weeks. RTSD (return to asymptomatic drinking) = individual drank more frequently than once a month and longer than 12 months but with no discernible alcohol-related problems. ?Alcoholic = alcohol abuse for more than 2 but less than 6 months in a given year, or ambiguous evidence suggesting alcohol abuse, or no evidence of alcohol abuse but the individual exhibited clear alcohol dependence in the preceding or the following year. Alcohol dependent = unambiguous alcohol abuse for more than 6 months leading to hospitalization for detoxification. Institutionalized = in a nursing home, prison, or chronic disease hospital for more than 11 months of the year. Deaths were verified by death certificates.

One-tenth of the patients aged less than 40 years on admission were dead eight years later; and one-quarter of those aged 40–50 and almost half of those aged 50 on admission were dead. Eight of the 29 deaths were from homicide, suicide, or accident; and 9 or more were alcohol-related (for example, hepatic failure, aspiration pneumonia, or exposure). Five Clinic alcoholics died of coronary thrombosis. Mortality was highly associated with poor premorbid psychosocial adjustment. Half of the 29 alcoholics who later died had manifested a “skid row” social adjustment at first admission; and half had received a Straus-Bacon score of 0. During the eight years of follow-up, half of the men who spent ten months or more in halfway houses died.

At the eight-year mark, 5 men and women had returned to asymptomatic drinking. Such drinking ranged from an occasional glass of wine by one man to one man who regularly drank four to six cans of beer a night. These 5 individuals, however, were premorbidly very different from the other 95. At first admission, they had enjoyed far greater social stability; they had experienced far shorter periods of active alcoholic drinking; and three of them had never required previous detoxification.

Although the numbers were too small to be conclusive, no important differences were observed between the 87 men and the 13 women alcoholics. Although the men were more likely to live in the streets, to be sent to jail, and to have lost control of their drinking in adolescence, both sexes were equally likely to recover and to become involved in Alcoholics Anonymous.

At this point three questions must be asked. First, do social variables on admission predict both clinical course and future social adjustment or is it recovery from alcoholism per se that is primarily responsible for the increased social stability observed for the stable remissions in Table 3.10? Second, what is the effect of treatment, if any? Third, if treatment affects outcome, are treatment effects independent of the favorable prognostic factors on admission?

The left-hand columns of Table 3.11 confirm the previous findings of many investigators. Over the short term, social stability is an important predictor of alcoholism outcome. Premorbid marital status, employment, residential stability, first-admission status, and the absence of previous drunk arrests all significantly predicted who would become a stable remission by 1979.

Many other factors often cited in short-term studies (Gibbs and Flanagan 1977) were not important at the end of eight years. These factors included length of education, presence or absence of physiological dependence on

Causes of death

Female - male comparison

Three key questions to be discussed.

- (1) what predicts success: a good social situation on admission, or just getting sober?
- (2) does treatment help?
- (3) does successful treatment depend on the patient's state at admission?

- (1) Predictors of success were marriage, employment, house, status at first admission, and no previous arrests.

TABLE 3.11. Association of ^{admission}premorbid and outcome social-adjustment variables with alcohol abuse and AA membership.

Variable	Clinical status (1979)		Use of AA (1972-1979)	
	Stable remission (n = 29) ^a	Chronic alcoholism (n = 47) ^a	0-99 visits (n = 68)	100+ visits (n = 32)
Admission variables (1971)				
Prognosis scale items				
Stable psychosocial adjustment				
Married	45	28	41	22*
Employed	31	13*	29	22
Never before detoxified	21	11	25	3*
2+ prognosis scale items present	31	13*	32	9*
3 or 4 on Straus-Bacon scale	31	13*	26	16
Never in jail	41	13*	29	28
Outcome variables (1979)				
Skid row adjustment	0	52*	30	22
Stable psychosocial adjustment				
Living with spouse	66	9*	24	47*
Employed	79	18*	35	58
Dead	10	40*	37	13*
300+ visits to AA	48	2*	0	60*

a. The 24 patients manifesting "intermittent alcoholism" have been omitted from this table.

*Significance $p < .05$ (chi-square test).

alcohol, a year or more of previous abstinence, previous exposure to Alcoholics Anonymous, age on admission, and adolescent alcohol abuse. As we have already seen in the contrast between the College sample and the Core City sociopaths in Figures 3.3 and 3.4, even social stability is not such an important predictor of alcoholism outcome over the very long term.

It can also be appreciated from Table 3.11, however, that when premorbid psychosocial adjustment was controlled, freedom from alcohol abuse was powerfully associated with improved future social adjustment. In 1972, 6 of the 29 stable remissions had been living a "skid row" psychosocial adjustment; none were in 1979. Similarly, only 8 of the stable remissions enjoyed a "stable"

The table shows an expected result: when the effects of initial psychosocial adjustment were removed, sobriety was strongly associated with better living conditions.

psychosocial adjustment in 1972, but 20 did in 1979. Twice as many of the stable remissions were employed in 1979 as had been employed in 1972. Compared to Clinic subjects with stable remissions, chronic alcoholics were four times as likely to die, four times as likely to be unemployed, and far more likely to be living in single rooms, halfway houses, or the streets. Age was not an explanatory variable.

Table 3.11 shows a striking finding that requires amplification. Half of the stable remissions, but only two of the chronic alcoholics, had made 300 or more visits to Alcoholics Anonymous. Once again, the question that prospective study must address becomes one of causality. Is AA attendance merely a manifestation of good premorbid social adjustment or a result of sobriety? Or does frequent AA attendance actually alter the course of the disease? The right-hand columns of Table 3.11 relate the premorbid and outcome social-adjustment variables to attendance at AA meetings. Whereas social stability in 1972 predicted stable remission, social *instability* in 1972 predicted heavy use of AA. Put differently, premorbidly socially stable alcoholics tended to become abstinent without Alcoholics Anonymous, but if socially unstable alcoholics were to recover, AA attendance seemed very important. Thus, 32 patients attended AA meetings 100 or more times (mean 600 visits) between 1972 and 1980; the number of these individuals with stable psychosocial adjustment went from 2 in 1972 to 15 in 1980.

Multiple regression analysis revealed that both the number of favorable preadmission prognostic items *and* the number of postadmission AA visits explained large and independent amounts of the outcome variance. The first four prognostic items in Table 3.11 explained 25 percent of the variance of current social adjustment and 7 percent of the variance in the categorization of clinical outcome; number of AA visits explained an additional 19 percent of the variance in current social adjustment and an additional 28 percent of the variance in the clinical outcome of alcohol abuse. If both the prognostic items and AA visits were controlled, then the Straus-Bacon scale and other premorbid variables explained little further variance.

Table 3.12 puts the relationship between Alcoholics Anonymous visits and premorbid prognostic factors into still sharper relief. There were 66 men who made fewer than 300 visits to AA *and* on admission had manifested fewer than three of the four favorable prognostic items: only 7 (11 percent) of these men achieved stable remission. There were 34 men who had more than 300 visits to AA *or* who had manifested three or four favorable prognostic items

As would be expected, chronic alcoholics had worse living conditions.

"Half of the stable remissions, but only two of the chronic alcoholics, had made 300 or more visits to AA." (Note: over 8 years, 300 visits = every 10 days)

Did people just go to AA when they were ready to get sober? Or was AA the cause of sobriety?

Interestingly, socially stable alcoholics got sober without AA, but socially unstable alcoholics attended AA and showed improvement in drinking and social adjustment.

TABLE 3.12. Interrelationship among good prognosis, Alcoholics Anonymous attendance, and stable remission.

Prognosis and AA attendance	Clinical status (1979)		
	Stable remission (n = 29)	Intermittent alcoholism (n = 24)	Chronic alcoholism (n = 47)
Two subgroups			
> 300 AA visits (n = 19)	48%	17%	2%
Prognosis score 3-4 (n = 15)	28	17	6
Total sample			
< 300 AA visits and prognosis score 0-2 (n = 66)	24	67	91
> 300 AA visits or prognosis score 3-4 (n = 34)	76	33	9

on admission: 22 (65 percent) of these men achieved stable remission. No clinic patient had three or four favorable prognostic items and subsequently made 300 or more visits to AA. In other words, social stability on admission and AA utilization seem clearly additive.

Four illusions obscure our view of the natural history of clinic treatment. One illusion is that early, intensive treatment of alcoholism is usually effective. The second illusion is that the chronic relapsing alcoholic is untreatable. The third illusion is that alcoholism must inevitably end in abstinence or death, and the fourth is that the course of alcoholism is so intermittent as to defy classification. Let me reconcile these illusions one by one with the Clinic results; in so doing, I hope to reconcile the black and white outcome of the Clinic study with contradicting studies in the literature.

On the one hand, the apparently high recovery rates reported in intensively treated alcoholics are often an illusion produced by studying a selected subsample of previously untreated samples of employed men who retain their jobs. For example, the outcome results from industrial alcohol programs are outstanding (Clyne 1965; Asma et al. 1971); but the design of such studies tends to emphasize successes and lose track of failures. The illusion can also result from a brief time frame. For example, Moos and colleagues (1978) reported that during the sixth month of follow-up, 46 percent of Salvation

There was very little overlap between socially stable patients and the socially unstable patients who attended AA. These results suggest that AA helped those who had nowhere else to go.

(end of this section)

8 *≈ The Doctor's Dilemma*

While writing this book, I received an invitation to a conference on alcohol treatment from Griffith Edwards, director of the Addiction Research Unit of the Institute of Psychiatry at the Maudsley Hospital in London. He noted that for seven years I had been codirector of an alcohol treatment program about which I was enthusiastic. He also noted that for many years I had been keen on long-term follow-up research. Keeping these facts in mind, Professor Edwards presented me with a dilemma:

What we are hoping is that you will try to portray the picture of the research-minded treatment man, who jolly well knows that much of the evidence isn't there to support his treatment methods, or who feels that the evidence may even contradict his practices. Nonetheless, he may sense that the research often in some ways goes blindly past what is seen in the clinic, and that he may choose to trust his own nose rather than what the papers say. Is he a fool, or a knave, or a sensible man? . . . How do we retain open-mindedness without losing confidence to deal with the next patient who is certainly expecting our help?

This chapter represents my efforts to resolve that dilemma.

Thomas Szasz (1972) would have us believe that alcoholism, like the dilemma, is a mythical beast. Unfortunately, sometimes mythical beasts are endowed with real horns. One horn of my dilemma is that Szasz, Al-Anon, and the best follow-up research instruct would-be caregivers that they are powerless over alcoholism. To try too hard to *cure* an alcoholic is to break one's heart, and many follow-up studies suggest that elaborate treatment may be no better than brief sensible advice (Orford and Edwards 1977). The other

British researcher Griffith Edwards set Vaillant a challenge: why give alcoholics clinical treatment when research shows that treatment doesn't work?

horn of my dilemma is that to ignore a chronic malady as painful to the individual, as damaging to his health, as destructive to his family, and as refractory to willpower, to motivation, and to common sense as alcoholism—for doctors to ignore such a malady—is unconscionable. What are we to do?

The Clinic Sample as an Illustration of the Dilemma

My own awareness of Edwards's dilemma began 10 years ago, when I was asked by the relatives of an alcoholic friend for help. The friend, aged 55, was quietly drinking himself to death. He had exhausted the patience of probably the wisest family doctor in Boston; he had frustrated the staff at perhaps Boston's finest teaching hospital; he had managed to spend several weeks in an excellent Boston psychiatric hospital as a "bipolar depression" without noticeable improvement. His relatives pointed out that I was considered knowledgeable about addictions. What or whom could I suggest? I called a few very senior colleagues and then reported back that no one on the faculty of my medical school was expert in the treatment of alcoholism and that, as best I knew, modern medicine had little to offer.

Shortly afterwards, as part of the trend in both America and England to acknowledge the enormity of the problem of alcohol abuse, the Cambridge and Somerville Program for Alcohol Rehabilitation (CASPAR), was started at the Cambridge-Somerville Mental Health Center. Since the sister cities of Cambridge and Somerville contained an estimated 20,000 alcoholics, the decision was made to redeploy present services so as to offer much less intensive help to many more people. The single staff member, who, by appointment, had offered therapy and counsel to these 20,000 souls was replaced by a much better staffed walk-in clinic.

Caught up in the historical moment and because private specialists and academic medicine had been found wanting, my friend turned to this public clinic. He found hopeful paraprofessionals who were willing to meet his needs as he saw them and who discussed alcoholism as if it were a disease—neither a psychological symptom nor some vague unnamed metabolic riddle waiting to be deciphered. The CASPAR staff invited him to groups that they led, with other alcoholics. In part, these groups were designed as stepping stones between the walk-in clinic of a municipal hospital and eventual use of the cheaper, more accessible resources of Alcoholics Anonymous. But my friend had often previously refused to consider Alcoholics Anonymous a viable alternative. He was no joiner; he rarely went to church; he was an artist; and

Anecdote: an 'untreatable' alcoholic who was treated in a brand new treatment network, started going to AA, and became sober.

he was much too sophisticated—both socially and intellectually—to get involved in AA. After two years of clinic contact in the acceptable “medical” environment of CASPAR, he found his way into AA. Two years later he became a group chairman, and to the best of my knowledge his family relationships and health have been gradually restored.

Supported by the generous infusion of government funds into community-based mental health programs for the treatment of alcoholism, I too, was caught in the historical moment. Two years after I had told my friend that I knew of no treatment for alcoholism, I joined the staff at Cambridge Hospital as a psychiatric consultant to CASPAR. This program was designed on a medical model, was based in a general hospital, and was directed by an internist. The program included round-the-clock walk-in counseling to patients and relatives, “wet” and “dry” shelter, groups, and immediate access to detoxification and to medical and psychiatric consultation. CASPAR offered alcohol consultation to the medical, surgical, and psychiatric wards of the hospital; it provided halfway houses for homeless men and women and a comprehensive alcohol education program to an entire city school system. At present, CASPAR sees 1000 *new* clients a year, carries out 2500 detoxifications (50 percent directly referred from the police), and receives 20,000 outpatient visits a year. Annually, the program costs about a million dollars including educational personnel; and no one is denied treatment because of multiple relapses, poor motivation, poverty, criminal history, or skid-row lifestyle. At the same time, because skilled and hopeful consultation is always available, the rich have come as well as the poor.

When I joined the staff at Cambridge Hospital, I learned about the disease of alcoholism for the first time. My prior training had been at a famous teaching hospital that from past despair had posted an unwritten sign over the door that read “alcoholic patients need not apply.” Next, I had worked for years at a community mental health center that, in spite of a firm commitment to meeting the expressed mental health needs of the community, ignored alcoholism—which, after all, was untreatable and might overwhelm the clinic. At Cambridge Hospital I learned for the first time how to diagnose alcoholism as an illness and to think of abstinence in terms of “one day at a time.” Instead of pondering the sociological and psychodynamic complexities of alcoholism, while at the bedside I learned how to keep things simple. (If the oversimplification inherent in Jellinek’s disease model works mischief in research, too much doubt and vagueness wreak havoc in the clinic.) My ability to interview alcoholics improved. To me, alcoholism became a fascinating

Vaillant joined this new treatment program as psychiatric consultant.

TABLE 8.1. Comparison of selected two-year follow-up studies.

Study	<i>n</i> in original sample	<i>n</i> followed up	Duration of follow-up (years)	Abstinent or social drinking	Improved	Abusing alcohol
Clinic sample	106	100	2	20%	13%	67%
Three pooled "no treatment" studies ^a	245	214	2-3	17	15	68
Four treatment studies ^b	963	685	2	21	16	63

a. These are studies by Orford and Edwards (1977), Kendell and Staton (1966), and Imber et al. (1976). Because at 1 year there was no difference between Orford and Edwards's treated and control populations and because at 2 years their report did not clearly separate the two populations, all 85 of their subjects on whom they had 2-year follow-up are included.

b. These are the studies by Belasco (1971), Bruun (1963), Robson, Paulus, and Clarke (1965), and van Dijk and van Dijk-Koffeman (1973).

disease. It seemed perfectly clear that by meeting the immediate individual needs of the alcoholic, by using multimodality therapy, by disregarding "motivation," by turning to recovering alcoholics rather than to Ph.D.'s for lessons in breaking self-detrimental and more or less involuntary habits, and by inexorably moving patients from dependence upon the general hospital into the treatment system of AA, I was working for the most exciting alcohol program in the world.

But then came the rub. Fueled by our enthusiasm, I and the director, William Clark, tried to prove our efficacy. Our clinic followed up our first 100 detoxification patients, the Clinic sample described in Chapter 3, every year for the next 8 years. Initially we created a control group comprising the patients we rejected because our beds were full, but after a few months this seemed pointless. Our treatment network was sufficiently widespread that eventually controls reapplied and were accepted for treatment.

Table 8.1 shows our treatment results. After initial discharge, only 5 patients in the Clinic sample never relapsed to alcoholic drinking, and there is compelling evidence that the results of our treatment were no better than the natural history of the disease. In Table 8.1, the outcomes for the Clinic sample patients are contrasted with two-year follow-ups of four treatment programs that analyzed their data in a comparable way and admitted patients similar to ours. The Clinic sample results are also contrasted with three studies of equal duration that purported to offer no formal treatment. Although the

Vaillant had high hopes for the new program of crisis intervention, multi-modal treatment (halfway houses, detox, etc.), and referring patients to AA.

However, the 8-year study of severe alcoholics showed a dismal recovery rate. For example, 95% of patients had at least one relapse during the 8 years, and the recovery rate was no greater than the natural rate of remission, without any treatment at all.

The success rate in the clinic study was no better than other studies of untreated alcoholics.

TABLE 8.2. Long-term follow-up of treated and untreated alcoholics.

<i>Study</i>	<i>n in original sample</i>	<i>n followed up</i>	<i>Duration of follow-up (years)</i>	<i>Abstinent or social drinking</i>	<i>Improved</i>	<i>Abusing alcohol or dead</i>	<i>Dead</i>	<i>Gamma alcoholics</i>
Clinic sample	106	100	8	38%	7%	55%	29%	95%
Myerson and Mayer 1966	101	100	10	22	24	54	20	100
Brattfos 1974	1179	478	10	12	25	63	14	87
Goodwin, Crane, and Guze 1971	123	93	8	26	15	59	5	c.75
Voetgin and Broz 1949	?	104	7	22	13	65	?	?
Lundquist 1973	200	200	9	27	20	53	22.5	c.75

treatment populations differ, the studies are roughly comparable; in hopes of averaging out major sampling differences, the studies are pooled. Costello (1975), Emrick (1975), and Hill and Blane (1967) have reviewed many more disparate two-year outcome studies and have noted roughly similar proportions of significantly improved and unimproved alcoholics. Not only had we failed to alter the natural history of alcoholism, but our death rate of three percent a year was appalling. How was I to answer Griffith Edwards's Socratic inquiry? However, if our death rate was rather inconsistent with a mythical affliction, it was all too consistent with the medical model of alcoholism as a disease.

The CASPAR treatment program was open-ended. A majority of the unremitted Clinic alcoholics continued to return to our treatment program and, as illustrated in Chapter 3, improvement continued.

In Table 8.2, the results of the Clinic sample at eight years are compared with five rather disparate follow-up studies in the literature which are of similar duration but which looked at very different patient populations. Once again, our results were no better than the natural history of the disorder. Admittedly, Kissin has warned us that "Perhaps negative results should be reported even more cautiously, since almost everyone tends to view positive ones with a jaundiced eye and to take negative ones at their face value" (1977, p. 1087); but I did not find this warning comforting. Edwards's dilemma seemed a real enough beast.

Natural Healing Forces in Alcoholism

Recently the *Annals of Internal Medicine* editorialized that "the treatment of alcoholism has not improved in any important way in twenty-five years" (Gordis 1976). Alas, I am forced to agree. Perhaps the best that can be said for our exciting treatment effort at Cambridge Hospital is that we were certainly not interfering with the normal recovery process. How can I, a clinician, reconcile my enthusiasm for treatment with such melancholy research data?

The answer derives from addressing the second horn of the dilemma. The problem of alcoholism is too immense and the pain it causes too severe to suggest that hospitals once again hang out signs that read "alcoholics need not apply." The demands alcoholism places on the health-care delivery system are too pervasive to tell government bodies that it is useless to fund large-scale treatment programs. It is not a step forward to say that alcoholism is the sole

(end of this section)

Shadel's rules #7 and #9 were "Develop other outlets" and "Get your strength for living from a desire to help yourself and others and not from the bottle. Help other alcoholics to master their problem." As they were encouraged in group activities, a comradeship developed among the patients. As well as taking disulfiram, Wallerstein's patients stayed in a psychodynamically oriented hospital for three months and attended therapy groups. Shadel wrote that as each alcoholic came into his clinic environment, "it is interesting to see how the gang of old patients goes to work on a new patient"; and Shadel's patients were encouraged to continue groups after leaving. As Beaubrun put it, "It was not enough to tell a patient to attend a meeting; someone was sent to bring him to the first few meetings until he got accustomed to the new group."

Why, then, has history been unkind to these individual treatment methods? Why, thus far, have none led to widespread replication? In the nineteenth century Sir William Osler wrote to a friend who had been treating tuberculosis, "That is a fine record . . . I'm afraid there is one element you've not laid proper stress upon—your own personality. Confidence and faith count so much in these cases" (Cushing 1925). Thus, because the clinicians listed in Table 8.3 brought the newest techniques of their decade to bear, they not only brought hope but also conveyed assurance to the alcoholics of their own power to cure. The Menninger Clinic in the 1950s was world renowned, and the Sobells' elaborate research unit at Patton State Hospital was an impressive stage set filled with scientific gadgetry.

Of course, with confidence and faith can come misleadingly enthusiastic evaluation of outcome data. Independent evaluation, especially after several years, is rarely as favorable as the initial report by the original treatment staff. Thus, the ten-year follow-up by Voegtlin and Broz (1949) suggested that Shadel's (1944) initial report of emetine aversion therapy was overly optimistic. The ten-year re-follow-up by Pendery and colleagues (1982) suggests that the Sobells' view of the value of training in controlled drinking was also too optimistic. Therapists must resign themselves to the fact that hope is unscientific.

The success of Alcoholics Anonymous—and its reasonable facsimiles, which are continuously being rediscovered—probably results from the fact that it conforms so well to the natural healing principles that Frank outlined and with Frank's general prescription for therapeutic group processes. Thus, the strategy behind our treatment of both the Clinic sample and the 8,000 other alcoholics who have sought help at CASPAR has been to involve them with Alcoholics Anonymous. As Table 8.4 illustrates, at Cambridge Hospital, if we have not cured all the alcoholics who were first detoxified over 8 years ago,

When dealing with incurable diseases, like tuberculosis once was, personality and state of mind helps. Hence AA's positive effects; it enhances the natural healing process.

TABLE 8.4 Use of Alcoholics Anonymous over time in the Clinic and Core City samples.

	<i>Core City sample</i>	<i>Clinic sample</i>	
n in original sample	110	106	106
n followed up	103	106	100
Duration of follow-up (years)	10–25	1	8
Abstinent or social drinking	51%	15%	38%
Improved	17%	19%	7%
Continued trouble or dead	32%	66%	55%
% of those abstinent who became abstinent through AA	37%	31%	65%
Average number of meetings per abstinent AA attender	300	n.a.	600

In the Clinic sample, 65% of stably abstinent subjects had attended AA.

the likelihood of members of the Clinic sample attending AA has been significantly increased. The table contrasts the AA use of the Clinic sample with that of the naturalistically derived Core City sample. In the Core City sample, 18 (or 37 percent) of the 49 men who achieved a year of abstinence became abstinent in part through AA. Each of these 18 men attended an average of 300 meetings. One year after treatment, 5 of the Clinic sample had achieved stable abstinence that had begun while regularly attending AA; but after 8 years, 19 patients—or 4 times as many—had attained a stable abstinence that began in part through AA. In the 8 years, these 19 patients, 65 percent of all those stably abstinent, had attended an average of 600 meetings. If one excludes the 3 highest attenders in each sample (who attended an estimated average of 1200 meetings each), then the 110 Core City alcohol abusers attended 3000 AA meetings and the 100 Clinic alcoholics attended 15,000—5 times as many meetings on a per capita basis. Admittedly, severity of alcohol abuse correlates with high AA utilization (Table 4.4).

In emphasizing the belief of the CASPAR program in Alcoholics Anonymous, I do not wish to suggest that Alcoholics Anonymous is the *best* answer; there are many paths to recovery in alcoholism, ranging from the diverse programs listed in Table 8.3 to the Anti-Bacchus and Amethyst Clubs in the

Soviet Union. We need to understand what is common to all of them. At the same time, we may need to recognize that the recovery process in alcoholism is best catalyzed not by a single episode of treatment but by fostering natural healing processes over time.

Resolution of the Dilemma

Let me now attempt to resolve my dilemma. First, and somewhat paradoxically, recognition of our limited ability to alter the course of alcoholism may lead to improved care, not chaos. Modern surgery took a giant stride forward when it realized that wounds healed best by natural methods and that wound healing could often be slowed, but could never be hastened, by zealous intervention. Modern medicine began when toward the end of the nineteenth century doctors gave up bleeding patients and abandoned virtually their entire pharmacopoeia. Today, psychiatry has a painful lesson to learn from the fact that schizophrenics have a better prognosis in underdeveloped countries than they do in developed ones (Sartorius et al. 1978). One of the few conclusions that Emrick (1975) drew from his scrutiny of 384 alcohol follow-up studies was that it may be easier for improper treatment to retard recovery than for proper treatment to hasten it. Once recovered, several of the College sample saw their psychotherapy as having retarded recognition of their alcoholism.

Second, we have much to learn from how medicine before 1950 learned to cope with tuberculosis. We do not wish to squander either our natural resources or our own time on just a few alcoholics. Rather, we want to reach as many patients as possible. By remembering the first step of Al-Anon, "And we admitted that we were powerless over alcohol," we protect ourselves from maintaining the guilty illusion that if we just try harder, we can *cure* the alcoholic. Indeed, a major task of any psychiatric consultant to an alcohol program is to remind the staff that they are not to blame for their patients' relapses. At the same time, we never want to ignore the problem. Not surprisingly, results reported by Kissin and colleagues (1968) suggest that openly ignoring alcoholics on a waiting list produced an improvement rate of only 4 percent—far worse than naturalistic studies in the literature. As Seligman (1975) reminds us, hopelessness kills.

Third, at the same time that Ambroise Paré gave us his humble epigram "I dressed him, God healed him," he had the wit to invent the surgical ligature to stop hemorrhage. In 1978, CASPAR provided medical and social assistance

So what to do about clinical treatment?

First, admit that it is of limited effectiveness.

Second, even if there is no cure, we can't simply give up on severe alcoholics.

to twice as many alcoholics as the entire Connecticut Department of Mental Health provided in 1965 to a catchment population that was *10 times* as large (Shepard 1967). I have no doubt that by providing consultation, detoxification, welfare, and shelter, we stop hemorrhage.

Besides, the samaritan role is not to be sneezed at—especially in chronic disease. When large benefits are not forthcoming, patients will be especially grateful for small ones.

Fourth, I believe that honesty brings its own reward. We must remain alert to the limitations of our alcohol treatment programs. Otherwise, national health schemes may suddenly regard as cost ineffective *all* alcohol treatment, rather than just long hospital stays. Anyone familiar with the therapeutic milieu of a high-cost, high-intensity, high-morale two-to-four-week inpatient treatment unit will find the pessimism of this statement hard to believe and yearn for a controlled study. But when such studies have been undertaken, their findings have indicated that prolonged inpatient treatment appears to contribute nothing additional to outcome (Stinson et al. 1979; Costello 1980; Edwards and Guthrie 1966, 1967; Willems et al. 1973).

The 67 percent rate of improvement with treatment originally suggested in the Rand Report (Armor et al. 1978)—an illusion produced by attrition, by cross-sectional design, and by ignoring the law of initial values—will become dangerous if clinical staff and legislators discover that such hopeful results are a cruel cheat, and if doctors and public funding sources withdraw support that give hope and care to alcoholics.

Fifth, even if alcohol treatment does not indubitably alter the long-term course of alcoholism, it does help over the short term (McLellan et al. 1982). Far more concretely, outpatient alcohol treatment saves money. There have now been at least 12 controlled cost-benefit studies of health maintenance organizations and employee-based alcoholism programs (Jones and Vischi 1979; Reiff et al. 1981). The uniform conclusion of these studies is that the cost involved in providing outpatient alcoholism programs is more than repaid by the decline in medical care utilization, in sick days, and in sickness and accident benefits.

Third, we can't cure, but we can still provide emergency care and shelter.

Fourth, stay aware of limitations: longer inpatient treatment does not give an advantage over shorter treatments.

(Honesty is important, or legislators may feel cheated.)

Fifth, clinical treatment does help in the short term, and many studies show a concrete result: the costs of clinical treatment is more than repaid by reduction in health care costs.