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TREATMENT OF INEBRIETY.*

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WHAT I have to say may rightly be considered to be new applications of old theories. The problem of the cure and treatment of the drunkard has been before us for many years. The increasing prevalence of this condition, the enormous yearly expenditure of money incurred in taking care of these persons, and particularly the futility of the punitive system now so universally practiced, has aroused public interest, and there is a universal demand that adequate provision be made for the proper treatment and care of these unfortunates.

The lack of uniformity of opinion in the profession regarding the nature and treatment of inebriety must serve as my excuse for bringing before you a much-discussed subject. While many physicians accept the dictum that inebriety is a disease, others accept it tentatively and frankly acknowledge that their conception of the trouble is vague and misleading. This lack of cordiality of the physician, partially justified, it is true, is in great part responsible for the interest in the cure of the disease shown by lay members. Realizing that the medical profession as a whole is seemingly disinterested, they have championed measures for the cure of alcoholism, which cures have been effective to a greater or lesser degree. Besides these well-meaning persons who are making honest attempts to do something for the suppression or amelioration of inebriety, we have the omnipresent quack who, taking advantage of the credulity of the public, and recognizing the indifference of his natural enemy, the physician, has had a rich field in exploiting his cures for the treatment of drunkenness.

Twenty years ago disorders of the mind were understood by comparatively few physicians, and the differentiation and treatment of mental disease now so accurately defined was a mystery. The science of psychiatry is to-day well established; its development and recognition by the medical profession has resulted in much good to the public and has brought fame and honor to the physician.

This increased study given to morbid psychology has enhanced the value of the study of the neuroses, psychoneuroses and the borderland cases, and this has given us a recognized treatment which we conveniently call psycho- or

mental therapeutics. Whatever application we give to this form of treatment, or however we are inclined to interpret it, we cannot but acknowledge that its legitimate use is attended with good results.

It is one of the objects of this paper to show that inebriety from a diagnostic and curative point of view belongs to the medical profession. If this were generally recognized it is believed that many questions related to drunkenness, now debatable, would be satisfactorily answered. To emphasize this I quote authoritatively.¹ "The most important factor of all is the attempt to prevent the spread of alcoholism. Although it is supposed to be a sociological question, its ultimate solution rests largely with the medical profession. A great deal can unquestionably be done by the physician in educating the public to investigate these evils. Careful instruction should be given in schools regarding the effects of alcohol, but unfortunately much that is now given is based upon imperfect observation, and facts are so distorted that, to say the least, little good has thus far been done. The causes of inebriety are in many cases so complex and so far reaching in their consequences that a very careful analysis is desirable before this question can be successfully dealt with."

It is unnecessary to state that the physician should be the one in authority to direct and control such educational measures. The physician should take the initiative and should be the promoter of any contemplated plan for the custodial or curative treatment of these delinquents. I am pleased to report that several states have recognized the importance of this and that at least two states have legislation pending in which the medical man has taken the initiative. I do not want to be misunderstood when I maintain that the problem is a medical one, as I realize that there is no question of public interest that needs to be more thoroughly studied by the student and worker in sociological fields. We need help and lots of it, but as a medical profession we should direct and control this work. My experience has convinced me that the greater number of non-medical workers on this subject are willing to accept the directorship of the medical profession and are anxious and ready to lend aid; likewise, I am confident that without their co-operation our work would be unsatisfactory. Parmelee² writes as follows:

"The study of inebriety, like the study of every social evil, has many aspects. It has its biological and psychological as well as its economic, political and other social aspects. On account of its pathological character it is frequently of interest to the neurologist and alienist. It is, therefore, evident that in the course of a single investigation made by a single individual it would not be possible to cover the whole of the subject of inebriety. In fact, no single individual could very well, in the course of an indefinite number of investigations, study all the varied aspects of

* Read at the annual meeting of the Suffolk District Medical Society, April 30, 1910.

¹ Paton: Psychiatry, p. 310.

² Inebriety, Boston, p. 7.

inebriety, for he could not possess all of the special knowledge necessary for so complete a study."

Therefore, from both a sociological and medical point, the question is of importance and the time is certainly propitious for the inauguration of a plan which will differentiate the types of inebriates, care for them scientifically and practically, and place them under medical supervision.

Before describing the modern treatment of inebriety as practiced at the Foxborough State Hospital, I wish to prove the clinical entity of the inebriate. As we are dealing with the habitual drunkard, one in whom intoxication is frequent or constant, I quote from the special report of the board of trustees, submitted to the General Court of 1910: "Medical experts show that where drunkenness has become habitual, a predisposing cause is almost invariably traced in the mind or body of the patient. Drunkenness must in such cases be regarded as a disease, or as the form which certain illnesses take with certain patients. The starting point of disease is often difficult or impossible to trace. The habitual drunkard cannot be sharply distinguished from the occasional drunkard. There is an intermediate group, in whom, through use of alcohol, a craving for that drug is developing. They drink, not to satisfy the thirst which water satisfies, but to fill a craving for either the immediate (stimulating) or remote (narcotic) influence of the drug alcohol. Continued use of alcohol, especially in large quantities, weakens will-power and gradually destroys responsibility. In this borderland are cases who begin to show signs of abnormality — men ordinarily industrious, who let their business suffer through debauch; men ordinarily affectionate, who neglect their homes for saloon or club. They are habitual drunkards in the making.

"Medical specialists in inebriety classify habitual inebriates as follows:

"The first group comprises men originally of normal health of mind and body, but who, through overwork, domestic or business trouble, coupled perhaps with poor hygiene, unsanitary homes or poorly cooked and ill-chosen food, have lowered their power of resistance. With frequent indulgence in alcohol or drugs, self-control gradually has been destroyed and the patient becomes powerless to discontinue his habit. The craving for narcotics (narcomania) becomes all-absorbing. Under ordinary conditions he is unable to overcome the habit. Cases of this type studied at the Foxborough State Hospital almost invariably have displayed further symptoms of mental abnormality. This is the most curable class of pathologic inebriates.

"A second group, whom physicians often treat apart, are the 'periodic drunkards,' men ordinarily temperate or even abstinent, who at periods some weeks or even months apart are seized with a mania for drunkenness which may be continuous through a number of days. This period is followed by complete sobriety for weeks or months. This form of dipsomania, which is sometimes simulated by willful drunkards, is more

rare than other forms of inebriety and is often classed technically as a variety of insanity.

"The last group comprise the defectives and degenerates among drunkards. Alcoholism of the patient or of his parents may in some of these cases have brought on directly or indirectly the low mental or physical condition. But it is equally true in other cases that imbecility, insanity or other forms of defectiveness or degeneracy have preceded and have been responsible for the excessive use of alcohol. The physicians in charge of the largest houses of correction and other institutions in Massachusetts to which drunkards are sent are inclined to assert that the large majority of habitual drunkards in their care are men of less than normal mentality. To this class must be added a considerable group of men past their prime of life, in whom the habit of drinking has been intensified as the period of mental and physical decline (involution) has set in. Resistance in such cases is constantly lessened and inebriety may become chronic. The reduction of mental power characteristic in all members of this group renders cure improbable.

"There is another classification of drunkards which deserves to be considered apart. This differentiates the criminal from the non-criminal drunkard. The inebriate who offends against the law by larceny, assault or any crime other than public intoxication may be found obviously among accidental, occasional or habitual drunkards. But the type of treatment which he should receive should be different from that of other members of the foregoing groups. Even among criminal drunkards each case should be considered with reference to whether the man is criminal during periods of sobriety or only during periods of intoxication. Among women drunkards, also, distinction should be made with regard to the morality of the case during periods of sobriety and intoxication. If a man or woman is criminal or immoral only when intemperate, the vice may be but a phase of the disease of inebriety and curable with the cure of the original malady."

Perhaps these descriptions could be better emphasized by giving conclusions seemingly justified by our examination of 700 cases of inebriety which have come under our observation during the past two years:

1. Inebriety is an expression of nervous weakness or nervous instability; used in its simplest sense it could be called a psychoneurosis, many cases showing symptoms which are found in neurasthenic states and allied conditions. Addiction to alcohol is a symptom of an unstable nervous system, and the contrary view expressed by the laity is not justified by clinical observation or experience.

2. The exciting causes of inebriety are of a physical and psychical origin. Given a neurotic subject, crises may be precipitated by any marked departure from the ordinary routine (psychical) or by any disturbance of organic nature (physical).

3. Inebriety is prone to develop as a frank case at the critical epochs of life, namely, pubescence, adolescence and involution. Developing during

involution, it is generally the effort of an individual to maintain his productive power by recourse to artificial stimulation. The frequent inception of inebriety at these periods suggests an analogy to the psychoneurosis.

4. Inebriety, being an expression of neuropathy or psychopathy, may be preceded by or accompanied with a multiform nervous syndrome; thus each case is essentially different.

5. The heredity element in inebriety is considerable and is undoubtedly a powerful predisposing cause. A history of decided intemperance in the parents existed in over 40% of our cases, while 15% gave a history of defective ancestry, insanity, neuropathy, drug addiction or tuberculosis being present on the maternal or paternal side.

6. Approximately 5% of our cases showed pre-existent mental symptoms which could be differentiated. Some of these were distinct cases of psychasthenia, others were of the milder forms of manic-depressive insanity.

We feel warranted in corroborating the statement made by others that an inherited neurotic or psychic tendency is present in a considerable number of inebriates. Many of these cases admit peculiarities during pubescence and adolescence, showing clearly neurotic or psychopathic conditions which have antedated the alcoholic manifestation. We venture to say that our future study will support these conclusions.

The treatment of inebriety requires that we should consider the inebriate a diseased person in the sense before described. Recognizing that long-continued use of alcohol is capable of causing organic disease or a much impaired nutrition, we may, therefore, have a mental or physical syndrome. Necessarily the ordinary physical symptoms of acute alcoholism first demand our attention. If one be free from organic disease it is often a matter of surprise to see the marked recuperative power of some of the more confirmed and protracted cases of inebriety. Institutional treatment of the physical symptoms of alcoholism does not differ markedly from that ordinarily practiced. It is generally found that during convalescence from an alcoholic debauch the patient has little or no desire for alcoholic stimulants. If a patient should demand or require stimulants, the appetite can, as a rule, be controlled with little difficulty. It must be conceded, however, that hospital treatment has its advantages in that a physiological life can be more easily enforced. Symptomatic treatment of the inebriate is often indicated, and differs in no way from that commonly used.

There is no known drug which, when taken into the system, can permanently eradicate the desire for drink in an inebriate. When considering the value of drug treatment for the cure of inebriety it is first necessary to remember that the inebriate by nature is markedly neurotic, and, therefore, suggestible; this emotionality is pronounced but unfortunately not persistent unless special measures are instituted. There can be no doubt that the drug treatment in inebriety has resulted in

some happy successes. Unfortunately, we have no reliable statistical knowledge of these cures and, therefore, we are compelled to rely on individual statements. Many of the cases which have been under my observation during the past two years have had a drug treatment on one or more occasions. I have made a particular study of these patients, and with a few exceptions the patients credit any benefit which may have resulted from treatment to their determination and influences which would have resulted from a change of environment and consequent new interests and enforced mental and physical hygiene. Again, when placing any value on any special method of treatment of inebriety we think it necessary to consider the types of inebriety, namely, to determine whether the patient has been a regular, irregular or periodical drinker; the length of time a patient has been abstinent, and, lastly, a comparison of the man's present mode of living with his daily habits previous to his admission to the hospital. All of the patients discharged from the Foxborough State Hospital have been subjected to this investigation. Unfortunately, statements regarding cures of inebriety are generally lacking in these details, and until we adopt a uniform method of classification I do not believe that it will be possible to make any specific statement regarding the curability of the disease based on any method of treatment. There is no sure and rapid cure for inebriety. Remembering this, we can truthfully say that a certain percentage of cases can be permanently helped, others benefited by hospital methods, while still others are apparently incurable.

It should be understood that the matter of curability or amelioration in inebriety does not imply simple abstention from alcohol, nor does the hospital treatment include this and nothing more. It may be true that in some cases abstinence, whether voluntary or compulsory, is an incentive to the correction of the habit, but that it in itself is inadequate is clearly shown by the futility of prolonged and repeated terms of imprisonment.

Our experience has shown us that the success of hospital treatment in these cases depends upon (1) the ability of the patient to co-operate in treatment; (2) on our ability to introduce into the patient's life or mentality some tangible substitute for the desire for artificial stimulation. This substitute includes a redevelopment of the patient's self-respect and an entire readjustment of the patient to his environment. Such a result is brought about by attention to the patient's mental and physical hygiene, and necessarily depends upon educational measures inaugurated at the hospital and continued after the patient's dismissal from the institution. If aggressiveness to these principles, which may be shown by the patient, cannot be overcome, it is not probable that our treatment will meet with any great measure of success.

This seems an opportune time to say something of the promising case for hospital treatment. Our records show that, everything considered, the hopefulness of a case is in direct ratio to the

duration of the habit. The susceptibility of the patient to educational measures should also be considered. The younger case, if the case be a frank and uncomplicated one, is preferable, as in such a patient the habit is incompletely formed and the mind is freer from fixed prejudices and defects. Such a patient reacts more promptly and effectively to moral measures. All youthful cases are not desirable, as we have proven that in some of these cases the drinking habit is one of the many expressions of a moral perversion or delinquency. We have found that in some of the cases of an advanced age there has been a decided improvement after hospital treatment. It must, therefore, be remembered that the hospital may benefit some of the so-called unfavorable cases, and before eliminating these cases our purpose and custom is to give each case the closest possible scrutiny and medical analysis. It should, however, be understood that if we consent to receive these patients we should have the privilege at any time of discharging them and of refusing their return to the hospital for treatment.

Remembering that we have in inebriety a nervous weakness plus a habit, the mental treatment of the inebriate, as may be surmised, does not differ materially from the usual methods employed in the treatment of the so-called neuroses and many cases of functional nervous disease. As is well known in many neurasthenic, hysterical and obsessional cases, we have, excluding the manifestations of the nervous condition, a habit which requires correctional methods. This analogy is seen in all cases of inebriety.

The methods of treatment employed at the hospital are of the simplest nature and have proven eminently practical. The personal equation is always considered, and educational measures are consistently employed.

The object of psychotherapeutic treatment, as declared by the French school, would be to make the patient master of himself, this being accomplished by the education of the will or, more exactly, of the reason. E. W. Taylor's admirable article on "Simple Explanation and Re-Education as a Therapeutic Method" is an excellent exposition of a successful and concise way of applying psychotherapeutics.³ The method clearly described is a ready means of applying mental therapeutics, and we have used it with good results in the treatment of many of our cases. As the author states, its purpose is to draw attention to the simplest and, therefore, to the most widely available methods of psychotherapeutics and to attempt to show how such a method may be made practically useful by the physician.

We must not forget that in inebriety, as in other nervous diseases, individualization is demanded and is essential if we wish to obtain any great degree of success. Those who have had experience in the treatment of functional nervous cases of whatever type will agree with me when I say that after-treatment of these cases is all-

important and that after-care should be provided. Relapses are likely to develop when least expected and should be carefully guarded against.

Inebriety is no exception to this rule. The recovery from the social and financial loss which the inebriate invariably experiences is often a matter of considerable difficulty, and notwithstanding his best efforts, continued reverses may prove a hindrance to his complete recovery.

To provide for this condition, and aid us in our policies which we have inaugurated at the hospital, we have established an out-patient department. This department is in the charge of a physician, and its purposes can be defined as follows: (a) To assist in determining whether a prospective patient is a proper subject for the hospital; (b) to visit friends and relatives of patients previous to their discharge from the institution and to investigate their home surroundings, social conditions, etc.; (c) to aid patients to find congenial and remunerative work; (d) to give suitable medical after-care.

This department is now organized and is in successful operation. The anticipated benefits are already seen, and it is not only of value to the patient, but is of decided economic value to the state.

It was also early demonstrated that in many cases prolonged institutional treatment was a decided hindrance to cure as well as a hardship to the patient. With the aid of the out-patient physician it is now possible to allow patients to leave on trial at an opportune time, placing them, with their consent, in charge of the physician, who, with the patient's co-operation, continues the treatment which has been begun at the hospital. If the surroundings of the patient are not congenial, or if he should relapse, his return to the hospital is recommended.

I have before maintained that a state hospital for the treatment of inebriety should receive and treat exclusively the case which is likely to be benefited. It should have adequate equipment for the treatment of such cases and should have facilities for segregation and individual treatment of the diverse types.

The conditions at present at the state hospital are inadequate; we believe that with better facilities the usefulness of the hospital would be considerably extended.

The trustees of the hospital have petitioned the legislature for an appropriation in order that they may establish a new hospital and colony which will take care of not only the hopeful inebriate of both sexes, but will also give custodial care to the better class of chronic or apparently incurable alcoholics. These requests are made in accordance with recommendations made by the board and incorporated in their report to the legislature.

To the question whether it is advisable to recommend institutional treatment for all cases, I would say that, in the majority of cases, the educational or re-educational measures, the basis of our treatment, can best be inaugurated at the hospital, the continuation of this treatment can be carried out away from the hospital under

³Taylor, E. W.: Simple Explanation and Re-Education as a Therapeutic Method. *Psychotherapeutics*, p. 77.

medical supervision and direction. No general rule can be given; as formerly stated, no two cases are similar, and for this reason individual treatment is required.

The position of the physician is clear; the case is seen by him in its incipency, in the formative stage, at the time when treatment will be most effective; it is his privilege at this opportune time to advise and sanction treatment. If the conditions and environment are not conducive to home treatment by the physician, treatment at the hospital should be advised. It cannot be denied that there is often a reluctance on the part of persons to place themselves under treatment until one or more of the physical symptoms related to alcoholism appear, or until the habit has been of some years' duration. The individual is inclined to look upon hospital treatment as a last resort, and unless correctly advised he is slow to take advantage of any opportunity for institutional care.

When a patient is discharged from the hospital he is placed in the charge of the out-patient physician, or, if the patient's physician should so desire, he can again come directly under his jurisdiction.

The recommendations as embodied in the special report of the board of trustees are timely and should receive personal consideration from each member of the medical profession. I anticipate that the medical profession of the state will be interested in the policies of the Foxborough State Hospital, as we realize that without their help any great measure of success is impossible. I am sure that I voice the sentiments of the board of trustees of the Foxborough State Hospital when I ask for your earnest consideration and complete co-operation.

TUBERCULOUS PERITONITIS.*

A PLEA FOR THE TREATMENT OF PERITONEAL TUBERCULOSIS BY HYGIENIC RATHER THAN SURGICAL MEASURES.

BY ARTHUR K. STONE, M.D., BOSTON,

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In regard to the treatment of tuberculous peritonitis, most American operators and many physicians hold practically the following view, which was expressed at a symposium held in New York in 1909:

"It is a peculiar thing, but it is thoroughly demonstrated, that surgical treatment of tubercular peritonitis gives relief in the vast majority of instances by simply opening the abdomen. Nothing further is required. Another point is that the surgeon can remove, sometimes, a focus of tuberculosis, for instance, in the appendicitis cases, also in tuberculosis of the tubes and uterus; he can remove his focus and then have an enormous advantage over any possible thing he could do for the lungs. Otherwise the cases should go along just about as in the lung cases."¹⁴

* Read at a meeting of the American Climatological Association, Congress of American Physicians and Surgeons, Washington, D. C., May 5, 1910.

This belief in the miracle of surgery has a firm hold upon very many of the medical profession, and by it, the desire to do something decisive is satisfied. But the thoughtful surgeons take a much more conservative ground, and though they may not be willing to subscribe to the extreme position of Borchgrevink, the Swedish surgeon, that all operations are harmful, yet they are more and more reluctant to operate. Where, however, there are no distinct indications beyond the presence of ascitic fluid, and the diagnosis of tuberculous peritonitis, they justify their operations by reference to the statement of Mayo, that tuberculous foci can frequently be found and removed to the great advantage of the patient.

To oppose indiscriminate operation in the face of the work of the past twenty years is an uphill proposition. The burden of proof is in favor of operation. Nevertheless, it is our duty to scan the various facts that have been collected and see if they are all in accord with the present interpretation of them.

Altogether there has been a great deal of misconception of the subject of tuberculous peritonitis, although it is really not difficult to understand when one considers the pathology of the condition. Cases are either of primary infection of the peritoneum, or of extension from distinct tuberculous foci in nearby organs, as the intestines, the tubes, the appendix or the retroperitoneal lymph nodes.

All cases are probably in a way secondary, for the method of invasion and lodgment of the bacillus of tuberculosis and development in any given individual has not been absolutely settled as yet. So far as we can make out, we find that the disease may be primary in the lungs, on a serous surface, in a bone or in a joint, or a lymph node, or some special organ, and no other focus be established that can be demonstrated. As the disease progresses, other organs are attacked, and by the time death intervenes to relieve the suffering patient, many unsuspected foci may be found at the autopsy. That there are not more such foci, and that the lesions are not more extensive and important, is always the wonder when one considers how, for example, in the pulmonary cases, the lesions are so situated as to make it seem that their most general diffusion would be inevitable.

To the man who would understand the development of tuberculosis in the abdominal organs, Ernest Mayland's²⁰ comprehensive book on abdominal tuberculosis is indispensable as a ground work.

Let us take a brief survey of the subject of tuberculous peritonitis that we may have a definite foundation on which we shall build our superstructure. Tuberculous peritonitis has been found in the newborn,⁹ and from this early starting point on to the octogenarian,³ no age is exempt, though naturally the two decades from ten to thirty years of age furnish the greatest number of cases.

In the matter of sex, the statistics of the general hospitals are of greater value than either those of autopsy records or reports of operations.