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THE AFTER HISTORY AND CARE OF INEBRIATES.*

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I PROPOSE to divide my subject into two parts, and to deal first with the question of After-History, taking as material for any figures I may employ, or any deductions that may suggest themselves, the records of a group of 1,024 inebriate patients who were consecutively discharged from Dalrymple House Retreat. Half the number have been under my care, the other half were under the treatment of my predecessor, Dr. R. Welsh Branthwaite, who is now His Majesty's Inspector of Retreats under the Inebriates Acts. After-Care, the valuable supplement to treatment, I propose to touch upon in the latter portion of my paper.

For the purpose of this communication I have particularly examined the records and histories of the patients to whom I have referred, in the hope that they would throw some light on the conditions, apart from after-care, which tend to give an inebriate a good chance of success. I have also dealt with points which may be of some little assistance, when added to the experience of others, in arriving at a reliable prognosis.

In taking some percentages concerning those who are reported as doing well—*i.e.*, under items 1, 2, 4, and 5, as given below—I have dealt with my own patients only, for about sixteen years have elapsed since Dr. Branthwaite left the Retreat, and it has

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not been possible for me to follow up his cases to the same extent that I have been able to do with my own. I do not propose, however, to trouble you with more figures than I can possibly avoid.

The particulars which I have selected, and to which I desire to make special reference, are: (1) Length of residence under control and treatment. (2) The type of inebriety, whether (*a*) regular (that is to say continuous) or (*b*) periodic. (3) Period or duration of excessive addiction. (4) Heredity—a family history of inebriety, insanity, or both. (5) Age at time of commencement of treatment. (6) Whether married or single. (7) Temperament.

1. LENGTH OF RESIDENCE UNDER CONTROL AND TREATMENT.

I find that of those who remained under treatment—

2 months or less	about 33 per cent.	are doing well.
Over 2 to 3 months	„ 41	„ „ „
From 3 to 6 months	„ 43	„ „ „
From 6 to 12 months	„ 45	„ „ „
Over 12 months	„ 47	„ „ „

The average period of treatment was about 5½ months.

It should be noted that included in those under two months are such cases as have, at an early stage, been found unfit for treatment, and also others who, for various reasons, have remained only a few days and have been barely “sobered up.” On the other hand, the last two periods embrace more borderland, mentally deficient and chronic cases in whom any permanent improvement can hardly be expected.

In the management of inebriety, in addition to any drug treatment or control that may be employed, time is a factor that has to be considered; it is in itself a continuation of treatment into which, though drugs may be discontinued, enters suggestion and self-education, the tiding over of periodic impulses and recurrences of desire for alcohol, and the training of the patient to a life of total abstinence. While endeavouring to give a person a sufficient time for this purpose, one has to avoid producing a condition of staleness, and to differentiate this condition from a returning craving.

The individual must be studied, and apart from the questions of finance, business, and domestic calls, etc., it is not always

easy to decide on the necessary length of stay in a retreat. In some cases a month is ample time—others require a year or more. I had one patient who remained with me for five years—far longer than I wished—and I had eventually practically to turn him out of the Retreat. However, this prolonged stay did him no harm, for he has more than once informed me, when we have met, that those five years were the making of him.

2. THE TYPE OF INEBRIETY—REGULAR AND PERIODIC.

After-histories show that while among the regular (or continuous) inebriates who have undergone treatment about 37 per cent. have continued to abstain, among the periodics the figure is 54 per cent. Patients have been classed in our Retreat records under these two main types according to the histories obtained: the regulars outnumber the periodics by about three to one. The proportion, however, is probably still greater, for the periodic *may* be a person who would be a regular inebriate if he could. The questions of opportunity and supply of ready money arise, and sobriety may be enforced by circumstances, rather than on account of lack of desire. Instances may be recalled of persons who take to drink on coming into a fortune—I have had such persons as patients—and there are doubtless many potential inebriates of the continuous type to whom comparative poverty is a blessing in disguise. One has only to call to mind the natives of North America, most of the African natives, and some of the Polynesian tribes who will, given the chance, drink themselves to death, and for some of whom legislative measures have to be enforced to prevent their extermination by alcohol.

3. PERIOD OF EXCESSIVE ADDICTION.

When the inebriate types are dealt with separately, I find that among total discharges the regular inebriate has an average of two years more excessive addiction than has the periodic.

Among those doing well the same average difference remains. In taking the mean addiction of some 1,100 to 1,200 cases discharged (the two types being taken together), a period of 8·8 years was arrived at. Among those doing well, out of the 1,024 discharges dealt with, the average addiction is 9·1 years. It will be noted that there is only a fractional difference in these figures. It is generally held that the shorter the addiction the better the chance of success. While this aphorism without

doubt holds in drug cases, it does not appear, taken by itself, to be applicable in the prognosis of alcoholism, unless due consideration be given to the amount of alcohol taken, its effect on the individual, and the sober intervals. Of course, even with continuous drinkers there are times, even months or years, when but little or no alcohol may be taken; and the periodic with a history of many years' periodicity may have long intervals between bouts. In obtaining the above figures there have been made no deduction for such breaks, which certainly have a beneficial effect.

4. THE RÔLE OF HEREDITY.

The point how far the patient's future will be affected by a family history of inebriety or insanity arises not only in consultation, but in the treatment of the patient himself, who is apt to excuse his failing on the ground that his father, mother, or other relatives were similarly affected; that therefore he "has no chance," "has it in the blood," "can't help himself," and so on. Among the 1,024 discharged patients there is a family history of drink or insanity in 64 per cent. Of these, taking drink histories only, 41·2 per cent. are doing well; taking very bad drink histories only, 37 per cent. are satisfactory; and taking those with family insanity only, 20 per cent.

I have mentioned that the regular inebriate outnumbers the periodic by three to one. An hereditary history is found in these types in the same proportions.

As regards good results, I find that each class of patient loses 4 per cent. by possessing such histories. Among my group of patients, commencing in the year 1899, about whom I received good reports, some are dead, others have relapsed after some months or years of abstinence, and there remain 41·3 per cent. who were doing well when I last heard of them. It appears, therefore, that a family drink history, excluding insanity, does not materially affect the after-history of the inebriate, unless the family addiction is a severe one, embracing both sides of the family or one side very largely. When there is a history of insanity the prognosis is still worse.

5. AGE OF THE INEBRIATE AT THE TIME OF TREATMENT.

By far the largest number of persons come under treatment when between the ages of thirty and fifty. Among my patients

more than two-thirds were between these ages. I have long noted the fact that drinking habits, which would not be deemed by some excessive, very frequently culminate in an inebriate condition at about the age of forty. Apart from the inebriety which follows head injuries, sunstroke, influenza, and other diseases, there is a large residue for whose condition no particular reason can be assigned, unless it be sub-acute chronic alcoholic poisoning. The usual history is that the patient drank like other men, with possibly an occasional excess, and perhaps no actual drunkenness till a period of one to three or more years before admission, when "the liquor seemed to take a hold of them." They didn't drink more, but what they took had an increased effect. It is quite customary to be told by such men that—"I used to stand it all right, now one glass upsets me." There must be in these cases some subtle physiological change in the person, in his metabolism, or in the power of nerve-cell resistance; an alteration which separates him from those who can continue to take alcohol with comparative impunity. The root cause may be temperamental, for they are mostly nervous and highly strung, and may spring from a neurotic stock.

I have grouped discharges under six periods of life, and give the percentages of good results, which are as follow :

Age.					Percentage doing well.
Under 25	...	...	...	...	about 26
26-30	...	...	...	...	show 50
31-40	...	...	...	...	„ 42
41-50	...	...	...	...	„ 40·7
51-60	...	...	...	...	about 46
Over 60	...	...	...	...	„ 36·8

The numbers admitted of those under twenty-five and over sixty are but small.

I think it may be laid down that the very young are the least likely to do well. They often have no intention to abstain, resent control, do not come under treatment voluntarily, and consider themselves badly treated by their parents or guardians who have exerted pressure in order to place them in a retreat.

6. WHETHER MARRIED OR SINGLE.

About an equal number among those discharged were married or single, but the married show much better results than do the single, and in the proportion of three to two. This is what one might expect, for, to touch on the after-care side, such extra domestic and financial troubles the married man may have are, presuming that he is happily married, more than compensated by the affection and care he receives from his family. He has not the same inclination to visit clubs, restaurants, or bars, for companionship. The welfare of his family, the example he should set to his children, and the good opinion of his neighbours and friends, are all assistant factors for the strengthening of his good resolutions.

7. TEMPERAMENT.

A large number of the cases I am dealing with were of a nervous or nervo-sanguine temperament; comparatively few phlegmatic persons have occasion to go to a retreat for treatment, but they show the best proportion of good results.

The following appear to be the temperament order arranged according to results: (a) The *Phlegmatic*; (b) the *Nervous*; (c) the *Sanguine*; (d) the *Highly Nervous and Neurotic*; (e) the *Passionate*. The last group have the lowest average of success, but the number is not 2 per cent. of admissions, and is, therefore, too low to be taken into consideration.

THE MANAGEMENT OF AFTER-CARE.

The object to be aimed at in the carrying out of after-care is to place the person at once in suitable surroundings and healthy climate, and to give him an occupation. In addition to regular work, a hobby is of value; an idle life is a constant danger. The employment should be as free as possible from temptations to drink, avoiding, naturally, those in which "treating" is necessary, or where visits to breweries, restaurants, hotels, and so on, are required. A change of district or residence may be advisable in order to afford escape from former drinking companions, depressing recollections, or conditions that may suggest alcoholic conviviality. Especially is this necessary for the over-sensitive man, when he knows, or imagines, he will have to return to a place where his acquaintances, knowing his former weakness, will discuss him, wonder where he has been, whether

to a lunatic asylum, or, as he wishes it to be understood, to a nursing home for a rest-cure. He believes they will point the finger of scorn at him, and make him the subject of gossip, and perhaps of ridicule or contempt.

I have known many a man who dreads to return home for these reasons. He fears to face the music, and no assurance or argument will give him consolation or remove his morbid dread. If he does return, his first few months are a purgatory and a danger, for he always knows that a glass or two of liquor will enable him to face his world with equanimity. Over-confidence must be guarded against, and such functions as dinner parties, lodge meetings, and other festive gatherings should be shunned. He should eschew all drinks between meals. It is frequently fatal for an inebriate to go with friends into a bar. He intends to have a cigar or a "soft" drink, and yields to "the-one-glass-won't-hurt-you" advice. One glass means for him many, and a relapse. There is no *via media* for him, the "golden mean" of Aristotle would be in his case his downfall. To put it briefly, the recovered inebriate must ever avoid temptation and the placing of his head into the lion's mouth. Let me relate but one instance only of over-confidence: A former patient of mine wrote me some little time back from Canada to let me know how he was getting on, and stated how that, a few months previously, he had felt so sure about himself that he had given a champagne lunch to his friends. As a result he was, the same evening, just sober enough to realize his peril, and immediately started off for a house forty miles away from all saloons. He fled from the drink devil, and told me that he did that flight, in a sledge, in record time.

The above suggestions are, perhaps, mere commonplaces for those of you who are engaged in the reclamation of the inebriate, but I wish to mention one other point of much practical importance. I have repeatedly had to warn wives and relatives against over-suspicion and unpleasant references to the past of the patient. This is often necessary, not only during retreat residence, but especially after treatment has expired and the patient has returned to his home and his associates. Not infrequently has a man relapsed on account of a well-meaning but imprudent wife, or an injudicious and censorious relative. Injured and long-suffering they may have been, but if their object really be to assist the recovered man, they should hide their sores, and

employ sympathy, encouragement, tact, and manifest confidence. The patient during his stay at the retreat has had full time to consider the past, to brood over the mess he has made of his life, fortune, family prospects and opportunities. He requires no reminder, and to fling all this into his face, or to treat him as if he were a child or a lunatic, is to drive him to desperation. The influence of temperament should also be considered. In the case of the phlegmatic such goading may prove harmless, but for the sensitive and highly strung it is worse than folly—it is a deplorable error. I think it was Kipling who wrote, “the toad beneath the harrow knows exactly where each tooth-point goes.” In the *British Journal of Inebriety* of July last, under the heading, “The Psycho-Analysis of an Inebriate,” an article was published bearing on my subject. The anonymous writer of the article had evidently been “beneath the harrow,” and his reflections merit serious study, for they are a true expression of personal experience.

GENERAL CONCLUSIONS.

The following concise concluding summary is to be taken as being rather the presentation of an individual's experience than a dogmatic setting forth of anything like general conclusions applicable to all cases. And it should be added that these deductions are based on an analysis of male inebriates, the majority of whom were members of the middle class.

(1) Though a long residence in a retreat is unsuitable, and undesirable for some, there is an increased average of good results corresponding to an increase in the length of treatment up to about twelve months.

(2) The regular (continuous) inebriate usually has a rather longer period of excessive addiction, before submitting to treatment, than has the periodic inebriate.

(3) The periodic inebriate responds much better to treatment than does the regular inebriate.

(4) Length of excessive alcohol addiction does not appear to materially affect prognosis. In dealing with numbers, the average period of addiction (in both classes) is about the same among those doing well as among the total number of patients discharged.

(5) A hereditary history of inebriety does not militate against the success of treatment, unless the family history is a bad one.

(6) A hereditary history of insanity does materially lessen likelihood of success.

(7) The married have a three to two better chance of doing well than have the unmarried.

(8) As to temperament, the phlegmatic show the best results, and the highly nervous the worst, excepting, perhaps, the passionate.