DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

The abstinent alcoholic.

Gerard, D., Saenger, G., Wile, R.

Archives of General Psychiatry: 1962, 6(1), p. 83–95.

Classic description of the patient who has sustained abstinence after treatment but is still unhappy, unfulfilled and/or nervously hanging on – in other words, not really 'recovered'. They formed the majority of patients seen at Connecticut's alcohol clinics in the 1950s who were not drinking at follow-up.

SUMMARY *In places the language of this article written in 1961 or before may today be considered undesirable. Not all these terms have been changed.*

Modern psychiatry sees alcoholism as a symptom of a complex personality disorder which expresses itself (among other ways) through excessive drinking. In the context of this article, two antithetical aspects of alcoholism are especially pertinent. The first is the adaptive function of drinking; the second, the non-adaptive consequences.

Researchers have identified a "consistent thread" running through contributions to knowledge about the causes of alcoholism suggesting that for dependent drinkers, alcohol "dispels tension and depression, relieves the sense of aloneness, places an instantaneously available source of pleasure at [the drinker's] disposal, permits the mastery and simultaneously the expression of unmanageable hostile feelings". Others have described the "normalising" effects of alcohol on those with a drinking problem on a variety of physiological and psychological measures.

On the other hand, it is well known that problem drinking usually damages the total life situation of the individual – their physical health and ability to obtain and keep a job, sustain a family, and engage in satisfactory social relationships.

This makes it important to know what happens to alcoholics who stop drinking. To what extent is abstinence associated with a general improvement of the adjustment of the alcoholic? What are they like in their current abstinent state? Are other symptoms which may or may not be less detrimental to society and the patient substituted for alcoholism when the 'normalising', adaptive assistance of alcohol is withdrawn? In these terms, what does it signify to say that a person has 'become abstinent'? How does this relate to the conception of 'improvement'?

Key points
From summary and commentary

New patients seen at alcohol clinics in Connecticut in the 1950s were interviewed up to eight years later.

22% of those still alive had been abstinent for at least a year while living in the community. Compared to the remainder they were in better health and had better family, social and work lives.

Nevertheless, over three-quarters were overtly disturbed or led limited lives and would not be regarded as mentally healthy. Just five of the 50 who could be classified seemed to have achieved a measure of identity, comfort, and purpose without becoming dependent on Alcoholics Anonymous.

In general, degree of drinking after treatment is only loosely related to measures of well-being in societies where drinking is integral to a 'normal' personal and social life.

The purpose of this paper is to help clarify these and other issues by reviewing case histories obtained in a follow-up study of patients first seen between 1950 and 1956 at the five outpatient clinics established by the US state of Connecticut, focusing on those who had been abstinent for at least a year prior to the follow-up interview. At follow-up, each was asked by the research team's psychiatric social worker about their drinking, state of health, living arrangements, family adjustment, social life, employment, and adjustment to work, as well as their attitudes, reactions, and ideas about their treatments prior to, during, or after contact with the state's services. In many cases informal corroborative data was obtained from spouses, relatives, AA friends, or employers. Of 1,149 cases (half those seen at the services) a random sample of 400 was selected for study, of whom 299 had been traced and interviewed by the end of the study, a sample constructed to include proportionate numbers from each of the clinics who had been interviewed two, five or eight years after first attending.

Based on follow-up contacts, the former patients' own accounts, and the observations of the interviewer,

the participants were classified as:
• deceased;
• institutionalised in mental hospitals, jails, or hospitals for the chronically diseased and/or dependent; or
• alive and maintaining themselves in the community and either:
– substantially unchanged and continuing to drink to such a degree that they and the interviewer noted the persistence of a drinking problem;
– for at least a year before the interview, drinking but improved in that they have not been drunk, had binges, been arrested, or had medical care related to alcoholism;
– abstinent for at least a year before the interview.

Main findings

By the end of the study 299 patients had been traced and interviewed. Of these, 41 or 14% (16% of those still alive) were classified as living in the community for at least a year and drinking but without this causing major problems, and 55 or 18% (22% of those still alive) abstinent for at least a year while living in the community.

Overall, patients who had been able to maintain abstinence for at least a year were in the best health and had the best family relationships and social and occupational adjustment. Next best were those drinking but without major problems, and worst were those still with a drinking problem or institutionalised.

However, 'best' or 'better' does not necessarily mean 'good'. There was sufficient data to classify 50 of the 55 abstinent former patients as more or less broadly successful in their lives:
• 27 were overtly disturbed – former patients whose abstinence is sustained in the context of an unstable state. They suffer with tension to a degree which concerns them and/or they are angry, dissatisfied, resentful, projecting aggressive attitudes or ideas into their environment, or driven by anxiety so that they are restless, unable to relax, seeking to distract or sedate themselves from their conflicts by spending inordinate amounts of time at work or in social activities, or overtly psychiatrically ill; see panel for an example.
• 12 were conspicuously inadequate personalities – characterised by meagreness of their involvement with life and living. Though there is nothing grossly 'wrong', there is no positive sense of excitement, purpose, or interest in their lives.
• 6 were 'AA successes'. They have acquired a sense of purpose and value in life through membership of Alcoholics Anonymous. Some spend all or practically all their free time at AA or in activities related to its '12 steps' to recovery, and have little or no social life apart from AA. They are as dependent now on AA as they were on alcohol and the relationships in which their alcoholism had been integrated.
• Just 5 were classified as 'independent successes'. They have achieved a state of self-respecting independence, personal growth, and self-realisation, engage in a variety of personal interactions on the basis of positive interests rather than avoidance, and their efforts at self-realisation are independent rather than institutionally supported; see panel for an example.

Example of an 'abstinent alcoholic'

At intake in 1953 Mr H.B. was a 34-year-old married man. He is now divorced from his wife. He says he is restless and jittery, that he is very unsure of himself, that he has episodes of tearfulness and depression which "get out of control". His communication is characterised by pressure of speech and a grandiose intellectual attitude; his conversation is focused on his theories about alcoholism and psychiatry. He takes tranquilisers; he is very active in the group-therapy program at his local outpatient [Veterans Affairs] clinic; he drinks great quantities of coffee – at least eight cups before breakfast. He has been in mental hospitals several times since he was last seen by the [alcoholism clinics].

Example of an 'independent success'

Mr. U.S. was a 30-year-old man at intake in 1956. He was separated from his wife at that time and is planning to divorce her now and marry a woman who will be better for him. He is making a success at work, with promotions and raises. He socialises actively and widely with both male and female friends and acquaintances. He presents himself as standing on the threshold of his adult life, without alcohol, with a confident and optimistic attitude.

It might be expected – perhaps preferred – that abstinence would have come about through an interpersonal interaction in a treatment setting, during which the patient acquired insight into their difficulties and/or experienced the support and encouragement of a skilled listener. However, in this study abstinence was rarely initiated or sustained in such a context. Only one patient reported participation in such an interaction and that it was helpful. Instead, the most common factors associated with becoming abstinent may be classified as 'fear-motivated'. Among these were 15 patients who became abstinent because they were afraid of dying due to alcoholism.

With rare exceptions, the 41 socially marginalised 'skid row' patients did not improve through participation in Connecticut's alcohol services. Only two were abstinent at follow-up, and none described themselves as controlled drinkers. In contrast, socially included patients who were

married, stably employed, and residing in a family setting at the time of intake had a better prognosis than other patients. Nevertheless, many were drinking heavily, if interspersed with periods of abstinence. What seemed to have made a difference was a change in attitude to the use of alcohol based on the person's experiences which, in the vast majority of cases, took place outside of any clinical interactions.

The authors' conclusions

Only a minority of patients (55 of 299) with a drinking problem had sustained a year of abstinence at the time they were followed up two, five, or eight years after first visiting alcohol clinics. Compared to other patients, they were in better – but not necessarily 'good' – health and had better employment and family relationships. Within this abstinent minority, most were either overtly disturbed (27 of 50) or functioning with gross inhibitions and limitations in their personal relationships (12 of 50), and would not be regarded as mentally healthy. Some of the remainder (6 of 50) had achieved a sense of identity, comfort, and purpose through total involvement with the philosophy and activities of Alcoholics Anonymous; a few more (5 of 50) seemed to have achieved this without sacrificing their independence to an institutional source of support. Anticipating that abstinence would come about through insight or personal growth or growing rapport with a therapist, researchers and interviewers were often astonished at how prolonged abstinence could accompany gross mental disturbance and maladjustment.

Among patients who became abstinent, little of their attitudes and expectations about treatment corresponded to the treatment philosophy of the services they had attended, characterised by a psychodynamic approach to the understanding and treatment of alcoholism. Instead, patients seemed to accept some of the attitudes associated with Alcoholics Anonymous, even though very few participated. They believed their drinking had to be given up because they could never become social drinkers. Rather than crediting treatment or helpers and supporters with their remission, they believed that their alcohol-related pain and suffering had became so bad that they had to stop drinking. With regard to what sustained their abstinence, they said people liked them better as reformed rather than active drunkards.

Researchers and interviewers were often astonished at how prolonged abstinence could accompany gross mental disturbance and maladjustment

These findings remind us that alcoholism is notoriously difficult to modify, and that the loss of a symptom may be as threatening to the person's total adaptation (or more so) as the maintenance of the symptom may be harmful in terms of its effect on health and social adjustment.

FINDINGS COMMENTARY This classic paper from the early 1960s reminds us that formerly dependent drinkers can sustainably stop drinking and yet remain far short of the ideals encapsulated by the term 'recovery'. Of competing visions of recovery, most influential for the UK was the formula thrashed out in 2008 by 16 experts brought together by the non-governmental UK Drug Policy Commission. They agreed that becoming recovered is "characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society". Their report expanded on each element of the definition, explaining that that by "control" they meant "comfortable and sustained freedom from compulsion to use" – the traditional treatment goal of sustainably ending addictive patterns of substance use. But that was, they said, not enough: recovery is not just about ending pathology, but about gaining "positive benefits … a satisfying and meaningful life".

Despite at least a year without drinking, arguably just five out of 50 of the featured study's former patients met all these criteria. Without their accustomed sedative and the friends and social activities that went with it, most in this study were living an empty and/or unhappy life, their underlying pathologies and difficulties exposed to themselves and others with no drink problem to mask, excuse, explain or help (no matter how destructively) them cope. At the same time, it is important to remember that overall they were better off than the continuing drinkers, and presumably also than they had been as the 'drunkards' they recalled. Perhaps related to this picture are the reasons they gave for stopping drinking – typically a negative fear motivation rather than a positive choice to reach for a better life.

Disjunction between drinking and well-being common

More contemporary findings derived from a survey which attempted to reach all adults in a single county in Norway in 1984–86 and again in 1995–97. Its distinctive feature was to distinguish between respondents who typically did not drink alcohol *and* identified as 'abstainers', from those who also did not drink but rejected that label. By doing so, it was able to reveal that "those who label themselves as abstainers are at increased risk of both

depression and anxiety … the odds of depression were higher than even the heaviest alcohol consumers". Of greatest interest in the current context were the self-identified abstainers in 1995–97 who eleven years earlier had reported heavy drinking then or in the past. Here anxiety and depression were at their most common, affecting 29% and 31% respectively, compared to 17% and 16% among abstainers as a whole. The researchers speculated that "In a society where use of alcohol is the norm, abstinence might be associated with being socially marginalized and at increased risk for mental disorders." Again though, it is important to acknowledge that if their behaviour is a guide, these at best partially 'recovered' abstainers seemed to think that staying away from drink was preferable to their former heavy drinking.

In respect of treatment populations, evidence of a disjunction between conventional outcome measures (including abstinence) and patients' own assessments of their physical, emotional and social well-being has emerged from the relatively few studies which have reported these measures. Among the alcohol treatment studies was one from the USA of 628 previously untreated problem drinkers who had contacted information/referral services or detoxification units and were followed up one, three and eight years later. Across the eight years, treatment duration was consistently linked with better drinking outcomes, but there was generally no link with improved social functioning or relief from depression. In another US study primary care patients in Pittsburgh were screened for actual or potential alcohol problems and randomised to two different forms of brief intervention or standard care, none of which seemed preferable to the others in terms of outcomes. A year later there were only modest relationships between drinking reductions and improvements in quality of life. Depending on the cut-off points used (20%, 30% or 40% drinking reductions), these relationships were either not statistically significant or only marginally so.

Other studies confirm what is implicit in the work cited above: that using the patient's own account of their quality of life can overturn conventional assessments of which treatment is best. For example, a US study of severely dependent drinkers being treated for medical illnesses randomised them to referral for alcohol treatment as usual (few went) or to receive alcohol treatment integrated with their medical care. Relative to usual care, two years later integrated treatment had led to significantly increased abstinence rates and reduced drinking, but there were no significant differences in how well the two approaches had improved the patients' self-assessed quality of life.

At least two treatment studies have been able to directly address the issue of whether quality of life is more closely related to alcohol use or problems than to illegal drug use. Both found the relationship with drinking was looser – that drinking can be more or less severe without quality of life following suit, while illegal drug use is more closely linked to measures of wellness. The first interviewed a representative sample of patients undergoing publicly funded substance use treatment in Massachusetts. Quality of life was unrelated to the severity of alcohol problems, but there was a modest relationship with the severity of drug problems in the expected direction: quality of life was lower the more severe were the patient's problems. Similarly, at two Canadian addiction treatment centres, psychological and social functioning and life satisfaction 12 months after treatment were generally unrelated to the extent of drinking among either alcohol or drug clients. However, drug use outcomes among drug clients were strongly related to emotional well-being and life satisfaction.

If there is a different relationship between quality of life and drug versus alcohol use outcomes, it may (as hypothesised in the Norwegian study described above) stem from the more socially integrated position of alcohol in the societies where the studies have been done. In these societies it is easier to sustain a normal and fulfilling life while drinking than while using, say, heroin or cocaine, and possibly also easier than when not drinking at all. Additionally, because it is a far more normal activity, having a drink is less likely to be a marker of life problems than relapse to heroin or cocaine use. The latter mechanism seems apparent in the Canadian study's finding that negative emotions strongly predicted a more rapid return to drug use, but not to drinking.

Such findings have a bearing on whether dependent drinkers should always be advised to aim for abstinence, an issue addressed by an Effectiveness Bank hot topic.

We are grateful to Professor Nick Heather of Northumbria University for bringing the featured article to our attention.

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