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COMBINED THERAPY FOUND EFFECTIVE

A treatment approach which brackets rapid detoxification with immediate convalescence in an AA center has been described by Dr. Percy E. Ryberg, Clinical Director and Director of the Alcoholism Program at Falkirk Hospital, Central Valley, N.Y. Speaking to the Psychiatry Section of the Pan-American Medical Association, Dr. Ryberg commented that the approach seems to be unique although various modifications have been employed elsewhere.

Dr. Ryberg's program, a tight knit combination of detoxification and convalescence, is conformed to the individual needs of the patient. The typical plan calls for two days of detoxification at Falkirk Hospital and then a five-day period of convalescence and adjustment to sobriety at Ferguson Hall, a

(Continued on page 3 col. 2)

VIEWS ALCOHOLIC AS M.D. RESPONSIBILITY

The physician, the professional capable of developing a long-term relationship with the patient, should have the responsibility for treating alcoholics, Dr. Richard M. Silberstein, Pro Tem Co-Chairman, Physicians' Institute declared in his summation at the conclusion of a one-day meeting sponsored by the Committee on Alcoholism, Community Council of Greater New York, R. Brinkley Smithers, chairman.

Over eighty of the outstanding medical men in New York City attended the institution and participated in group workshop sessions.

Dr. Silberstein observed that medical care is not the only problem; the need for para medical attention also makes alcoholism difficult to treat.

The conference was organized around five workshops conducted by Drs. Alex B. Bearn, Robert J. Campbell, Luther A. Holoud, Phillip Friedland and Hans Nieporent. Consultant-reporters were Drs. Adele E. Streeseman, Leclair Bissell, Harvey G. Bluestone, Wallace Mandell and Frank A. Seixas.

SMALL SUBURBAN HOSPITAL BECOMES ALCOHOL CENTER

NEW YORK—Since July, 1966 Dr. Donald Ottenberg has been medical director of the Eagleville (Pa.) Hospital and Rehabilitation Center for Alcoholics. Speaking at the meeting of the American Medical Society on Alcoholism (February), he said, "These have been the most hectic months of my life . . . but among the happiest."

In those months the EHRC began to come of age. Until April, 1966 it had been a TB hospital. With government funds withdrawn and the last patient gone, heated discussions took place in Philadelphia medical circles to determine what use might be made of the small suburban hospital. A center for children with birth defects? Patients with chronic diseases? A residential treatment center for children with behavior problems? A center for the rehabilitation of alcoholics?

Dr. Ottenberg explained the basic assumptions which have guided the EHRC program — principles which have made it perhaps unique. "First of all," he said, "we considered alcoholism as a disease. Our skid row patient is like any other. He is a human being and must be treated like any other. In everyday practice this has meant a firm policy of no segregation. There are no classes of patients, no privileges that are not shared by all. And there is no overt prejudice. Cleaned, shaven and dressed, it is hard to tell an indigent skid row patient from one of our middle class patients who is paying his way.

"We have come to realize more and more that alcoholism has ramifications in many areas of life — physical, social, economic, sexual, psychological — and that to aid our patients we must have many types of therapy and a multi-disciplinary staff. We have discovered over and over again the value of using the man 'who has been there', that is the recovered alcoholic, as a member of the team. AA, of course, is valuable to some patients, but as an adjunct to other therapy and not as the total program.

"At EHRC we do not rely on drug therapy," Dr. Ottenberg said. "We have found drugs of only limited value, pri-

(Continued on page 4 col. 1)

DESCRIBES FUNCTION OF BOWERY PROJECT

New York—A first step in a community approach to the problems of alcoholism and the "skid row" alcoholic is being taken at the Manhattan Bowery Project, located on New York's lower East Side. Since November 27, 1967, when the Project opened its doors to the indigent homeless, Bowery alcoholic, it has admitted close to 300 men for an intensive five-day program of detoxification.

Dr. Robert Morgan, medical director, in an interview with *Physicians Alcohol Newsletter*, explained the needs for such a facility.

"In recent years the approach to the alcoholic as a criminal has fallen into greater and greater disfavor. The practice of daily arrests of Bowery derelicts has been formally halted. Not only on a local, but even on a Federal level, the constitutionality — as well as the morality —of arresting a person simply because he is drunk is being questioned:

"The Vera Institute of Justice, which planned the Project with a grant from the Ford Foundation, urges that drunkenness not be treated as an offense and recommends civil detoxification centers—in numbers adequate to the need — be created to handle alcoholics. We are such a detoxification center."

Key to operation of the Manhattan Bowery Project is its street patrol—men who comb the Bowery looking for the severely intoxicated or seriously debilitated alcoholic. They urge these men to come to the center. Of the men so approached, 85% accept the invitation, Dr. Morgan said. Another 10% refuse and about 5% are considered too ill to be treated at the project and are taken

(Continued on page 2 col 1)

DIRECTOR DESCRIBES FUNCTION OF BOWERY PROJECT

(Continued from page 1)

either to Bellevue or St. Vincent's Hospital.

When the men enter they are showered and deloused and then given a complete physical, including chest x-ray. For the "shakes" they receive phenobarbital. Psychotic patients are treated with thorazine. During their five-day stay all men are given high doses of vitamin B. Whatever medical care is required, short of major surgery, is provided.

Dr. Morgan explained his preference for phenobarbital over the more usual paraldehyde treatment as follows: "Both drugs, and Librium as well, tend to replace alcohol and will assure a safe and secure withdrawal because of cross tolerance. One of the drawbacks—in this setting at least—to paraldehyde is its characteristic odor. The patient who has not received it knows, by the odor, when another patient has—and a great fuss can be raised. Why haven't they given it to him? Everyone receives the drug in doses tailored to his needs and the 'me-too' problem is obviated. Phenothiazine drugs are used as a second line of defense in indicated patients and all medications are withdrawn before discharge.

The chest x-rays have revealed that about one per cent of the men have active tuberculosis, 20% had arrested TB and 15% chronic lung disease. On admission, 5% of the men had D.T.'s and 5% impending D.T.'s. Some 15% were considered psychotic on admission and 10% were suffering from malnutrition and 20% from dehydration.

"The major purpose of the project," Dr. Morgan explained," is to provide a period of detoxification and care at the end of which the patient can hopefully be amenable to guidance to another facility where he can receive long-term care. Two thirds of the men accept referral to other services. One third refuse. Many of these return to us, a number have been back a second time, and so far three a third time. All told, 10% of patients have been readmitted. We will accept anyone but—were we to be pressed for space—we would first accept a sicker person who needed the emergency care we can provide, rather than a repeater who was just slightly drunk. We are thinking, too, of making readmission a little more difficult—that is asking for more commitment — that is emotional commitment—on the part of the person seeking readmission."

Asked to describe a typical patient, Dr. Morgan said, "The average age is 45. We are dealing with a man who has never succeeded, who has drifted from job to job and from place to place. In many cases he and his problem have been sheltered by his family for years. But then the time always seems to have come when the family stops and the man who has never been on his own *is* on his own. He drifts down the social ladder and lands on the Bowery. One in three has not finished grade school. One in three has and one in three has at least started high school."

Further defining the group, Dr. Morgan said about 25% have had some experience with AA before they come to the project. "But the others, the loners, have done their drifting alone. They are non-communicative, largely non-verbal.

"Many of the men have families but a good 90% have not been in touch with them for 10 years or more. When a man wishes, and only then, we will contact his family for him.

"I believe we are showing here that withdrawal can easily be accomplished in a hospital setting. The men are not treated as pariahs, they are not troublemakers. They respond to the kindness, undertanding and warmth which the staff shows them. There is a lesson to be learned here by the city hospitals, which so often show the alcoholic a closed door. Our door is open 24 hours a day."

Editorial

COMPLEX PROBLEM

Two papers in the current issue of the *Physician's Alcohol Newsletter* demonstrate the tough problems confronting researchers into alcoholism and its physiology. In the Canadian 'epidemic' of beer-drinker's heart, it has been determined that alcohol, cobalt, and a constitutional or enzymatic predisposition were necessary for the outcome of cardiomyopathy. In another paper, Dr. Lieber has demonstrated that different lengths of fatty acid in the diet can alter the percentage of fat laid down in the liver by alcohol.

These insights may hold the key to unravelling many clinical mysteries. For instance, it does seem that there is a spectrum of patients, all alcoholic, of whom some will suffer predominantly nervous system abnormalities; others visceral complications such as cirrhosis, with a paucity of neurological stigmata. Perhaps more attention to the type of foodstuffs ingested either during or between alcoholic bouts may provide important clues to the microetiology of alcohol related disease.

All of which leads to the observation that to make etiology simple c must perhaps start out with complexity. This agrees with the findings of alcoholism clinicians who have noted that the seemingly simple prescription of abstinence must often be obtained by a long and circuitous route.

LITERATURE REVIEW

The Treatment of Alcoholism— A Study of Programs and Problems

Publication of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1700 18th St., N.W., Washington, D.C., 20009, ($3.00). "In the United States today there is not one single alcoholism facility that provides a full range of services that accord with the most-up-to-date convictions about good services for the alcoholic, and provides it in a definitive way to all applicants," is one of the conclusions of the report prepared under the direction of Drs. Donald W. Hammersley, Chief, Professional Services, American Psychiatric Assn.; Francis J. O'Neil, Director, Central Islip (N.Y.) State Hospital; Morris E. Chafetz, Director, Alcohol Clinic and Acute Psychiatric Service, Mass. General Hospital; Elaine Cumming, Ph.D., N.Y. State Dept. of Mental Hygiene; Thomas F. A. Plaut, Asst. Chief, Natl. Center for Prevention and Control of Alcoholism; Raymond M. Glasscote, M. A., Information Service.

Manual on Alcoholism

A publication of the Dept. of Mental Health, American Medical Assn., it analyzes the problem, discusses cause, metabolism and pharmacology.

The Dilemma: of the Alcoholic Marriage

Al-Anon Family Group Headquarters, Inc., has published a 65-page book which begins with The Nature of the Dilemma ends with practical advice.

Guide Lines for Admission of Alcoholics to General Hospitals

Christopher D. Smithers Foundation, New York.

Cooperation but not Affiliation

"How Alcoholics Anonymous Cooperates with Outside Organizations within the Framework of A.A. Traditions. General Service Board A.A. 305 E. 45th Street, N.Y.

RESEARCH AND REVIEW

A propensity for oxidation rather than for esterfication — even in the presence of alcohol — exhibited by medium chain fatty acids (MCFA) in contrast to the reverse tendency of long chain fatty acids (LCFA), is probably responsible for the lowered incidence of fatty liver in rats fed dietary MCFA and ethanol.

In a study conducted by Lieber, Lefevre, Spritz, Feinman and DeCarli of the Liver Disease and Nutrition Unit, Second (Cornell) Medical Division, Bellevue Hospital, and the Department of Medicine, Cornell University Medical College, it was demonstrated that in rats fed for 24 days on a diet containing LCFA and ethanol, the increase in hepatic triglycerides was eight times that of controls. In rats fed with MCFA and ethanol, however, the increase was only threefold. The composition of the MCFA-produced triglycerides, moreover, contained little MCFA while those occurring after the ingestion of LCFA were found to contain a large percentage of LCFA.

The differing hepatic metabolisms of long and medium chain fatty acids was examined in liver slice and liver perfusion studies. It was found that the ratio of esterfied lipids to CO_2 after ethanol was approximately one hundred times lower in experiments with MCFA than in those with LFCA. Ethanol suppressed CO_2 production in both instances but did not significantly affect the differences in behavior.

The researchers suggest that the high rate of hepatic oxidation exhibited by MCFA even in the presence of alcohol is the result of its reciprocally low tendency to esterfication and that this phenomenon accounts for the low residual content of dietary MCFA in hepatic triglycerides. (Journal of Clinical Investigation. Vol. 46, No. 9, pp. 1451-1460)

Telephone Calls

Chronic alcoholics are more likely to return for outpatient treatment after the drying-out interval if during that interval they have received a single phone call from someone at the referring agency expressing real interest in their progress.

A study, conducted by Koumans, Muller and Miller of Massachusetts General Hospital and Harvard Medical School stemming from the findings of Chafetz and Blane in 1959 and 1962 and of Koumans and Muller in 1965 concluded that a telephone call expressing interest in the patient has a definite positive effect on the motivation of the patient to return for treatment, as measured by the incidence of return.

The 1965 Koumans and Muller study indicated that a single personal letter to the alcoholic after referral to another institution for drying-out significantly increases the likelihood of his return for further treatment.

Forty-four percent of the group which received phone calls immediately after discharge from the custodial hospital returned for treatment, while only 8% of the group which was not called returned to the original hospital for renewed treatment. Of these four individuals, three returned within two days, sober on arrival, while the other returned after a week, intoxicated. All together, 26 members of the called group returned. Ten were sober on arrival, 12 were drunk and 4 were questionably intoxicated.

Beer Drinker's Heart

Cobalt, which may be consumed in relatively large doses by normal individuals without harm, was isolated as the critical etiological factor in an outbreak of congestive heart failure among heavy beer drinkers in Quebec. The mortality rate was 40 to 50 percent.

The discovery resulted from the coordinated efforts of the Canadian Ministry of Health, the Department of Forensic Medicine, and the Food and Drug Directorate. Canadian epidemilogists, toxicologists, physiologists, pathologists, biomedical researchers and police officers also participated in tracking down cobalt, as the cause of the disease now known as "Quebec Beer Drinkers' Cardimyopathy."

Those afflicted were admitted to hospitals with congestive heart failure of recent onset. The usual symptoms were dyspnea, weakness, abdominal pain, nausea, vomiting, cyanosis, massive cardiac enlargement, hepatomegaly, venous distention, peripheral edema, tachycardia, gallop rhythm and hypotension. Serum transaminase levels were frequently elevated, as were immunoglobulins and C-reactive proteins. Electrocardiographic changes — low QRS voltage, S-T complex and T-Wave anomalies, displaced transition zone through nonspecific—were always prominent.

Pathologically, the myocardiopathy was characterized by excess glycogen in the heart muscle, degeneration of myofibrils, dilation of sacroplasmic reticulum, shrinking of mitochondria and vacuolization of the cytoplasm. Thyroid epithelial hyperplasia and colloid depletion, gastrointestinal ulcerations, hemorrhages and thrombotic phenomena throughout the vascular tree were also noted.

The Canadian Medical Association Journal which devoted its entire October 7, 1967, issue to explication of the phenomena reports that consumption of alcohol probably lowers resistance to cobalt and increases cardiac vulnerability to the metal. The outbreak of "Quebec Beer Drinkers' Cardiomyopathy" started after cobalt was added to the brew and ended when the additive had been removed from the process.

COMBINED THERAPY APPROACH

(Continued from page 1)

spacious manor house located on hospital grounds. The hospital interval may lengthen in difficult cases. Ferguson Hall is staffed by successful members of AA; "AA's approach brings to mind the homeopathic principal of "like curing like", says Dr. Ryberg. These cured alcoholics guide and counsel the recently detoxified patient.

No alcohol is given during the patient's stay at Falkirk hospital. Supportive measures are prescribed to carry the patient through the difficult drying-out period. However, Dr. Ryberg does not permit the administration of sedatives or tranquilizers during the patient's last three days at Ferguson Hall.

Patients were classified as follows upon admittance:

1. Alcoholic psychosis which included mild stupor; psychomotor activity manifested by marked tremors; delirium tremons; hallucinations.

2. Acute intoxication in varying degrees. This describes the majority of patients. Most had a partial to complete awareness of their condition.

3. Ambulatory alcoholics who know that drinking must be curtailed if the pains of excess are to be avoided but who need a protective medical environment in which to regain sobriety.

Thirty eight of the 74 patients had a relatively rapid recovery and were admitted to Ferguson Hall for convalescence on their third day at Falkirk.

In all, 35 of the original 74 took full advantage of the program and though follow up is very difficult, Dr. Ryberg has received reliable reports of the continued sobriety of 16.

NEW ADDRESS

ACCEPT — Alcoholism Clinic Coordinating Education, Prevention and Treatment — has moved to new headquarters at 29 East 22 St., 10th floor and plans to expand services.

SMALL SUBURBAN HOSPITAL BECOMES ALCOHOL CENTER

(Continued from page 1)

marily in treating the acute symptoms of withdrawal, agitation or depression. Of course, in aversive therapy, antabuse has been extremely helpful. As a rule, however, reliance on drugs creates its own problems. Why substitute one crutch for another?

"When EHRC was first opened we saw that it offered a unique opportunity to carry out research. After all, no single method of treatment was *the* method. Therefore, we reasoned, all methods must be validated. In practice, we adopted two approaches. One was focused on traditional group therapy, insight-oriented. The other on behavior therapy. We simply selected alternate patients for assignment to one or the other. The behavior therapy did not stress the 'why' of alcoholism—on the theory that it's not necessary—but rather attacked the maladaptive behavior itself, step by step, in an effort to break the chain that leads to alcohol.

"We operate on the assumption always that our patients are valuable, sentient individuals. It sounds almost simplistic, but if a person is treated as a human being, that is the way he tends to respond. This is particularly true with our indigent skid row patients. They have lived in almost utter isolation. They have no relationships left, and little ability to create or nurture new ones. Experience has shown us repeatedly that unless the patient is connected back to other people—even one other person—he will succumb once again into loneliness and depression and, of course, into alcohol."

One of the big problems, yet unresolved, that has faced the therapeutic team at the EHRC has been whether to adopt a permissive or punitive attitude toward patients' drinking. "Together, that is staff and patients, we are now living out our first decision," Dr. Ottenberg said. "That required immediate dismissal of any patient who drank. It was a rigid decision and one that has occasionally been unfair to patients – especially one, for example, who came to us and reported his transgression. Perhaps the ideal policy lies somewhere in between. Happily, in March we will review our policy together and I am sure we'll opt for a more realistic, humane approach."

At present about 50% of the patients at the EHRC are men from Philadelphia's Skid Row. They are in their early forties and, in general outline, conform to the picture that is slowly being recognized as typical of the alcoholic whether he is an indigent or a middle-class citizen. He is a loner, isolated, easily depressed and frustrated. He is dependent and hostile and frequently the victim of his own chronic rage. Estrangement is the rule, but is not borne without effort for frequently the alcohol is used as a bridge to other people. "Alcohol serves the alcoholic," Dr. Ottenberg said, "in the way that other forms of addictive, maladaptive behavior serves others. It is, in the ultimate sense, a 'cop out', but it also provides relaxation to the chronically tense, false courage to the sexually and socially inadequate."

Dr. Ottenberg's own understanding and participation in the Day Top program for drug addicts has had considerable impact on the direction EHRC may take in the future.

Within the structure demanded of a hospital, Dr. Ottenberg hopes to provide a therapeutic ambience for patients which will permit them to express the deep feelings—particularly of anger, fear and love—which are locked in. It is an approach which, as the Day Top experience suggests, can permit members of a community to live and work together on a basis of what is most decent in them, rather than on what is most aberrant.

At the present time, he said, almost the entire EHRC staff is participating in intensive training for leadership of the 'marathon' group therapy sessions.

MEETINGS

APRIL 22, 1968: American Medical Society on Alcoholism at 8:30 p.m., Mt. Sinai Hospital, 100th St. & 5th Ave., Clinical Amphitheatre – Guest Speaker Mr. Mark Keller, Editor Quarterly Jr. of Studies on Alcohol, Rutgers Univ. "Alcoholism and Addiction."

SEPT. 15-20, 1968: The 28th International Congress on Alcohol and Alcoholism, a meeting expected to attract the largest attendance ever recorded for a conference in the field of alcoholism, will be held in Washington, D.C., at the Shoreham Hotel.

The central office of the North American Association of Alcoholism Programs which will act as Congress Secretariat, is located at Suite 615, 1130 Seventeenth Street, N.W., Washington, D.C. 20036.

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