John's Saga:
A Case Study of Alcoholism in the 70's

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The purpose of this paper is to present a brief account of a well-educated young man who is suffering from alcoholism in an academic setting. He has spent much of the last five years seeking help for this dangerous illness, but was met with rejection and disinterest from colleagues and other professionals whose advice he sought. There is some indication that the difficulties and frustrations that he encountered stem from current misunderstandings about alcoholism in younger people. There-is also a confusion of roles and a failure by some professionals to recognize individuals who possess knowledge about their illness as an asset rather than as a liability.

During a recent discussion, a colleague and friend related an interesting but distressing personal experience. John is a 25-year-old psychologist of linear (ectomorphic) build. He is presently an instructor in a southern university, concurrently working on his Ph.D. John began by stating that he was an alcoholic and told us his story. This surprised us for we had not supposed that he drank excessively and he never showed signs of alcoholism at work.

John came from a poor family in the coal mining regions of Northwestern Pennsylvania. He is the oldest of five children, both parents being alcoholics, and his mother is probably a chronic schizophrenic. There is also a long family history of alcoholism on both sides of the family.

In his particular subculture, it is the custom for younger males to drink heavily as this is held to be (1) a sign of manhood (i.e., some kind of initiation rite giving proof of masculinity), and (2) much more acceptable than other drugs such as marijuana, LSD, amphetamines, etc. Because of this environmental pressure combined with the possibility of being genetically predisposed towards alcohol, John began to drink early and heavily.

At 16, he started heavy beer drinking which served as an escape from his home and became a way of gaining prestige among his peers. He and his friends would get together to see who could

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consume the most beer in the shortest period of time. In competing to see who could drink the most, they would invariably resort to self-induced vomiting, thereby aiding further consumption of alcohol. Although this was uncomfortable and physically exhausting, social reinforcement from admiring peers coupled with the psychophysical effects of the alcohol was sufficient to perpetuate this behavior. Those who drank most became accepted as leaders for that night and their leadership and dominance tended to be generalized outside the drinking situation.

After entering college, this drinking pattern continued. John received encouragement for drinking in his fraternity where being able to hold your liquor was considered an affirmation of masculinity. He and his friends believed that the more one drank and the more girls one slept with, the bigger a man he would be considered by his peers.

Because of his temperament and typology he began to question his lifestyle and to notice his obvious attachment to alcohol. According to Dr. Renee Nell's (Osmond, 1974) variation of Jungian typology, John can be described as an introverted thinking-sensation type. He began to reflect very seriously upon his personal and family history after an uncle died of alcoholism at the age of 35, about four years ago.

His historical temperament led him to seek help from a psychologist/friend and teacher who had had an extensive background in psychoanalysis. The professor, a European, became much interested in John and usually over a dinner would discuss with him the many and various problems John was experiencing. Although the professor was highly competent, his cultural and personal inclinations led him towards a bibulous form of psychoanalysis. Consequently, when John left undergraduate school, he was still drinking beer almost as heavily as ever, but had in addition acquired a taste for wine. While this improved his social repertoire it did not allay his growing worries about developing alcoholism.

Upon receiving his B.S. in elementary education, John immediately entered a Master's program in educational psychology. Once away from his psychotherapist, John began a series of increasingly desperate attempts to get help for his drinking problem.

His first step, since the bibulous psychotherapy had failed, was to seek more orthodox assistance. He turned to Alcoholics Anonymous. However, knowing little about the many different kinds of AA groups he stumbled upon a very traditional, pious, and older AA group, mostly in their forties and fifties. He found the rituals and customs of this particular group tedious and soon left discouraged for he was not able to participate in what seemed to him empty mummery.

However, he continued to look for help and moved in the direction of medicine. He had heard that Antabuse (Disulfiram) helped many alcoholics and proceeded to research it in a systematic way. It seemed to him that since he had a strong and growing desire to stop drinking, but was under a variety of external pressures to continue, Antabuse might be the extra incentive needed to stop. He therefore approached several doctors and put the matter to them in a straightforward way. He outlined his suggested plan of action to them and received some totally unexpected and discouraging responses. Several of the doctors, confusing models (Siegler and Osmond, 1974), applied the moral instead of the medical model. They suggested a variety of treatments ranging from pastoral counseling to psychotherapy. However, all refused him Antabuse. Their explanations ranged from having no experience with the drug to calling it a crutch which must be avoided at all costs.

After obtaining his M.Ed, in Educational Psychology, John entered an Ed.S. program in School Psychology. At this time he received extensive training in behavior modification techniques which were espoused as a panacea for a great variety of problems. Since one of John's professors was an authority in this field, John approached him concerning the possibility of doing some type of

behavioral therapy with him. The answer he received was curt and direct. "Because prognosis for alcoholism is so poor, I avoid it." John was confused and distressed, for being aware that he had a potentially fatal illness, he had done everything that an intelligent person could do. He had been rejected by his own colleagues from whom he had sought help and the physicians whose advice he had solicited.

By May, 1975, John was still drinking and beginning to study for his Ph.D. at a southern university. He realized by now that his drinking was beginning to interfere with his academic/social functioning and this made him increasingly anxious and depressed. His temperament is such that he was becoming painfully aware of what probably lay ahead.

He once again reassessed his situation and rejected psychoanalysis and most derivatives of that model because, as Siegler and Osmond (1974) have noted (1) a person in the "psych" role has far more limited rights and is rarely told he must desist from his usual responsibilities lest they make him sicker, (2) if the person in this role does not get better, the question is raised whether he really wants to, and (3) in this role people are not expected to get well as fast as possible, due to the concept of resistance and the fact that psychoanalysis places great importance on the length of treatment. For many years long treatments have been considered especially beneficial because they are said to get to the root of the problem.

John again turned to medicine. He consulted another physician concerning his condition and explained his wish to use Antabuse. After consultation, the doctor failed to give John the benefits of the sick role. He was not given Antabuse, but received instead a prescription for Valium (Diazepam). Whatever the doctor's motives may have been, the essence of his message was, "Sorry, I don't think I can help you." By this time John was becoming very frustrated. He had tried for four to five years to obtain help and for the previous two years had intensified his efforts, but had failed to discover even the vestige of an answer to his grave problem. Becoming seriously depressed and seeing no hope, he began to consider suicide.

It was in this condition that we first met John. He was more or less resigned to becoming an alcoholic. However, he was still open to suggestions and we indicated that a staffing conference could be held to discuss his alcoholism and search for new help. Because of his training, temperament, and personal involvement, our colleagues thought it best that John should remain in the conference while the possible solutions were being explored. We hoped that through this procedure we would give him immediate reinforcement in the form of (1) hope, (2) further alternatives, (3) a greater understanding of his condition.

During the conference the following ideas were generated: (1) John should read **Models of Madness, Models of Medicine** (Siegler and Osmond, 1974), paying particular attention to the chapter dealing with models of alcoholism. This would give him an opportunity to further understand his illness and to discover why he had had so many discouraging difficulties in getting treatment. (2) At the time of the conference he had gone four days without drinking, and was beginning to experience withdrawal symptoms. These symptoms included shaking, disturbance of sleep patterns, increasing free-floating anxiety, etc. Minor tranquilizers should be prescribed to reduce his symptoms. (3) Changing his diet, reduction of carbohydrates and increased protein consumption, increasing his exercise, and possibly using megavitamins (Smith, 1974). (4) Once his withdrawal symptoms had been alleviated, the use of Antabuse as a means of establishing and maintaining a new pattern of behavior. (5) The possible use of Jungian psychotherapy because it deals especially with enlarging one's knowledge of one's own temperament.

Discussion

John's approach to his illness was

sensible and systematic. Indeed, it is quite unusual to find a young man who is so interested in and aware of the implications of his condition. However, as this story shows, for the best part of five years John was not in the least benefited by what one might have thought would have been a notable asset, that is, his training as a psychologist. He discovered that many professionals appear to be intimidated or annoyed when a patient deviates from what they believe to be the traditional patient role. Many professionals, it appears, perceive this type of person more as a threat than as an opportunity and are liable to shun him.

However, with so much increased education about alcoholism, more patients like John who heed this education and attempt to get help before they have been psychologically, socially, and physically impaired are to be expected. This attitude should be strongly encouraged for it is the attitude of a responsible patient and is in every way admirable. Yet John received no encouragement and a good deal of bad advice.

This seems to have been due in part to the various professionals involved being unaware of the special qualities of the responsible patient. They also failed to recognize that in alcoholism as in many other illnesses, intelligent and well-trained people take the educational material available seriously enough to try to make use of it.

In a recent study, David McClelland (1971) noted that "The public bias that alcohol is bad—and particularly bad for alcoholics—is interfering seriously with efforts to find an effective cure for excessive drinking." This attitude, combined with confusion of models that exists, tends to project a poor prognosis for individuals who have characteristics similar to John's.

It is ironic that John's efforts did him so little good for much of the last five years, and it is only because he was unusually persistent that he finally got himself installed in an appropriate version of the sick role. John cannot be the only young and intelligent person in the university
setting suffering from early alcoholism. There must be hundreds like him. We should be alert to the way in which this illness presents itself in this particular and rather special population.

It should be noted that once John was offered the appropriate version of the sick role, he accepted it. It appears that one of our major functions in the future will be to inform other professionals that alternative roles exist. It will only be through careful matching of the individual's particular temperament and illness with the appropriate role that success is likely to occur.

Conclusion

John is currently in excellent health. The changes in diet combined with megavitamin therapy have increased his feelings of optimism and self-esteem. Although he occasionally has the desire to drink he feels that the use of Antabuse provides him with an external incentive needed to establish himself *as* a non-drinker with accompanying behavioral patterns.

Comment by Dr. A. Boyd on John's Saga:

This account shows two problems of deviating from the medical model in dealing with social dysfunction that has its roots in human biology:

1. The tendency for illness to run its natural course during nonmedical therapy, spontaneous remissions as a part of the self-limiting nature of many disorders being interpreted as therapeutic success; and, on the other hand,
2. John's rejection of such people when it is known that this is not likely to occur as an apparent therapeutic success, thus denying the hope found in an appropriate sick role and the role of responsible patient seeking to understand the illness and deal with it in a manner uniquely suitable for that individual.

As a psychiatric practitioner and consultant involved in a wide range of clinical settings, I have learned that with well-informed and intelligent young people (as well as much of the mass media-indoctrinated general public)

there is often an expectation of either the "psych role" or a "model muddle" approach. This requires considerable educational effort in using the medical model and conferring the sick role when needed in dealing with medically treatable perceptual (schizophrenic), affective, and other disorders. Providing patients with copies of their evaluation reports and on occasion copies of memos concerning them derived from teaching conferences with our colleague, Dr. Humphry Osmond, has been helpful in encouraging greater patient responsibility. Many of these people are highly motivated toward understanding the reasons for a diagnosis and the treatment prescribed; in fact, some are unable to collaborate effectively without such information.

In one case, this process has proceeded to the point that our patient seems now to be in the role of a professional associate more than in the role of a patient.

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Comment by Miriam Siegler on John's Saga:

I met John on one occasion, at the height of his distress. He had typed himself, using the Jungian schema, as a thinking type. I confirmed his auto-diagnosis, adding that I believed him to be an introverted thinking-sensation type, the same as myself. Because we shared the same temperament, I had a fairly good idea what John might need to extricate himself from his current state: a new and feasible plan for the future, based on a new concept of what was wrong with him and what could be done about it. The plan had to have more in it than the mere solution of his difficulties, pressing as those were; it had to have intellectual excitement, so that he could see his difficulties not merely as being soluble but as enlarging his understanding of himself and of the world. This may seem a tall order, but alas, nothing short of that could generate hope. It proved relatively easy to communicate to John that there were a number of relevant ideas which we could teach him and which he could learn to use himself. Among them were: further ideas about typology; the idea of the responsible patient; the idea of alcoholism as an illness now being diagnosed at an earlier stage than previously; the idea that he was part of a group of unknown fellow sufferers from alcoholism who could, in principle, be contacted.

John was distressed about the fact that he had been in so many unsatisfactory therapeutic situations which he had known to be unhelpful, but from which he had extricated himself only with difficulty. I told him that this problem was common to our type, and that it derived in part from the inability to correctly identify one's feelings, and partly from the paralysis that sets in when one has no intellectual justification for moving out of a situation. I told him that one could learn to act on the inner signals of distress, even if one did not yet know the reasons for that distress. This simple maneuver prevents one from wasting a great deal of time and energy on solutions which do not work. John had used up all his endurance by his courageous but misguided efforts to explore various blind alleys described here.

John respects sapiential authority and seemed comforted to learn that there were others who knew more about his illness than he did. He was visibly relieved that there were other and better moves open to him than those he had as yet encountered. It allowed him to see the future once again as open, as full of opportunities to learn new ideas.

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