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Report on the First Session of the Alcoholism Subcommittee

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EXPERT COMMITTEE ON MENTAL HEALTH

First Session of the Alcoholism Subcommittee

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* Unable to attend owing to illness.

EXPERT COMMITTEE ON MENTAL HEALTH

Report on the First Session of the Alcoholism Subcommittee [1]

The Alcoholism Subcommittee of the Expert Committee on Mental Health held its first session in Geneva from 11 to 16 December 1950. The

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[1] The Executive Board, at its eighth session, adopted the following resolution:

The Executive Board

1. NOTES the report, on its first session, of the Alcoholism Subcommittee of the Expert Committee on Mental Health;
2. THANKS the members of the subcommittee for their work;
3. AUTHORIZES publication of the report, and
4. RECOMMENDS its distribution;
5. REQUESTS the Director-General to base future programme proposals in this field on the general recommendations of this report, and to co-operate in any programme concerned with the social and legislative aspects of the problem of alcoholism which may be developed by the Social Commission and other organs of the United Nations;
6. AUTHORIZES the holding of a meeting of the Expert Committee on Drugs Liable to Produce Addiction, to be devoted to problems of alcohol, and requests the Director-General to make provision for a meeting of this committee in his budgetary proposals for 1953;
7. REQUESTS the Director-General to place on the agenda of this committee the matters referred to it by the Alcoholism Subcommittee of the Expert Committee on Mental Health, and other matters concerning the effect of alcohol on the physiological, psychomotor, and psychological reactions of the human being;
8. APPROVES the proposal for the meeting of a small working-group of experts on the statistical problems connected with alcoholism, prior to the next meeting on alcoholism to be held by the Expert Committee on Mental Health, within existing budgetary provisions;
9. REQUESTS the Director-General to circulate to governments the recommendations of the subcommittee regarding the use of Disulfiram (tetraethylthiuramdisulfide);
10. REQUESTS the Director-General to consider the possibility of publishing a classified bibliography on alcoholism, within the authorized publication programme of the Organization;
11. REQUESTS the Director-General to study the possibility of making available, to important libraries, sets of the Abstract Archive of the Alcohol Literature existing at Yale University, and to submit detailed proposals and budgetary estimates to the ninth session of the Executive Board for its consideration;
12. REQUESTS the Director-General to bear in mind the value of international courses and travelling study-groups on alcoholism when framing future proposals for the mental-health programme of the Organization; and
13. AUTHORIZES the holding of a second meeting on alcoholism by the Expert Committee on Mental Health in 1951, within the existing budgetary provision.

(Resolution EB8.R45, *Off. Rec. World Hlth Org.*

session was opened by Dr. Martha M. Eliot, Assistant Director-General, Department of Advisory Services.

1. General Considerations

The first point that the subcommittee wishes to emphasize in its report is the importance of alcoholism as a disease and a social problem. It appears to the members that this problem is one to the prevention and treatment of which public-health services could make extensive contributions. They feel, however, that at present in many countries the public-health authorities have been slow to recognize the extent and seriousness of the problem involved and the extent to which health workers could contribute to its prevention and treatment.

This, however, is not surprising; it is only within comparatively recent years that a medical and scientific outlook on the problem has developed which makes public-health action possible. The subcommittee was interested to note, for instance, the evident lack of such medical and scientific knowledge which prevented the League of Nations Health Committee from undertaking an active programme when it considered the matter at its thirteenth session in 1928.[2] There was at that time no differentiation between a medical and scientific outlook on the one hand and the approach of lay reform-groups on the other. Action against alcoholism was confused with political and social action against alcohol. It is probable that at that stage any attempt on the part of physicians and public-health workers to prevent and treat alcoholism failed largely because the public could not differentiate between the two approaches.

The subcommittee recognizes the value of legal or social measures related to the distribution and use of alcohol. Although the preparation of such legislation may be no part of the activities of public-health services, they have a duty to advise the authorities responsible for such legislation on the public-health aspects of the problem; but even more important is the recognition by public-health authorities that scientific knowledge on alcoholism now exists which enables a serious attempt at the medical prevention of alcoholism and the successful early treatment of individuals suffering from this disorder to be started.

The subcommittee's first recommendation, therefore, is that WHO should take all steps within its power to stimulate public-health services to undertake work on this problem and should be prepared to provide advisory, educational, and other services on this subject to such national health authorities as request them.

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[2] League of Nations, Health Committee (1929) *Minutes of the thirteenth session*, Geneva, p. 16

2. Definition of the Problem

It is clear from the subcommittee's own discussions that one serious obstacle to international action in this field lies in the lack of a commonly accepted terminology. The term " chronic alcoholism", for instance, is used in a different sense in practically every country from which the members of the subcommittee are drawn. In its narrowest connotation it implies a state in which an individual, as a result of long-continued drinking, has sustained permanent organic damage or serious mental deterioration presumably dependent on such organic changes.

At the other end of the scale, in some countries it is used in a much broader sense to signify continued excessive drinking regardless of irreversible physical or psychic damage. It appears to the subcommittee, therefore, that, for international use, the term " chronic alcoholism " is liable to provoke confusion, since, although the subcommittee finds within its members a high degree of agreement about the clinical phenomena involved and the stages by which they develop, they are equally impressed by the misunderstandings which may arise from the international use for terms which have a different significance in different countries.

The general term " alcoholism " on the other hand appears to have a much more constant meaning in the countries in which this problem is of importance. In this report the subcommittee uses this term to signify any form of drinking which in its extent goes beyond the traditional and customary " dietary " use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behaviour and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiopathological and metabolic influences.[3]

From a clinical point of view, the subcommittee is agreed that the development of alcoholism (using the term in the sense defined above) may pass through a series of recognizable stages, each of which has a different significance both for prognosis and treatment.

In the first of these, which has aptly been described as " symptomatic drinking ", alcohol is taken to deal with a current problem. The problem may be that of stress on the individual arising either from physical conditions, from psychological factors, or from social circumstances. The excessive drinking is used as an anodyne to enable the individual to face the current problem. It is important to realize that this may occur not only in individuals who have previously been unaccustomed to alcoholic beverages but also in those who have for many years taken alcoholic beverages in a moderate manner without deviating from the acceptable drinking

[3] This broad ad hoc definition implies that alcohol addiction is regarded here as a special and extreme form of alcoholism.

patterns of the community in which they live. The use, however, of alcohol as a means of dealing with current stress, which we have termed above "symptomatic drinking", may well create further difficulties for the patient concerned. These difficulties again arise from physical symptoms, psychological factors, or social problems. As examples, one may quote anorexia due to gastritis, feelings of inferiority arising from behaviour while intoxicated, disturbances of personal relationships, or occupational ineffectiveness. It is at this stage that the patient who originally used alcohol in excess to ease a current stress now finds it necessary to use it also to mitigate the symptoms which the previous excessive use of alcohol has itself provoked. The anorexia of alcoholic gastritis, for instance, may be dealt with by the stimulating use of aperitifs. Alcohol may be used to overcome the individual's sense of social inferiority or, in the case of problems of social relationships or occupational ineffectiveness, to blunt the additional difficulties which these results of his previous drinking have created for the patient.

At this stage it is clear that a situation far more serious than "symptomatic drinking" has arisen. The patient is involved in a circular process whereby his excessive drinking creates additional problems for him which he can face only with the aid of further excessive drinking. The condition of true alcoholism has been established. In this second stage, in certain countries, the problem is referred to as that of "addictive drinking". In considering the use of this term the subcommittee has been interested to note the definition of drug addiction adopted by the Expert Committee on Drugs Liable to Produce Addiction in the report on its second session.[4]

At this stage, the subcommittee believes that a condition of addiction in terms of that definition may be said to exist with the reservation that point (2) (a tendency to increase the dose) is not necessarily present. It is uncertain whether or not the pharmacological concomitants of drug addiction exist in the sense of a profound modification of metabolism creating a physical dependence on the drug. This is a matter urgently demanding research and the subcommittee recommends that consideration should be given to the setting-up of a Subcommittee on Alcohol of the Expert Committee on Drugs Liable to Produce Addiction to consider this and other matters concerning alcohol (as opposed to alcoholism) which will be referred to later in this report.

[4] "Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

(1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;

(2) a tendency to increase the dose;

(3) a psychic (psychological) and sometimes a physical dependence on the effects of the drug."

(*World Hlth Org. techn. Rep. Ser.* 1950, **21**, 6)

The third stage in the development of alcoholism is the appearance of organic disease or psychic deterioration, e.g., the Korsakoff psychosis. In certain types of organic damage the appearance or non-appearance will depend to a considerable extent on factors other than the extent and length of excessive drinking, as in the case of delirium tremens. The development of polyneuropathy, for instance, can be completely prevented regardless of the extent of alcoholism by an adequate intake of vitamin B complex. Similar extraneous factors influence the appearance of cirrhosis of the liver. Certain complications will therefore be much more prone to occur in countries where nutritional deficiencies are common and where the medical treatment of acute intoxication is inadequate.

These three stages in the development of an individual case of the disorder of alcoholism are of considerable clinical significance. Current psychiatric practice suggests that in the first stage of symptomatic drinking it is in many cases possible to deal with the underlying cause which has provoked the symptom. If this is successfully done, the patient can resume moderate controlled drinking such as may have been his practice before the development of his alcoholic episode. In the second stage, however, which has been referred to as " addictive drinking ", not only is the prognosis much more serious and the therapy more difficult, but the aim of the therapy itself must be modified. It must be recognized that such an individual cannot expect again to become a moderate drinker; the aim of the therapy must therefore be the achievement of complete abstinence. It is clear that some irreversible change in the individual has taken place, and it remains for further research to demonstrate the extent to which this irreversible change rests on psychological and physiopathological factors.

The indications of recent researches are that the so-called " addictive phase " of alcoholism may have a physical basis which may be of a constitutional nature. Since, however, the excessive " symptomatic" drinking which is a prerequisite of the " addictive phase " is psychogenic or sociogenic, or both, psychotherapy remains indispensable. Furthermore, while great advances have been made in the investigation of the physical basis of " uncontrolled drinking " (the addictive phase), the theories are still too little developed to warrant statements such as " the treatment of alcoholism is purely a problem of internal medicine ". Such statements can lead only to a discrediting of efforts toward the rehabilitation of alcoholics, to the discouragement of their families from using the facilities at present available, and to the shattering of many hopes. But although it is not solely a medical problem, the main responsibility for leadership in the early treatment of alcoholism must rest with health workers.

Apart from the definition of the clinical stages of alcoholism, many other problems of definition arise. The term " tolerance ", for instance,

is used in the scientific literature of alcoholism in many different senses. From the clinical point of view, it appears desirable to the subcommittee that the use of this term should be restricted to signify the relation between the amount of alcohol ingested and the effects produced upon the individual. In other words, tolerance describes the level of the threshold dose of alcohol for a given individual beyond which impairment of functional efficiency occurs. In this sense, therefore, the concept of tolerance falls within the field of pharmacology. Should the subcommittee's recommendation for the setting-up of an Alcohol Subcommittee of the Expert Committee on Drugs Liable to Produce Addiction be acted upon, it is recommended that this problem of tolerance to alcohol, in the sense in which the term is defined above, should be referred to this subcommittee for study.

One other term frequently used in the literature on alcoholism requires some discussion, namely, the term " cured ". Once an individual sufferer from this disorder has passed the first stage of " symptomatic drinking " and entered that of " addictive drinking ", as the subcommittee has stated above, he cannot expect to become again a moderate drinker. Therefore, once an alcoholic has reached this stage, " cure ", in the strict sense of the word, is impossible; the aim of treatment at this stage is to arrest the condition by enabling the individual to remain permanently abstinent.

In assessing the efficacy of various forms of treatment, therefore, the proportion of patients able to remain abstinent for a predetermined period can be used as an index of the success of the treatment in arresting the condition, but such success should, in the opinion of the subcommittee, be referred to as a percentage of cases " successfully arrested " rather than " cured ". In addition, the subcommittee feels that, in much of the literature on this subject, the criterion of " successfully arrested " is far too lax. This term should be used only for those patients who have been able to remain completely abstinent for several years. A scientific paper, which presents as " arrested " cases who are reported as continuing abstinent after such short periods as three or six months, cannot be considered a serious contribution to the literature. The most responsible workers on the other hand have tended to adopt very rigorous criteria and not to report cases as successfully arrested until the abstinence has continued for at least two or more years.

3. Extent and Nature of the Problem

The discussion of the experience of the various members of the subcommittee in their own country makes it apparent that to view alcoholism internationally brings to light aspects of the problem which the national observer within his own country would fail to see. One of these is the extreme variation in social drinking customs and habits in different