Drinking Before Detention

A Survey of the population of a Senior Detention Centre to ascertain if excessive drinking or alcoholism could be detected

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IN VIEW OF THE RESULT of a survey, carried out by one of us (P.M.S.) in a corrective training prison, which revealed an estimated rate of alcoholism in the order of between 30 per cent and 40 per cent, it appeared important to ascertain if drinking problems could be discerned in an earlier age group. Permission was sought and granted to carry out a survey at New Hall Detention Centre, Flockton, near Wakefield.

The inmate population of this Centre is approximately 85 and it was decided to screen 100 consecutive receptions. A questionnaire was compiled which enabled us quickly to eliminate those who quite obviously were not accustomed to heavy drinking and at the same time assess the method of drinking and indicate whether any symptoms of early alcoholism were present in those who were accustomed to heavy drinking. It was necessary to define alcoholism and clarify the early symptoms of both excessive and alcoholic drinking.

Excessive drinking is any form of drinking which in its extent goes beyond (i) the traditional or customary "dietary" use, or, (ii) the ordinary compliance with the social dietary customs of the whole community concerned, irrespective of the aetiological factors leading to such behaviour, and irrespective also of the extent to which such

aetiological factors are dependent upon, hereditary, constitutional, or acquired physiological and metabolic influences.

Summarized, this is drinking in excess of normal dietetic and social customs; this is irrespective of any hereditary, personality, mental, or physical factors relevant to the individual.

Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance, or an interference with their bodily and mental health, their interpersonal relationships and their smooth social and economical functioning, or who show the prodromal signs of such development.

The early symptoms of both excessive and alcoholic drinking within these definitions are those suggested by the late Professor Jellinek (W.H.O. Techn. Report Series No. 48), which is a pattern of symptomatology which our own experience as well as all other workers in this field has confirmed. Excessive drinkers have the same sort of symptomatology, except, of course, this is non-progressive. It must be remembered that one in four excessive drinkers become alcoholics after about fifteen to twenty years of drinking. In alcoholics the progression extends over some ten to twenty years, so we shall only consider the pre-alcoholic, prodromal, and start of the crucial phases. These will now be given in full from:

World Health Organization
Technical Report Series Number 48.

Expert Committee on Mental Health.
Alcoholism Sub-Committee, 2nd Report.

THE MEANING OF SYMPTOMATIC DRINKING

The use of alcoholic beverages by society has primarily a symbolic meaning, and secondarily it achieves "function". Cultures which accept this custom differ in the nature and degree of the "functions" which they regard as legitimate. The differences in these "functions" are determined by the general pattern of the culture, e.g. the need for the release and for the special control of aggression, the need and the ways and means of achieving identification, the nature and intensity of anxieties and the modus for their relief and so forth. The more the original symbolic character of the custom is preserved, the less room will be granted by the culture to the "functions" of drinking.

Any drinking within the accepted ways is symptomatic of the culture of which the drinker is a member. Within that frame of cultural symptomatology there may be in addition individual symptoms expressed in the act of drinking. The fact that a given individual drinks a glass of beer with his meal may be the symptom of the culture which accepts such a use as a refreshment, or as a "nutritional supplement". That this individual drinks at this given moment may be a symptom of his

ratigue, or his elation or some other mood, and thus an individual symptom, but if his culture accepts the use for these purposes it is at the same time a cultural symptom.

In this sense even the small or moderate use of alcoholic beverages is symptomatic, and it may be said that all drinkers are culturally symptomatic drinkers or, at least, started as such.

The vast majority of the users of alcoholic beverages stay within the limits of the culturally accepted drinking behaviours and drink predominantly as an expression of their culture, and while an individual expression may be present in these behaviours its role remains insignificant.

For the purpose of the present discussion the expression "symptomatic drinking" will be limited to the predominant use of alcoholic beverages for the relief of major individual stresses.

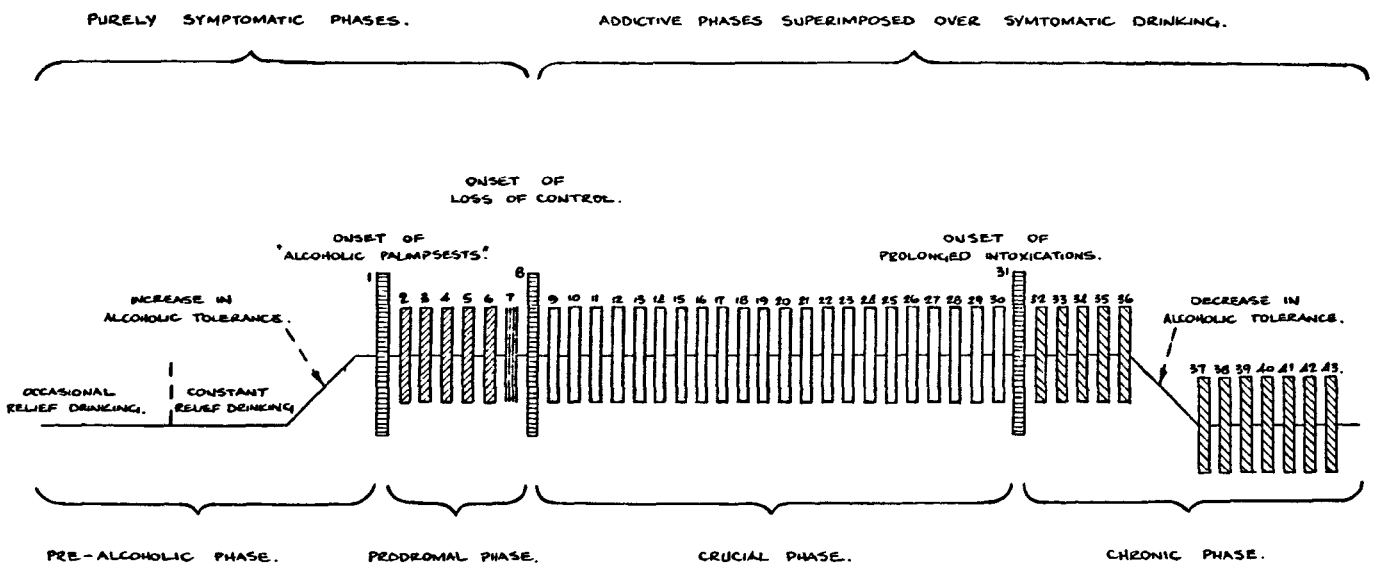
A certain unknown proportion of these users of alcoholic beverages, perhaps 20 per cent, are occasionally inclined to take advantage of the "functions" of alcohol which they have experienced in the course of its "cultural use". At least at times, the individual motivation becomes predominant and on those occasions alcohol loses its character as an ingredient of a beverage and is used as a drug.

The "occasional symptomatic excessive drinker" tends to take care of the stresses and strains of living in socially accepted — i.e. "normal"—ways, and his drinking is most of the time within the cultural pattern. After a long accumulation of stresses, however, or because of some particularly heavy stress his tolerance for tension is lowered and he takes recourse to heroic relief of his symptoms through alcoholic intoxication (this group does not include the regular "periodic alcoholics"). Under these circumstances the "relief" may take on an explosive character, and thus the occasional symptomatic excessive drinker may create serious problems. No psychological abnormality can be claimed for this type of drinker, although he does not represent a well-integrated personality.

Nevertheless, within the group of apparent "occasional symptomatic excessive drinkers" there is a certain proportion of definitely deviating personalities who after a shorter or longer period of occasional symptomatic relief take recourse to a constant alcoholic relief, and drinking becomes with them a "mode of living". These are the "alcoholics" of whom again a certain proportion suffer "loss of control", i.e. become "addictive alcoholics".

The proportion of alcoholics (addictive and non-addictive) varies from country to country, but does not seem to exceed in any country five per cent or six per cent of all users of alcoholic beverages. The ratio of addictive to non-addictive alcoholics is unknown.

PHASES OF ADDICTION TO ALCOHOLISM.



The Chart of Alcohol Addiction

The course of alcohol addiction is represented graphically in a chart of the phases of addiction. The diagram is based on an analysis of more than 2,000 drinking histories of male alcohol addicts. Not all symptoms shown in the diagram occur necessarily in all alcohol addicts, nor do they occur in every addict in the same sequence. The "phases" and the sequences of symptoms within the phases are characteristic, however, of the great majority of alcohol addicts and represent what may be called the average trend.

For alcoholic women the "phases" are not as clear-cut as in men and the development is frequently more rapid.

The "phases" vary in their duration according to individual characteristics and environmental factors. The "lengths" of the different phases on the diagram do not indicate differences in duration, but are determined by the number of symptoms which have to be shown in any given phase.

The chart of the phases of alcohol addiction serves as the basis of description, and the differences between addictive and non-addictive alcoholics are indicated in the text.

The Pre-Alcoholic Symptomatic Phase

The very beginning of the use of alcoholic beverages is always socially motivated in the prospective addictive and non-addictive alcoholic. In contrast to the average social drinker, however, the prospective alcoholic (together with the occasional symptomatic excessive drinker) soon experiences a rewarding relief in the drinking situation. The relief is strongly marked in his case because either his tensions are much greater than in other members of his social circle, or he has not learned to handle those tensions as others do.

Initially this drinker ascribes his relief to the situation rather than to the drinking and he seeks therefore those situations in which incidental drinking will occur. Sooner or later, of course, he becomes aware of the contingency between relief and drinking.

In the beginning he seeks this relief occasionally only, but in the course of six months to two years his tolerance for tension decreases to such a degree that he takes recourse to alcoholic relief practically daily.

Nevertheless his drinking does not result in overt intoxication, but he reaches towards the evening a stage of surcease from emotional stress. Even in the absence of intoxication this involves fairly heavy drinking, particularly in comparison to the use of alcoholic beverages by other members of his circle. The drinking is, nevertheless, not conspicuous either to his associates or to himself.

After a certain time an increase in alcohol tolerance may be

noticed, i.e. the drinker requires a somewhat larger amount of alcohol than formerly in order to reach the desired stage of sedation.

This type of drinking behaviour may last from several months to two years according to circumstances and may be designated as the pre-alcoholic phase, which is divided into stages of occasional relief-drinking and constant relief-drinking.

The Prodromal Phase

The sudden onset of a behaviour resembling the "black-outs" in anoxaemia marks the beginning of the prodromal phase of alcohol addiction. The drinker who may have had not more than 50 to 60 g. of absolute alcohol and who is not showing any signs of intoxication may carry on a reasonable conversation or may go through quite elaborate activities without a trace of memory the next day, although sometimes one or two minor details may be hazily remembered. This amnesia, which is not connected with loss of consciousness, has been called by Bonhofer the "alcoholic palimpsests", with reference to old Roman manuscripts superimposed over an incompletely erased manuscript.

"Alcoholic palimpsests" (1) (the figures in parentheses following the descriptions of the individual symptoms represent their order as given in the chart of the phases of addiction) may occur on rare occasions in an average drinker when he drinks intoxicating amounts in a state of physical or emotional exhaustion. Non-addictive alcoholics, of course, also may experience "palimpsests", but infrequently and only following rather marked intoxication. Thus, the frequency of "palimpsests" and their occurrence after medium alcohol intake are characteristic of the prospective alcohol addict.

This would suggest heightened susceptibility to alcohol in the prospective addict. Such a susceptibility may be psychologically or physiologically determined. The analogy with the "black-outs" of anoxaemia is tempting. Of course, an insufficient oxygen supply cannot be assumed, but a malutilization of oxygen may be involved. The present status of the knowledge of alcoholism does not permit of more than vague conjectures which, nevertheless, may constitute bases for experimental hypotheses.

The onset of "alcoholic palimpsests" is followed (in some instances preceded) by the onset of drinking behaviours which indicate that, for this drinker, beer, wine, and spirits have practically ceased to be beverages and have become sources of a drug which he "needs". Some of these behaviours imply that this drinker has some vague realization that he drinks differently from others.

Surreptitious drinking (2) is one of these behaviours. At social gatherings the drinker seeks occasions for having a few drinks unknown to others, as he fears that if it were known that he drinks more than the others he would be misjudged: those to whom drinking is only a custom or a small pleasure would not understand that because he is different from them alcohol is for him a necessity, although he is not a drunkard.

Preoccupation with alcohol (3) is further evidence of this "need". When he prepares to go to a social gathering his first thought is whether there will be sufficient alcohol for his requirements and he has several drinks in anticipation of a possible shortage.

Because of this increasing dependence upon alcohol, the onset of avid drinking (4) (gulping of the first or first two drinks) occurs at this time.

As the drinker realizes, at least vaguely, that his drinking is outside of the ordinary, he develops guilt feelings about his drinking behaviour (5) and because of this he begins to avoid reference to alcohol (6) in conversation.

These behaviours, together with an increasing frequency of "alcoholic palimpsests" (7), foreshadow the development of alcohol addiction: they are premonitory signs, and this period may be called the prodromal phase of alcohol addiction.

The consumption of alcoholic beverages in the prodromal phase is "heavy" but not conspicuous, as it does not lead to marked, overt intoxications. The effect is that the prospective addict reaches towards evening a state which may be designated as emotional anaesthesia. Nevertheless, this condition requires drinking well beyond the ordinary usage. The drinking is on a level which may begin to interfere with metabolic and nervous processes as evidenced by the frequent "alcoholic palimpsests".

The "covering-up" which is shown by the drinker in this stage is the first sign that his drinking might separate him from society, although initially the drinking may have served as a technique to overcome some lack of social integration.

As in the prodromal phase rationalizations of the drinking behaviour are not strong and there is some insight as well as fear of possible consequences, it is feasible to intercept incipient alcohol addiction at this stage. In the United States of America, the publicity given to the prodromal symptoms begins to bring prospective alcoholics to clinics as well as to groups of Alcoholics Anonymous.

It goes without saying that even at this stage the only possible modus for this type of drinker is total abstinence.

The prodromal period may last anywhere from six months to four or five years according to the physical and psychological make-up

physical and physiological make-up of the drinker his family ties, vocational relations, general interests, and so forth. The prodromal phase ends and the crucial or acute phase begins with the onset of loss of control, which is the critical symptom of alcohol addiction.

THE CRUCIAL PHASE

Loss of control (8) means that as soon as any small quantity of alcohol enters the organism a demand for more alcohol is set up which is felt as a physical demand by the drinker, but could possibly be a conversion phenomenon. This demand lasts until the drinker is too intoxicated or too sick to ingest more alcohol. The physical discomfort incumbent upon this drinking behaviour is contrary to the object of the drinker, which is merely to feel "different". As a matter of fact, the bout may not even be started by any individual need of the moment, but by a "social drink".

After recovery from the intoxication, it is not the "loss of control" —i.e., the physical demand, apparent or real—which leads to a new bout after several days or several weeks; the renewal of drinking is set off by the original psychological conflicts or by a simple social situation which involves drinking.

The "loss of control" is effective after the individual has started drinking, but it does not give rise to the beginning of a new drinking bout. The drinker has lost the ability to control the quantity once he has started, but he still can control whether he will drink on any given occasion or not. This is evidenced in the fact that after the onset of "loss of control" the drinker can go through a period of voluntary abstinence "going on the water wagon".

The question of why the drinker returns to drinking after repeated disastrous experiences is often raised. Although he will not admit it, the alcohol addict believes that he has lost his willpower and that he can and must regain it. He is not aware that he has undergone a process which makes it impossible for him to control his alcohol intake. To "master his will" becomes a matter of the greatest importance to him. When tensions rise "a drink" is the natural remedy for him and he is convinced that this time it will be one or two drinks only.

The report carries on describing all the remaining symptoms which are not relevant for the purpose of this summary.

We now give the questionnaire and the form used for completing the initial enquiry. We submit that these questions give a useful lead to the symptoms relative to the heavy drinker, the pre-alcoholic, the prodromal and the crucial phases of alcohol addiction.

H.M. DETENTION CENTRE
NEW HALL, FLOCKTON, WAKEFIELD

The following lad was received here on.....196.....
Name..... Number.....
Home Address.....
Date of Birth.....Earliest Date of Release.....
Last Job.....Offence/s.....Previous Offences.....
Education .....
Behaviour Pattern .....
Home Background .....

1. Do you drink alcoholic beverages?
2. When, where and why did you have your first drink?
3. What do you drink—beer, wine, spirits, etc.?
4. What is your pattern of drinking—daily, weekends only, etc.?
5. Do you drink more now than you did 12 months ago?
6. How long do you go without having a drink?
7. How much do you drink in a session?
8. For how long have you been drinking like this?
9. Was there any particular reason for a change in your drinking habits?
10. Do you drink alone, in company, or both?
11. Do you try to drink more than the other chap?
12. Do you go to dances? If so, do you need a drink to enjoy yourself?
13. Do you usually drink before attending any social function or going into strange company?
14. Do you drink before committing a crime?
15. Have you ever stolen for the purpose of obtaining money to go drinking?
16. Do you lie to your family and/or friends about your drinking?
17. The morning after a drinking session can you remember clearly all that happened, or only part?
18. Does it take more alcohol now to get intoxicated than it did 12 months ago?
19. Do you spend more on drink than you can really afford?
20. Have you ever tried any drug or pill taking—pep pills, purple hearts, reeters?

It will be seen therefore that we are concerned with the first eight symptoms of the W.H.O. description of this progressive disease, most of the basic research we owe to the late professor Jellinek.

The youths on reception were allowed a settling-in period of two weeks, during which period some of the receptions were re-allocated to other establishments, of the remainder we have checked 100

consecutive youths (completely unselected).

The questionnaire as already given was completed by the social worker. Then, by a process of elimination of all those who very rarely drank, or if at all in only very moderate amounts, we accumulated a list of those who needed to be interviewed and screened more accurately. This screening was done by the two authors.

Those interviewed were divided into groups, as follows: Normal or no problem (as far as drink is concerned) and problem drinkers. The latter group we broke down into four sub groups: Heavy drinkers or potential heavy drinkers; escape (or relief) drinkers; early alcoholics (prodromal phase); alcoholics (crucial phase, showing evidence of addiction). The results are set out in the following table: —

Normal	Problem drinkers				
No problems	Heavy drinkers	Escape drinkers	Early alcoholics	Alcoholics	Total
53	17	12	16	2	100

Broken down into age groups these results can be expressed:

Age in years	Assessment of drinking				Total
	No problems	Excessive or Heavy drinking	Pre-alcoholic	Alcoholic	
17	19	3	2	2	26
18	18	3	4	5	30
19	15	7	4	6	32
20	1	4	2	5	12
Total	53	17	12	18	100
		47 per cent problem drinkers			

From this table it will be seen that 53 were considered to show no evidence of any drink problem at this age, whilst 47 showed definite evidence of some drink problem, 12 per cent being escape drinkers (or to use the W.H.O terminology, symptomatic drinkers or pre-alcoholics), 18 per cent already showed evidence of the disease of alcoholism. The remaining 17 per cent were heavy drinkers, and all the evidence shows that a proportion of heavy drinkers (about one in four), after a period of from 15 to 20 years, become alcoholics.

The fact that 47 per cent of receptions of this group of young offenders have a drinking problem warrants further study and investigation. It would also appear to justify the setting up of some pilot scheme of treatment, and to

ascertain if alcohol has any relationship to crime.

A comparison with other surveys to discover the size of this problem will now be given, and will serve to summarize our work.

Three such surveys have been carried out—one by Dr. Powers at Leeds, another by one of us at Wakefield and a third by both of us at New Hall Detention Centre.

LEEDS (*Dr. Powers*): 150 unselected and consecutive receptions were analysed. 35.2 per cent were considered to be either addictive or non-addictive alcoholics.

WAKEFIELD (*December* 1965): 630 inmates were screened for addictive alcoholism. I considered 171, or 27.4 per cent to be addictive alcoholics.

NEW HALL (*January* 1966): 100 unselected and consecutive receptions were screened. 47 per cent were considered to be problem drinkers, and 18 per cent were addictive alcoholics, while 12 per cent were in the pre-alcoholic phase. This means that at the age of 17 to 21 years, 17 per cent are excessive drinkers, or non-addictive alcoholics, whilst another 30 per cent are potential or actual addictive alcoholics.

To test the accuracy of these pilot surveys, more should be done, but these suggest that alcoholism is a major problem within the Prison Service to the extent of between 25 per cent and 50 per cent of inmates.

Being ourselves rather surprised at the high figures obtained, we are to institute a follow-up of these 100 youths to see whether there are any natural remissions. The possibility of changes of environment and re-establishment within the family circle may, in fact, effect this. The follow-up will also enable us to check on the accuracy of this technique of assessment.

Two other points of interest have arisen out of this work. The Warden, as a result of his experience, suggested that certain youths were unlikely to respond to being in a Detention Centre, and these were in fact amongst those whom we classified as problem drinkers. The social worker, who worked extremely hard on this project, reported that as a result of having a positive interview and enquiring into details of their drinking, found that she had obtained a much better rapport with the whole group than she had previous to this survey.

We conclude by expressing our appreciation to the warden, Mr. Winston, the social worker, Mrs. Rogers, and all members of the staff who have given us every kind consideration and assistance. The 100 youths themselves who must be nameless, readily co-operated with us, and the time at each session spent explaining to them the purpose of calling upon them to give up what was their free time resulted in their full co-operation and they must be congratulated for having assisted in something worthwhile.