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Direct Treatment of a Symptom

Harry Tiebout. M. D.

Therapists with alcoholics have a twofold task. They must treat the disease alcoholism and they must treat the person afflicted with it. Psychiatrists have tended to bypass the disease and treat the individual, but again and again under this approach the patient has proved recalcitrant to all therapeutic endeavor. As a result, alcoholics have been considered very unlikely prospects for therapy of any sort.

The difficulty, of course, was in the main symptom of the disease: the fact that the patient would get drunk, which repeatedly nullified all attempts at assistance. As a consequence, work with the person who drank was stymied by the fact that he drank. In the face of this dilemma, therapists have thrown up their hands in dismay and have turned to greener pastures.

The mistake we made was our failure to recognize that the task was twofold. In rather doctrinaire fashion, we persisted in treating the alcoholism as a symptom which would be cured or arrested if its causes could be favorably altered. The drinking was something to be put up with as best as one could while more fundamental matters were being studied. The result of this procedure was that very few alcoholics were helped. The drinking continued and the symptom remained untouched.

In other medical treatment this concept of getting at causes is not considered sufficient. No one ignores a cancer, for instance, while searching for its origins. It is cut into or treated with x-ray or radium in the hope that the growth will either be removed or will stop advancing. Once the cancer is detected, the question of etiology is academic.

Exactly the same thinking applies to the treatment of alcoholism. It is a symptom which becomes dangerous in itself. Until it has been effectively stopped, little of real help can be offered. Alcoholics Anonymous stresses the danger of the first drink and Antabuse simply stops the ability to take it. Both attack the symptom and both have recorded a substantial measure of success.

The advent of these new tools not only has given us a means of treating the symptom directly, it has focused attention upon a factor whose importance was hitherto insufficiently appreciated. That factor is the significance of the first drink and what it represents to the psyche of the drinker.

Such focusing has two results. First, it directs thought toward the problem of stopping, that is, of not taking the first drink. Second, it leads to a new approach to the understanding of what must transpire in therapy if the alcoholic is to remain sober.

This paper will discuss both those points, namely, the direct treatment of a symptom and the individual's reaction to such a direct approach.

1. The Direct Treatment of a Symptom

The direct treatment of a symptom is and has been the subject of much controversy. A review of the past is necessary to set the controversy in perspective.

Roughly, we can divide the past into the time before Freud and the time after. Prior to his epoch-making revelations about the unconscious and its controlling influence over behavior, all treatment perforce was direct. If a person was acting in a disturbed manner, he was placed in an institution. If he broke the law, he was imprisoned. A naughty child was spanked. Treatment was aimed at behavior and was essentially disciplinary, the big stick. For the most part, it was applied blindly, woodenly, as the only known means of combating the behaviors being encountered.

Then through Freud's work conduct was recognized as an outgrowth of unconscious functioning, and, before long, the field of psychiatry embraced as one of its major tenets the principle that all behavior sprang from the unconscious, and that therapy, when necessary, had as its goal the determination and elimination of the pathology behind upsetting behavior. The validity of such a shift was indisputable. Since former blind methods could be replaced by much more precise measures, direct treatment of a symptom lost all caste. The day of scientific therapy had arrived.

Strangely, though, a new kind of woodenness then appeared. Anything prior to Freud was out, to be viewed dimly and with alarm.

I, too, was an early believer and expounder of the theory that all behavior was symptomatic. 1, as much as anyone, searched energetically for unconscious forces to help alcoholics, and 1, too, fell flat on my face. It just did not work.

Then, as related elsewhere, Alcoholics Anonymous came along and I saw it succeed not only in arresting the drinking, but in helping a person to mature. All my' pet assumptions were knocked into a cocked hat (and it took me many a year to realize the full import of what I had seen happen to my patient as she made the grade through Alcoholics Anonymous).

Unconcerned with causes and not bewitched by dogma, the A.A. program was designed to get the individual to stop drinking, and really nothing else. The aspects of personality inventory and of spiritual growth were useful in A.A. chiefly because they tended to insure the individual's capacity for not taking the first drink. They had nothing to do with causation. The whole program was direct treatment of a symptom.

When this dawned, most of my previous thinking on getting at causes had to be shelved, placed to one side, so that this new fact could be studied open-mindedly.

Antabuse came along to confirm the soundness of tackling the symptom, and the need to find an explanation for that heretical fact became more imperative. Finally, the significance of the first drink became apparent, and then the corollary fact that the individual must stop taking even "one".

With the recognition that total abstinence was the goal of both methods, pre-Freud direct management of symptoms took on a different significance. This, too, was to be seen as an effort to change the individual's behavior either by putting him in an institution for the mentally ill, or by jailing him, or by inflicting punishment. To be sure, these techniques might be applied without much precision and perhaps too often, but they nevertheless effectively stopped the symptoms, and perhaps that, in and of itself, was not only useful but necessary. Certainly, insofar as helping the alcoholic was concerned, the direct method worked. In my eyes, such treatment had been reestablished as a sound clinical procedure and a valid tool. Hopefully, it could be applied with more skill and finesse now that the Freudian insights were available, but to dismiss it totally would be inexcusable rigidity and evidence of very unscientific dogmatism.

2. The Individual's Reaction

With the acceptance of the validity of the direct approach, the treatment of the alcoholic individual takes on a new dimension. Instead of determining causes, the therapeutic aim is directed toward helping the patient to utilize available techniques, A.A., Antabuse, and/or psychiatry, to aid in his battle to stop drinking. The therapist, so to speak, has his prescription. His job is to sell it to the patient.

At this point, we run into a fundamental issue. Most patients take their doctor's prescription. Very few alcoholics respond that simply. As a result, the doctor has the task of inducing the patient to take the medicine offered, and it is ' here that we must consider the nature of the alcoholic, the individual who balks at taking the remedy suggested. This brings us to our second point, namely, the nature of the individual who so stubbornly refuses to stop drinking.

More accurately, the topic of this section is the nature of the individual's reaction to direct treatment. The physician for the alcoholic, regardless of his personal inclinations or his theoretical convictions about the function of the therapist, is placed in the role of someone who is trying to stop the patient's drinking. And although the alcoholic may desperately want help consciously, this does not necessarily overcome his unconscious resistance to such authoritative handling. The therapist inevitably acts as a depriving person.

To try to avoid that role is silly, misleading, and a very poor example. Silly because it denies the obvious, and misleading because it is attempting to sugar-coat an unpalatable truth. A poor example, because the therapist is denying realty-behavior at

which the patient is already expert. Fundamental respect can never be established on such a false basis.

As a consequence, the therapist must not fight the patient's identification of him as a depriving figure. There is no loophole from that position. The only hope is to help the patient learn to accept deprivation and therefore reach a state in which, as a mature person, he will realize that all his wants and demands cannot be satisfied and that there are some things he cannot have.

The therapist must not sidestep his depriving role; instead he must freely acknowledge it and let therapy begin right there. To do so clears the atmosphere and paves the way for establishing a sound working relationship.

The following clinical material shows not only these new tactics which must be adopted but also the patient's reaction to them. The patient is a man in his middle thirties who, after six years of stumbling success with A.A., decided to try psychiatry because, to quote him, "I'm almost as bad as when I started with A.A. I've got to do something." It was clear that he was strongly motivated, and consequently he was accepted for therapy. The patient was told that his immediate problem was drinking and that it could ruin his chances of profiting from assistance. There would be no insistence on total sobriety, but there would be the following stipulation: if in my opinion his drinking was interfering with therapy, I could require him to take Antabuse, which would insure sobriety over a period long enough to settle whether or not he could profit from treatment, so that later on he might be able to get along without the medication.

The patient promptly accepted this proviso, saying it made complete sense to him. On the surface he seemed completely receptive. He remarked in confirmation, "I know when I'm drinking it would be a waste of your time to try to help me; I just wouldn't get a thing." No trace of protest could be observed and I am sure none was felt. In fact the patient seemed to welcome a forthright statement of what lay before him. He at least knew where he stood.

Also during the first interview the patient was asked to record his dreams. At the next session, he reported the following:

I. Irritated and teased pet bird.

2. Vaguely remember X.Y. Think was drinking with him.

3. Accidentally pulled all the tail feathers out of pet bird.

The first dream he then expanded, adding, "the pet bird was mine and it was caged and visibly annoyed." Little imagination is required to read the unconscious thoughts at this point. Birds stand for freedom, i.e., "free as a bird." A caged bird is not free and, therefore, is "irritated" and "visibly annoyed," feelings which every freedom loving person would show if caged. And no one would deny that a caged bird was a stopped one. The first dream pinpoints the fact that therapy was designed to stop drinking.

The next dream finds the patient drinking with a boon companion, a person he was prone to turn to after sobriety had begun to pall. In this dream, quite literally, the bird becomes the patient, escaped from the cage, and the cage which has been escaped from is the knowledge about the danger of the first drink.

The report of the third dream also received interesting amplification. The patient volunteered that the bird flew by him and that, as it did, he grabbed at it and "pulled every last tail feather off, and all that was left was a bare little butt end." Again the message of the dream is clear. The free bird, again in the picture, presents its butt end to the world, an unequivocal gesture of defiance.

The story that these dreams have to tell seems unambiguous. The patient is coming for help about his alcoholism, which he knows can be treated only by his not taking the first drink. The symbol of the caged and annoyed bird is a brilliant condensation of three aspects of his own self as it reacts to his new situation. First, the bird is a symbol of freedom; second, it represents the sense of restriction which is the cage; and third, it shows the "visible annoyance" and "frustration" which the bird feels as it is confronted by the fact that it is not at liberty. In the second dream the patient is no longer stopped. The third dream reveals this clearly as a defiant response to the therapy.

No doubt other interpretations with which I would have no dispute may be offered for these dreams. The point is, however, that the theme of stopping is also unmistakably present in the patient's unconscious which shows a completely understandable reaction to the idea of being stopped and frustrated.

Despite the note of defiance on which they end, these dreams actually started therapy off on a good sound basis. First and foremost, the patient learned that he had unconscious attitudes. Although he protested vigorously that he had no feeling of defiance toward either the doctor or the treatment, he knew that on many occasions he had shown and felt just such inner attitudes. He could now appreciate that defiance was in his system even contrary to his desires and in spite of his failure to be aware of it. From now on, he would have to recognize the presence of an inner-feeling life which psychiatry might help him reach and learn to handle better. Any lurking misgivings regarding psychiatry were to some extent lessened.

In addition, the patient had to face his inner demand to be free and that inside he balked at any curbing. Recognition of this fact was comforting, for it gave him a belief that further insights might be forthcoming and that the possibility of help might exist.

Still a third advantage to his start sprang from the discussion of defiance and the insistence upon freedom. The patient's immediate reaction was to scold himself for acting that way and to feel guilty that he had allowed such attitudes to persist. When he could realize that these forces were deep-seated and real, he could drop his punitive reactions of guilt and focus upon the more important issue of how he could rid himself of

his tendency to defy and his desire to cherish his freedom at the expense of his sanity. The burden of guilt could be lifted and with it the tensions which contributed so much to his drinking. Therapy was obviously under way.

As this example shows, the patient's negative responses to the direct approach need not be feared, because they can be used to suggest to the patient the idea that their very presence, while easy to comprehend, is an indication of where his trouble lies.

Let me summarize briefly the points made so far. First, the treatment of the alcoholic must initially focus on his drinking. To say this is not to ignore the person or his body. They must always receive attention regardless of the ailment. However, the primary emphasis on the control of the drinking is essential if treatment is to succeed. Second, the patient's reactions to direct treatment not only do not undermine the therapeutic relationship, but may actually enhance it. As those reactions are discovered and faced, a solid foundation for a good therapeutic experience is created. To act otherwise can only result in confusion.

Before closing, a few comments are in order. First, the importance of timing cannot be overemphasized. The patient who reacted well to an active technique was ripe for the plucking. He wanted to quit and had been trying to for several years. He was a perfect candidate for the direct approach.

Actually he was at the end of a very long trail. It began with his drinking blithely and unconcernedly. It was nearing its conclusion hopefully with his' earnest desire not to take the first drink. Space limitations prevent my identifying and discussing all the various sections of that trail. Suffice it to say that he could now seek help with no conscious reservations.

Actually, such direct methods can be applied only when the patient is in a receptive frame of mind. A whole paper could be devoted to a discussion of how the patient's defenses must weaken so that he is willing and able to turn for help. To be direct when it is certain that such an approach will bounce off a shell proof exterior is obviously bad timing. It wastes ammunition which could later be effective. Other measures must be used first in an effort to soften these defenses. The direct approach can be ventured only when the patient is sufficiently vulnerable to make its success likely.

Secondly, what should be the doctor's attitude toward the patient's drinking during therapy? In the "platform" placed before the patient, I included a "wait-and-see plank." This I did for three reasons. In the first place, I did not want to give the impression of acting before I, too, was in possession of the facts about the drinking pattern. If it continued and caused difficulty, here was concrete evidence on which to base a decision about Antabuse.

A second reason for a tentative approach was the hope that the usual concept of the disciplinarian as dogmatic and arbitrary could be undercut if I adopted a less adamant program. If later on it became necessary to crack down, the patient would not be

justified in claiming that the new tactics were evidence of a hopelessly closed mind toward drinking.

One patient tried to puncture that stratagem by ferreting out the reason for the delaying tactics and accusing me of waiting until he had hanged himself. Since that was true, I admitted the charge and went on from there. I told him he still had to look at the fact that he had hanged himself. The focus was kept on the drinking problem; that he still had to face.

The third reason for adopting a non-dogmatic policy was to place myself in the position of being able to discuss the problem of the drinking with the patient directly. Generally with such delaying tactics the patient makes an extra effort at control and as a rule succeeds for a while, after which the condition usually takes its course and the patient gets drunk. At that point, it is possible to review with him his hopes of controlling intake and his consequent disillusionment and renewed awareness of his drinking problem. In this manner, the patient's feeling of need for help is revived and motivation is thereby strengthened. Therapy can thus proceed on a firmer footing.

My third comment opens up a vast area. It has to do with the significance of the direct approach in treating alcoholism or any other condition. The full import of this question can only be hinted, but an effort must be made to point out the far-reaching bearing of the direct approach with its stopping-attribute.

One way to discuss the significance of being direct is to ask the question, "How much of the handling of people is of the direct or stopping-variety?" To my mind the answer is, "Far more than most of us realize or have ever suspected." As already pointed out, incarceration is a form of direct treatment. It still has its values in certain situations. Its more respectable counterpart, the trip or vacation or residence in a sanitarium, serves much the same purpose, namely that of lifting the individual out of the whirling currents of his everyday existence and depositing him in a setting where he can slow down and stop. One can also wonder at the new therapies. Certainly shock gives the body and mind an awful beating which in some obscure fashion perhaps may serve a disciplinary, hence stopping, function. Again the sleep therapies put the patient in an enforced rest and, for the time being, effectively stop him.

Children are told to "cut that out" and know that they are being stopped. While the routine use of such a phrase is severely to be frowned upon, the teacher or person in authority who cannot use that phrase when necessary is badly handicapped in the performance of his job.

Youngsters in the nursery school or kindergarten reveal the need for stopping. Good practice has periods of free play interspersed with times when the children sit and draw or paint or listen to stories or have rest periods. These quiet times are designed to slow the youngsters down. On occasion, particularly with a new and inexperienced teacher, the class gets too keyed up and, since this kind of excitement is infectious, the class

goes "wild." It then must be dismissed for the day. The firm hand of the good teacher was lacking and the children got out of control.

Certainly a lot of preventive mental hygiene is of this same stopping variety. -- We sleep, we play, or take holidays to provide a break or a cut in the monotony of continued plugging. We seek avocation interests to change our life pattern. Part of the undoubted value of church attendance arises from the peace and quiet of the religious ceremonies and the soothing atmosphere of the church surroundings.

The list is long and could be expanded almost indefinitely. Most rule-of-thumb therapy is of this sort. To rule directness out because it is not scientific may hamstring our effectiveness as people. Neither was surgery, which is a "cut-it-out" technique, too scientific at the outset, but its value was never doubted, and as it went on, the skill in its application advanced until its use is now routine, always, of course, where it is indicated. Yet, obviously, surgery only tackles a symptom, a resultant of infection or tissue change. The surgeon's concern with cause does not hinder his taking appropriate action.

Similarly the psychiatrist should not hesitate to cut in. He should not be just a butcher with a knife, but perhaps more than is the custom, the psychiatrist should assume responsibility for things happening to his patient. He must not fall back on the excuse that his patient was uncooperative or poorly motivated; he must do his bit to shift attitudes so that cooperation is obtained. Sometimes a little discipline, artfully applied, works wonders. To discard it entirely may deprive one of a very necessary therapeutic resource.

In Conclusion

Let me repeat what I initially stated, namely that the treatment of the alcoholic must include direct treatment of the symptom. This does not exclude the value of deep insights; it merely rechannels them into an understanding of why the patient blocks from taking the remedy prescribed. The study of causation is shifted from origins to the causes which obstruct the therapy. As they are uncovered and resolved, not only is sobriety attained but the inner changes necessary to a sober existence can be and are developed.

The truth of this last statement I can only vouch for at this time. In a later paper I shall try to prove the validity of this claim. In the meantime, this paper will have served its purpose if it has alerted the reader to the dangers inherent in the rigid application of the concept of symptomatic behavior and has tempered his antagonisms to disciplinary measures when properly applied. If it has, the effort to prepare it has been worthwhile.