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Treatment of Alcoholism in Trinidad and Tobago, 1956-65

By M. H. BEAUBRUN

This paper describes and attempts to evaluate an alcoholism treatment programme in two Caribbean islands with a multi-racial population of just under a million. The programme, initiated by the author in 1956, combined emetine aversion treatment in a group setting, with milieu therapy and group psychotherapy of a didactic kind aimed at producing conversion (rather than aversion) to uncritical belief in the tenets of Alcoholics Anonymous.

Important features of the programme have been:

(1) Close collaboration with Alcoholics Anonymous.

(2) The employment of a well-motivated Group leader and a Rehabilitation Officer who was himself an alcoholic.

(3) Follow-up of discharged patients at an Alcoholism Out-Patient Clinic and by A.A. liaison.

(4) Mobilization of other community resources for public education, Government lobby and the changing of community attitudes.

(5) The role of "social gatekeepers" in making the diagnosis of alcoholism more acceptable.

The demographic peculiarities of the population under study are seen as significant to the measure of success achieved. Some discussion is attempted of an hypothesis which might explain the differential incidence between Negroes and East Indians among those seeking treatment.

Demography

Trinidad and Tobago, two islands at the southernmost point of the archipelago of the West Indies, together form one country which achieved independence within the British Commonwealth in August 1962. There, 950,000 people live on 1,981 square miles. The population is mainly of African and East Indian origin. The African and mixed groups comprise about 55 per cent. (African 38 per cent., mixed 17 per cent.) and the East Indians about 38 per cent. The remaining 7 per cent. are made up of Chinese, Syrian-Lebanese, English, Scots, Portuguese, Spaniards, North Americans and Latin Americans.

Size of the Problem

Accurate prevalence data are not available,* and hospital admission rates reflect only the availability of treatment resources and public awareness of the problem. Nevertheless, within the past ten years the growing number seeking admission to the Alcoholism Treatment Centre and the proliferation of groups of Alcoholics Anonymous (31 groups) has shown that there exists a problem of some size (*A.A. World Directory*, 1963 and 1965).

The author believes that throughout the Caribbean alcoholism is a significant problem, but the reported incidence has varied widely from 47·6 per cent. of mental hospital admissions in Nassau (62·5 per cent. of male admissions) and 53 per cent. in Martinique to 0·3 per cent. in Kingston, Jamaica.† Where treatment facilities for alcoholics are provided and where an interest is shown in the problem the incidence appears to increase.

Bordelau and Kline in a Report on Haiti expressed surprise "at the apparent rarity of alcoholism in a country where alcoholic beverages are so easy to obtain and where so

* A field survey of Drinking Habits in Jamaica (680 households, 1,472 interviews) has just been completed by the U.W.I. Department of Psychiatry and it is hoped to undertake a similar study in Trinidad and Tobago soon.

† Figures from annual returns of Sandilands Hospital, Nassau; Colson Hospital, Martinique, and Bellevue Hospital, Kingston (1965).

many of the circumstances said to be productive of alcoholism are present" (Bordelau and Kline, 1962). On the other hand psychiatrists in Martinique, where the culture and ethnic composition are similar to Haiti, report that more than half of the total admissions to the Colson Hospital are for alcoholism.

In Trinidad in 1956 it was commonly held that there was little alcoholism. When in 1957, in a radio address (subsequently published, Beaubrun, 1957), the writer estimated, using the Jellinek formula, that there were probably 25,000 alcoholics in Trinidad, there was much medical scepticism expressed. Annual admissions to the mental hospital had shown no more than 15 to 20 alcoholic admissions per annum prior to 1956, but the number increased rapidly as treatment facilities were made available. In 1956 there were still only 58 admissions, but in 1961, when the 20-bed Alcoholism Treatment Centre was opened at the hospital, the number admitted for treatment was 332, of whom 315 were treated at the Centre. Since then admissions have diminished a little only because they were curtailed deliberately to avoid a too rapid turnover, but the Alcoholism Out-patient Clinic run by the Centre recorded 993 attendances in 1962.

Alcoholics Anonymous began in Trinidad in 1956, and by 1963 had 21 active groups and a membership of 864 (A.A. World Directory, Spring 1963). By 1965, there were 31 A.A. groups in Trinidad and Tobago (29 Trinidad and 2 Tobago: A.A. World Directory, Spring 1966) and two groups of Al Anon (described below).

Type of Alcoholism, Diagnostic Criteria and Price of Beverage Alcohol

The type of alcoholism encountered was mainly "gamma" alcoholism, (Jellinek, 1960) characterized by loss of control and a steady progression from psychological to physical dependence, one drink being usually enough to start the patient on a drinking binge. The pattern resembled closely the alcoholism of North America and most spirit-consuming cultures. Rum was the drink most commonly consumed, as it was locally produced, readily available and cheap. The most expensive brands sold for W.I. $2·40 (U.S. $1·50, 10/- U.K.) per bottle. Strong "white" rum, 40 per cent. overproof, was considerably cheaper.

Programme

To deal with the problem, the resources of the community were effectively mobilized even without an official Government alcoholism programme. The effective agencies have been:

(1) The Alcoholism Sub-Committee of the Mental Health Association.

(2) The Alcoholism Treatment Centre and Out-patient Clinic of the St. Ann's Hospital.

(3) Alcoholics Anonymous.

(1) *The Alcoholism Sub-Committee of the Mental Health Association*

This voluntary body served the function of a National Council of Alcoholism. About half of its members were abstinent alcoholics, the others included a general practitioner, the psychiatrist from the Treatment Centre, a Catholic priest, a Presbyterian minister, the Health Education Officer of the Municipal Council, the Alcoholism Rehabilitation Officer and other interested persons. They carried out a continuous public education programme through the press, radio and television, and held public film shows with panel discussions. They also held closed discussion groups for members of the clergy and gave talks on alcoholism to the school-leaving classes of the secondary schools. They lobbied with Government for improved treatment facilities and gave lectures to employers of labour, e.g. the Chamber of Commerce.

This committee also ran an Alcoholism Information Bureau open daily in down-town Port of Spain.

An important step was taken when official recognition was granted by Government to the fact that the diagnosis "Alcoholism" should be acceptable on sick leave certificates and "that the patient should be treated as sympathetically as if he suffered from tuberculosis or any chronic illness".

(2) *The Alcoholism Treatment Centre: St. Ann's Hospital*

The present treatment programme at St.

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Ann's grew up gradually from small beginnings. Up to January, 1956 the only treatments in use were techniques of "drying out" with sedation and parenteral vitamins, some explanation to the patient of the nature of the illness and discharge on disulfiram (Antabuse). Further psychotherapy was seldom attempted, as the hospital of about 1,500 patients had never more than three or four doctors. It was found, however, that whenever two or three alcoholics were in a ward together, better results were obtained.

Emetine aversion treatment in a group setting combined with group discussions was begun in early 1956 and showed promise. Emetine was first chosen because in dealing with patients of lower socio-economic levels it was felt that a drastic treatment served to dramatize the starting point of the patient's sobriety. This was a day he had been putting off for years; the treatment should be something he would remember. In conversation with friends afterwards he would exaggerate its rigours and even boast of having undergone it. It was done in groups at first only to save staff time, but it soon became apparent that the group situation produced better results.

The emetine treatment (Voegtlin, 1940; Sargant and Slater, 1954) was used but patients were treated in groups of five or six at a time in a manner similar to that later described by workers at Tulane University (Miller, Dvorak and Turner, 1960). The important difference was that less attention was paid to strict Pavlovian principles and the aim was not so much aversion as conversion.* At first, attempts were made to employ the proper timing and to co-ordinate vomiting, but it soon became clear that this was difficult to achieve and that suggestion played an important role. Tape recordings of patients talking about their illness were played during and immediately after the vomiting sessions. Some patients developed a genuine conditioned aversion, but many others who did not appeared to benefit from the treatment nevertheless. An ego-deflation was produced and their suggestibility was enhanced; group feeling was fostered, and in the group discussions which followed patients who were formerly cynical and self-assured would accept defeat and listen in a receptive manner. Since then the emetine treatment has been used mainly to produce a temporary depression and ego-deflation and to make the patient more accessible to group influences (Sargant and Slater, 1954).

The technique was gradually perfected of debilitating the patient, implanting A.A. ideas in the group setting, then rapidly restoring his physical and mental state with vitamins (Parentrovite), protein anabolic agents (Durabolin) and/or modified insulin. Sometimes antidepressant drugs (phenelzine or imipramine) were needed as well. In the final phase some patients would put on as much as 40 lb.

The "thought reform" thus achieved resembled a religious conversion. Instead of the "transcendental peak" experience described by some mystics and by the users of psychedelic drugs, we seemed to produce something more like the "mobilization of existential guilt" described by Lifton (Lifton, 1963) in his studies of prisoners in Communist China. The patient who had come into hospital only to placate a spouse or to save his job and had had no sincere intention of giving up alcohol would begin for the first time to question his own value system and to think of the mistakes he had made in the past. The A.A. members called this "inducing an artificial bottom in those unable to hit bottom" (Tiebout, 1949).

During the debilitating phase, efforts were made to limit non-A.A. visitors but former patients and other A.A. members were encouraged to visit the unit and literature about alcoholism was left around in the sitting room.*

A Hospital group of Alcoholics Anonymous was formed in 1959, and from then on met every Monday evening on the wards. Members of A.A. were encouraged to come into the ward at all times to join group discussions and to lead groups themselves. As the psychiatrist's time

* Psychedelic drugs may in the future replace emetine in the programme as they seem to facilitate the conversion phenomenon. This would seem a more logical development than the substitution of other forms of behaviour therapy such as "electrical" conditioning.

* In addition to A.A. pamphlets and the Big Book, a pamphlet by Lincoln Williams "Letter to an Alcoholic in Hospital" was found most useful.

was severely limited, it gradually became necessary to have an occupational therapist conduct group psychotherapy of a superficial kind. This group met twice weekly for one and a half hours (Pinto, 1963).

One of our recovered alcoholics was also employed and given the title of Alcoholism Rehabilitation Officer. In fact his function was that of a combined group leader and rehabilitation officer, and he served to stimulate group activity on the ward and to bring reluctant patients into the discussions. His special role as catalyst and go-between was more effective because he was himself an East Indian of artisan class with a polio deformity and a disarmingly tolerant manner. His post is probably the only one in which a Government has laid down that the first qualification for the post should be that the candidate must be an alcoholic! As the majority of our patients were East Indian sugar-cane labourers, we found that having an East Indian of artisan class helped tremendously in breaking down the reserve and allaying the suspicions which the average alcoholic patient brought to the therapist.

The personality of the senior nurse in charge of the ward was also of some importance, as he played the role of a benign father-figure, firm but scrupulously fair in dealing with the patients.

The accent on the ward was on group activity, milieu therapy and work therapy. The ward was purposely understaffed so that the patients had to do a good deal of the work themselves.

In January, 1961 a new building became available and was converted for use as a twenty bed Alcoholism Treatment Centre. The architectural features of this building have probably played a part in therapy. Its design with apparently no doors gave a feeling of being completely open, and there was no suggestion of restraint of any kind (Pinto, 1963).

The average length of stay on the unit was from three to four weeks, and on discharge a note was sent to the secretary of the A.A. group nearest to the patient's home and active sponsorship urged. It was not enough to tell a patient to attend a meeting; someone was sent to bring him to the first few meetings until he got accustomed to the new group. By these measures, A.A. groups were fed continuously from the hospital, and this has probably been responsible for the phenomenal growth of A.A. in the area (see Fig. 1).

(3) *Alcoholics Anonymous*

A.A. was first started in Trinidad in April, 1956, but before this Alcoholics under treatment at St. Ann's had been told about A.A. and introduced to A.A. ideas. Reference has already been made to the rapid growth of new groups, fed from the Alcoholism Treatment Centre. Co-operation between A.A. and the hospital has at all times been excellent, but it has been found necessary to avoid too much helping, as A.A. groups, like alcoholics, become dependent if allowed to do so, and this limits their growth.

From Trinidad, new groups have been started in the neighbouring islands of Grenada and St. Lucia and in the mainland territory of Guyana (then British Guiana). Members have travelled to these territories to sponsor the new groups and to assist in public education programmes in the area.

Recently, the wives have been forming themselves into Al Anon groups, two of which have already celebrated their second anniversary and it has been found that where these groups exist the quality of the family life of the alcoholics has been very much better.

Social Effects

The impact on remote village communities has been quite striking: in small villages such as Williamsville, alcoholics have been elected to the Village Council, and the former "bad boys" almost run the village.

The growth of Al Anon groups has also strengthened the prestige of alcoholics in one or two areas. In little villages where there was little activity for bored housewives, merely being able to dress up and go to a meeting made them the envy of other wives in the village, and those whose husbands were not alcoholics felt left out. Their status was further enhanced by occasional visits from well-to-do alcoholics, from the towns; professional men and successful business men who came down to the meetings in large

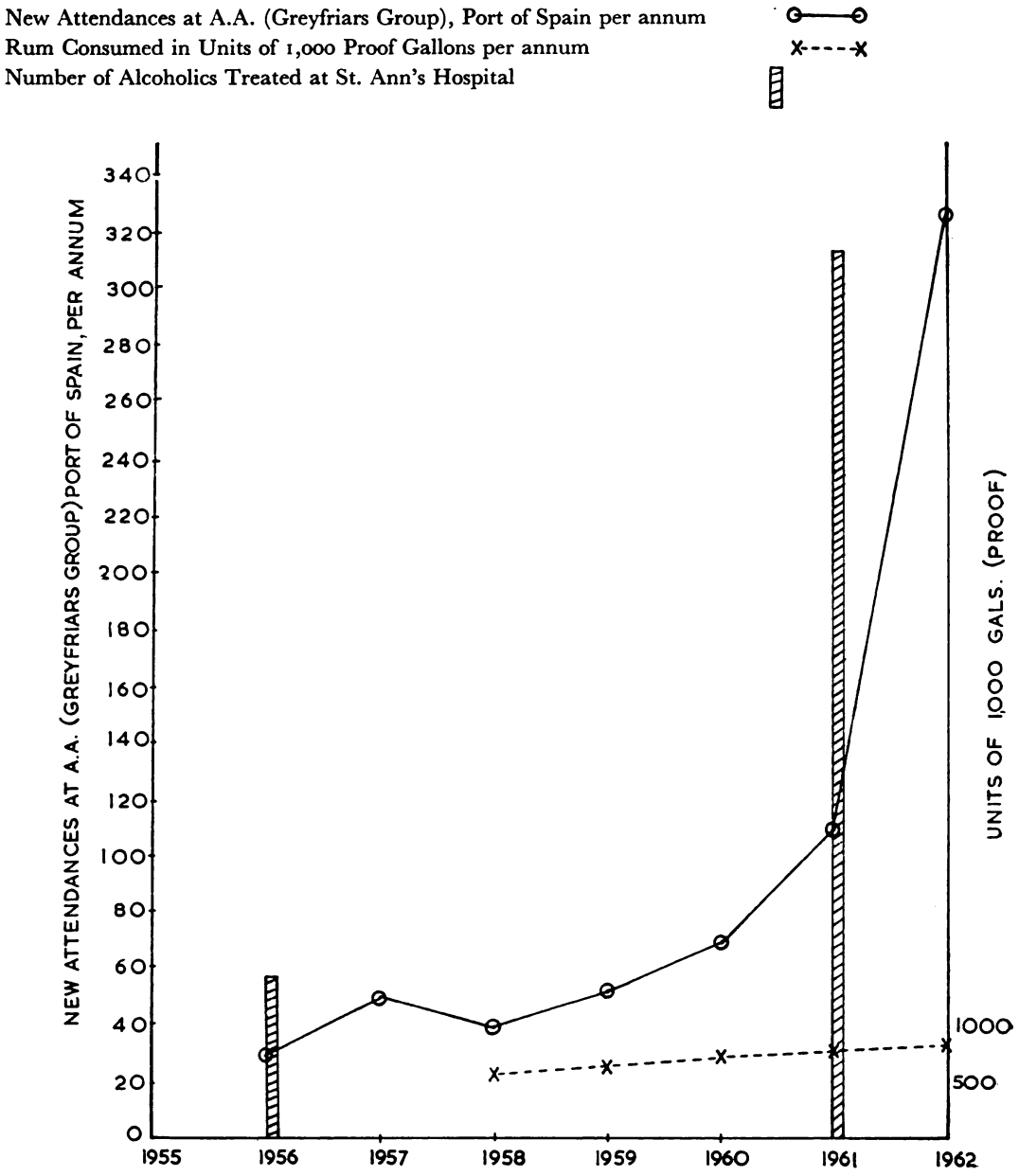

FIG. 1

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cars. The unusual situation arose of social support building up to make recovered alcoholics a prestige group.

In the urban areas an important role was played by the calypso singer or "Calypsonian", the local balladeer whose folk art is exceedingly popular, especially at Carnival time. A number of "calypsonians" were successfully treated at the Alcoholism Treatment Centre, and some sang calypsoes about their illness and did not hesitate to speak publicly about it. This went far to make the diagnosis of alcoholism more acceptable to the urban masses, for the calypso singer in Trinidad is a "social gatekeeper" of a sort and plays a significant role in shaping public attitudes and behaviour.

The readiness of one or two influential members of the business community to come forward and describe themselves as alcoholics, even on radio programmes, contributed to the cultural acceptance of the disease concept of alcoholism and its respectability.

Evaluation

The treatment programme was not initially designed for research, and such data as we have obtained by follow-up must be treated with the reservations due to all such retrospective studies with inadequate matching or controls. Despite these limitations, it is possible to make some useful observations from the contaminated data available.

Follow-up studies were carried out in 1963 and 1964 on two groups of patients:

Group I: all patients treated for alcoholism in 1956 (the year that group treatment with emetine was begun and A.A. started).

Group II: those treated in 1961, the year that the programme was moved into the new Alcoholism Treatment Centre (January, 1961).

In all, 370 patients were studied in these two years, 57 in Group I and 313 in Group II. These figures represented the total admissions for alcoholism, corrected to exclude those whose diagnosis later proved to be psychosis. Those who had been readmitted in 1961 from the 1956 group were also excluded.

Objects

1. To determine in terms of abstinence and social functioning the outcome in Groups I and II.

   (*a*) for all patients treated.

   (*b*) for those treated with emetine and group therapy and who attended A.A. on discharge.

   (*c*) for those treated with emetine and group therapy but who did not attend A.A. on discharge.

   (*d*) for those treated with group therapy who attended A.A. but had no emetine.

   (*e*) for those treated with group therapy who did not have emetine and did not attend A.A. on discharge.

2. To investigate the effects of social class, race, age and religion in terms of outcome.

Method

Follow-up was by questionnaire in the first instance, but the answers received were checked via the grapevine of Alcoholics Anonymous and by our Alcoholism Rehabilitation Officer. In a captive island population of less than a million it was possible for much of the information to be checked in this way, save where the patient had emigrated. Where, however, information was of uncertain validity it has been omitted.

Preliminary information was available from patients' case notes on age, sex, ethnic category, occupation, presence or absence of complications, and whether the patient had had emetine or not.

The questionnaire was devised to elicit information about whether the patient had continued to attend A.A., whether he had had one or more "slips", the duration of such slips, and the period of sobriety intervening; whether he was still with the same wife or partner; how many children and whether supported by him or not; whether still in the same job; number of jobs held since leaving hospital, whether presently employed or not whether he had changed his religion or not. The patient was invited to call at the Alcoholism Out-patient Clinic if not already attending. In many instances

the questionnaire elicited replies not only from the patient but from his relatives. Many patients of whom we had lost sight turned up at the Clinic again. Others were checked on through their nearest A.A. group.

From all this an attempt was made to put together a composite picture of the alcoholic's "social functioning" mainly in terms of his marital adjustment and success in holding a job. Seven categories in decreasing order of successful adjustment were used.

1. Total abstinence or at least two years' abstinence with adequate social functioning.
2. Sobriety of at least six consecutive months with adequate social functioning.
3. Returned to social drinking with good social functioning.
4. Still drinking but making attempts to stop, employed and socially functioning.
5. Failure. Still drinking. Poor social adjustment.
6. Institutionalized for dementia or psychosis.
7. Dead.

Criteria for Admission

All patients were admitted who sought help for an inability to control their drinking.* In fact nearly all patients seen were of the Gamma type (Jellinek, 1960). Alpha and Beta alcoholism were not culturally considered as illness and did not seek help. Delta alcoholism was seen only occasionally.

Factors Influencing Composition of Groups

There was no change in admission policy between the two years under study. Nevertheless, there are significant differences in the composition of Groups I and II which make them not comparable in terms of outcome; but comparison of their characteristics gives information about the changing attitude of the community towards alcoholism in the intervening five years. (Table I.)

The large increase in the total number of admissions and in the percentage of voluntary admissions and the lowered average age reflect the greater acceptance of the diagnosis of alcoholism. The change from a preponderance of Negroes in the smaller first group to a large majority of East Indians (Hindu mainly) 3:1 in the second group, reflects the spread of the catchment area from the capital, Port of Spain, to the country as a whole including more and more rural villages, which are predominantly Indian (The East Indian population was 92·36 per cent. rural, 7·64 per cent. urban in the 1946 census).

Results

Table II shows the outcome in terms of two-year success rate. Group I had by then been followed up for seven years, and in most instances the figures in the first column represent abstinence for practically the whole seven years. Of those on whom full information is available 66·6 per cent. were recovered or improved. Even if all "lost to follow-up" are considered as failures, the overall improvement is still 52·6 per cent. and the total abstinence 36·8 per cent. There is moreover good reason to doubt whether those lost to trace represent failures. Their overall characteristics did not differ materially from those of the group as a whole, except for Social Class. Of the twelve missing from Group I, half were illiterates of Social Class V unable

* After 1961 there was some screening of admissions.

Table I

Some Characteristics of Groups I and II

	Year	No. of patients	Average age	Sex M	Sex F	Certified	Voluntary	East Indian	Negro	Mixed	White	Chinese
Group I	1956	57	43·3	53	4	20 35·1%	37 64·9%	15 26·3%	25 41·1%	9 15·8%	8 14·0%	1 1·7%
Group II	1961	313	40	293	20	38 12·1%	275 87·9%	196 62·6%	70 22·4%	34 10·9%	11 3·5%	2 0·6%

TABLE II

Overall Outcome

(Percentages given as of the total number treated including those lost to follow-up)

	Total abstinence or more than two years consecutively	Adequate social functioning with sobriety of at least six months consecutively	Returned to social drinking	Still drinking but employed, socially functioning and on the wagon from time to time	Failure. Never stopped drinking. Poor social functioning	Institutionalized for dementia or psychosis	Dead	Totally improved and socially functioning. (Successes)	Total failures (including Dead and Institutionalized)	Lost to follow-up	Total Number of Cases
Group I	21 36·8%	4 7%	2 3·5%	3 5·26%	7 12·26%	2 3·5%	6 10·5% (3 by suicide)	30 52·6%	15 26·3%	12 21%	57
Group II	110 35·14%	15 4·79%	0 0%	8 2·55%	43 13·73%	0 0%	10 3·19%	133 42·5%	53 16·9%	127 40·8%	313
	Successes and partial successes				Failures			Sub-totals			

to respond to a questionnaire, and in the absence of paid field workers this probably accounts for the lack of information about them.

In Group II, however, the size of the group lost to trace (40·8 per cent.) assumes more formidable proportions and makes the results less meaningful. Here there are three reasons for the large gap in information.

(1) Illiteracy of the rural population.

(2) Death and migration.

(3) The unpaid research assistant engaged in the study becoming unavailable in 1964, leaving the study incomplete.

Here again the characteristics of the group lost to follow-up do not differ significantly from those of the group as a whole, except for social class. It seems unlikely, therefore, that they are all failures. Presenting the figures in their most pessimistic light still gives a rehabilitation rate of 42·9 per cent., with a total abstinence rate of 35·14 per cent. The ratio of successes to known failures improved from 2:1 in Group I to 2·5:1 in Group II.

We have no information on the fate of untreated alcoholics in Trinidad and Tobago, but a recent paper from the Maudsley Hospital (Kendall and Staton, 1966) shows that in London 15 per cent. of untreated alcoholics had become abstinent and 18 per cent. were dead, 8 per cent. by suicide when followed up six to seven years later. This follow-up interval is directly comparable with our Group I, of whom 36·8 per cent. were abstinent and 10·5 per cent. dead, half of these by suicide.. Our abstinence rates compare favourably with the treated group of 50 reported on previously by Davies, Shepherd and Myers (1956) and by Wing (1956), and though we have a larger group lost to follow-up, we have the distinct advantage of having been the only treatment facility for alcoholics in the country and have therefore none treated elsewhere during follow-up. (Table III.)

TYPE OF TREATMENT

Table IV attempts to correlate outcome with whether or not the patient had emetine or

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TABLE III

Comparison with Maudsley Treated and "Untreated" Alcoholics

	Treated (Davies *et al.*) 50	Untreated (Kendall *et al.*) 49	Trinidad Group I 57
Abstinent	11 (22%)	8 (16%)	21 (36·8%)
Normal drinking	5 (10%)	4 (8%)	2 (3·5%)
Dead	3 (6%)	9 (18%)	6 (10·5%)
Dead by suicide	1 (2%)	4 (8%)	3 (5·26%)
Lost to follow-up	3 (6%)	4 (8%)	12 (21%)
Treatment elsewhere during follow-up	18 (36%)	17 (34%)	0

attended A.A. The usefulness of this breakdown is limited by the fact that there was no matching and no controls. All patients took some part in the group activity and group psychotherapy, but emetine aversion treatment was only given to patients who requested it, and usually only if they had failed with more conservative methods, e.g. disulfiram and A.A. Some patients were not given emetine because of cardiac or other physical complications.

All patients who had not previously been attending A.A. were introduced to A.A. on the Unit, and most of them continued to attend one or more groups outside on discharge.

TABLE IV

Type of Treatment

	Total abstinence or more than two years consecutively	Adequate social functioning with sobriety of at least six months consecutively	Returned to social drinking	Still drinking but employed, socially functioning and on the wagon from time to time	Failure. Never stopped drinking. Poor social functioning	Institutionalized for dementia or psychosis	Dead	Totally improved and socially functioning. (Successes)	Total failures (including Dead and Institutionalized)	Lost to follow-up	Total Number of Cases
Group I:											
Emetine and A.A.	12	1	0	0	0	0	1	13	1	1	
Emetine but not A.A.	3	2	2	0	1	1	4	7	6	4	
A.A. but not emetine	3	1	0	1	2	1	1	4	4	3	
Neither	3	0	0	2	4	0	0	5	4	4	
Total	21	4	2	3	7	2	6	30	15	12	57
Group II:											
Emetine and A.A.	74	8	0	3	10	0	2	85	12	45	
Emetine but not A.A.	10	0	0	0	9	0	1	10	10	39	
A.A. but not emetine	18	5	0	4	14	0	4	27	18	26	
Neither	8	2	0	1	10	0	3	11	13	17	
Total	110	15	0	8	43	0	10	133	53	127	313
	Successes and partial successes				Failures			Sub-totals			

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It is no surprise, therefore, to find a high positive correlation between successful outcome and both emetine and A.A., since both represent the better motivated patients. The figures, however, are reproduced, as the difference in outcome is striking, those who had both emetine and A.A. having a ratio of successes to failures of 98:13, compared with 16:17 for those who had neither emetine nor A.A.:

Those with emetine but not A.A. 17:16;
Those with A.A. but not emetine 32:22.

These figures suggest a synergistic effect between emetine treatment and A.A. We note, however, that A.A. alone seems better than emetine alone.

Table V shows a tendency for success to be correlated positively with skilled and partly skilled manual occupations (Social Classes III and IV). Social Class I did relatively poorly,

TABLE V

Occupational Category

(Using U.K. Registrar-General's five categories plus Retired, Housewife and Not Ascertained)

	Total abstinence or more than two years consecutively	Adequate social functioning with sobriety of at least six months consecutively	Returned to social drinking	Still drinking but employed, socially functioning and on the wagon from time to time	Failure. Never stopped drinking. Poor social functioning	Institutionalized for dementia or psychosis	Dead	Totally improved and socially functioning. (Successes)	Total failures (including Dead and Institutionalized)	Lost to follow-up	Total Number of Cases
Group I:											
Professional, Business and Admin.	4	1	1	1	1	1	2	7	4	2	
Management and some Professional	1	0	0	0	0	0	1	1	1	0	
Skilled occupation, Manual and Clerical	11	3	0	1	2	1	2	15	5	3	
Partly skilled	2	0	1	1	0	0	0	4	0	0	
Unskilled	1	0	0	0	4	0	0	1	4	5	
Retired	2	0	0	0	0	0	0	2	0	1	
Housewife	0	0	0	0	0	0	1	0	1	0	
Not ascertained	0	0	0	0	0	0	0	0	0	1	
Total	21	4	2	3	7	2	6	30	15	12	57
Group II											
Professional, Business and Admin.	4	0	0	1	7	0	4	5	11	9	
Management and some Professional	5	0	0	0	0	0	0	5	0	4	
Skilled occupation, Manual and Clerical	41	3	0	4	15	0	4	48	19	45	
Partly skilled	14	2	0	2	9	0	1	14	10	16	
Unskilled	42	10	0	1	10	0	1	53	11	47	
Retired	1	0	0	0	0	0	0	1	0	0	
Housewife	3	0	0	0	2	0	0	3	2	6	
Not ascertained	0	0	0	0	0	0	0	0	0	0	
Total	110	15	0	8	43	0	10	133	53	127	313
	Successes and partial successes				Failures			Sub-totals			

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especially in Group II, and this may be because the programme was geared more to the needs of Social Classes III, IV and V.

Table VI showed Negroes doing better than Indians but not as well as Whites. The Indians seemed to improve in Group II as the programme became predominantly Indian, but no valid conclusion can be reached, as the number of Indians lost to follow-up was greatest. The Mixed group paradoxically did best in Group I and worst in Group II. Again, however, the large group lost to trace in Group II makes this unreliable.

Table VII shows the age groups having fairly equal rates, the prognosis being best in the thirties, forties and fifties and not quite as good in the twenties and sixties.

Table VIII shows the main religions of Trinidad represented in almost the same proportions as the population at risk, with Hindus and Roman Catholics the largest groups. Roman Catholics, the largest Christian denomination, are slightly underrepresented. The figures do not allow us to make valid assumptions, but Roman Catholics seem to do best, their successes being nearly eight times their failures. The Hindus and Anglicans are next, and the Moslems do worst of all. Presbyterians show a success rate comparable with Catholics, but are too few in number to allow valid assumptions.

Roman Catholicism is still the prestige religion in Trinidad because of early French and Spanish settlement (Braithwaite, 1953; Klass, 1960), and this may be the significant factor.

TABLE VI

Race

	Total abstinence or more than two years consecutively	Adequate social functioning with sobriety of at least six months consecutively	Returned to social drinking	Still drinking but employed, socially functioning and on the wagon from time to time	Failure. Never stopped drinking. Poor social functioning	Institutionalized for dementia or psychosis	Dead	Totally improved and socially functioning. (Successes)	Total failures (including Dead and Institutionalized)	Lost to follow-up	Total Number of Cases
Group I:											
East Indian	3	0	0	1	4	0	1	4	5	6	
Negro	8	1	2	2	3	1	1	13	5	6	
Mixed	7	0	0	0	0	0	2	7	2	0	
White	3	2	0	0	0	1	2	5	3	0	
Chinese	0	1	0	0	0	0	0	1	0	0	
Total	21	4	2	3	7	2	6	30	15	12	57
Group II:											
East Indian	68	9	0	4	26	0	5	81	31	84	
Negro	28	3	0	2	11	0	0	33	11	26	
Mixed	9	2	0	1	6	0	3	12	9	13	
White	5	1	0	0	0	0	2	6	2	3	
Chinese	0	0	0	1	0	0	0	1	0	1	
Total	110	15	0	8	43	0	10	133	53	127	313
	Successes and partial successes				Failures			Sub-totals			

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Discussion

Any attempt to evaluate the results of this programme must take into account the work of the Alcoholism Sub-Committee and of Alcoholics Anonymous in promoting acceptance of the disease concept of alcoholism. The aetiology and nature of alcoholism are still unknown, and it is not difficult for sceptical researchers to question the validity of the disease concept, yet in any culture where "Gamma" alcoholism prevails the most helpful thing which the therapist can say to the alcoholic is that his problem is an illness. There is a world of difference between therapeutic and research orientations in this respect. The therapist knows that the semantic distinction between "addiction" and "disease" can make all the difference to his patient's sobriety. It is the distinction between a criminal and a sick person. The man who perceives himself as "ill" is still a member of society and will accept his role and try to get well, while the man who perceives himself as criminal or deviant will not. The appearance in the local press from time to time of articles copied from abroad, questioning the validity of the disease concept or suggesting that life-long abstinence might not be absolutely necessary, has invariably resulted in a temporary rash of inebriety. The success achieved has been due to our relative isolation from such communications.

A finding of special interest has been the large proportion of East Indians in our study. East Indians in Trinidad tend to be rural sugar cane labourers and market gardeners (Klass, 1961) while Negroes and Mixed ("Creoles") find employment in oil and other industries and tend

Table VII

Age

	Total abstinence or more than two years consecutively	Adequate social functioning with sobriety of at least six months consecutively	Returned to social drinking	Still drinking but employed, socially functioning and on the wagon from time to time	Failure. Never stopped drinking. Poor social functioning	Institutionalized for dementia or psychosis	Dead	Totally improved and socially functioning. (Successes)	Total failures (including Dead and Institutionalized)	Lost to follow-up	Total Number of Cases
Group I:											
20-29 years	2	0	1	0	1	0	0	3	1	0	
30-39 years	5	2	0	1	3	0	1	8	4	5	
40-49 years	9	1	0	0	2	2	3	10	7	3	
50-59 years	2	1	1	2	1	0	2	6	3	3	
60-69 years	3	0	0	0	0	0	0	3	0	1	
Total	21	4	2	3	7	2	6	30	15	12	57
Group II:											
20-29 years	7	1	0	1	5	0	1	9	6	13	
30-39 years	39	6	0	3	13	0	3	48	16	34	
40-49 years	36	6	0	1	15	0	2	43	17	47	
50-59 years	24	1	0	3	8	0	3	28	11	29	
60-69 years	4	1	0	0	2	0	1	5	3	4	
Total	110	15	0	8	43	0	10	133	53	127	313
	Successes and partial successes				Failures			Sub-totals			

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to be more urban. Despite some acculturation there are two fairly distinct sub-cultures. The East Indians came as indentured labour after the abolition of slavery (Williams, 1962). Their family units were less broken up and they managed to retain more remnants of their culture of origin, but as the newest immigrants they suffered for a considerable time from being lowest in the social scale and were stigmatized for years as "coolies". This stigma has largely disappeared as they have succeeded in business and the professions and, more recently, have begun to get a footing in the Civil Service and white collar jobs, formerly the prerogative of white, mixed and negro in that order. A study of schoolchildren's essays, however, indicates that up to 1961 the East Indian still felt himself victimized and was probably still at the bottom of the "ethnic pecking order" (Rubin, 1962).

Since 1956 the political party in power has been predominantly negro in composition, and the relative status of negro and mixed groups has probably been enhanced.

Much has been written about the matrifocal family of the Caribbean with absent or itinerant fathers (Herskovitz, 1946; Henriques, 1953; Matthews, 1953; Clarke, 1957; Smith, 1960 and Beaubrun, 1963). This type of family is less characteristic of Trinidad and Tobago today, but it is mainly the negroes of Social Class V who exemplify it, and psychoanalytic theory

TABLE VIII

(Groups I and II combined)

Those lost to follow-up could not be included here as no information was available about their religion. Total number of cases is therefore 231—(45 from Group I and 186 from Group II)

	Total abstinence or more than two years consecutively	Adequate social functioning with sobriety of at least six months consecutively	Returned to social drinking	Still drinking but employed, socially functioning and on the wagon from time to time	Failure. Never stopped drinking. Poor social functioning	Institutionalized for dementia or psychosis	Dead	Totally improved and socially functioning. (Successes)	Total failures (including Dead and Institutionalized)	Total Number of Cases
Roman Catholic	49	8	2	3	8	0	0	62	8	70
Hindu	36	6	0	4	16	0	0	46	16	62
Church of England	16	2	0	2	8	0	0	20	8	28
Moslem	8	1	0	2	5	0	0	11	5	16
Christian	1	0	0	0	0	0	0	1	0	1
New Testament Church of God	1	0	0	0	0	0	0	1	0	1
Seventh Day Adventist	1	0	0	0	0	0	0	1	0	1
Protestant (unspecified)	0	0	0	0	1	0	1	0	2	2
Methodist	1	1	0	0	0	0	0	2	0	2
Presbyterian	7	0	0	0	1	0	0	7	1	8
Baptist	1	0	0	0	0	0	0	1	0	1
Pentecostal	1	0	0	0	0	0	0	1	0	1
Bible Student	1	0	0	0	0	0	0	1	0	1
No Religion	2	0	0	0	0	0	0	2	0	2
Not ascertained	5	1	0	0	11	2	15	6	28	34
Total										231
	Successes and partial successes				Failures			Sub-totals		

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would lead us to expect highest rates of alcoholism in this group with its maternal dependence and loss of male role models (Jones, 1963).

Paradoxically it is the East Indians who have during the past ten years provided the majority of our alcoholic admissions. Between 1956 and 1961 they increased from 26·3 per cent. to 62·6 per cent. of all admissions and the proportion has since continued to increase.

These are not true incidence data but a self-selected group, and it could be postulated that the relatively intact East Indian family brings pressure to bear on its alcoholic member to seek treatment sooner than does the loosely knit Negro unit; but other explanations are possible. The social rejection caused by the Indians' relative status in the "ethnic pecking order" may affect his self-image and create ego-need and inferiority feelings. It is worth noting that it is commonly said in many parts of the Caribbean that the East Indian is "constitutionally unable to manage liquor," exactly as is said of the Negro and especially of the American Indian in the U.S.A. and Canada and for similar reasons (Dozier, 1966). It is most unlikely that any physiological susceptibility exists (Diethelm, 1955), and socio-cultural deprivation seems the common explanation. The results of this study indicate that membership of a prestige ethnic group or a prestige religion seems to carry with it a better prognosis. Such membership may also confer some degree of protection from becoming an alcoholic, but the latter conclusion must await an epidemiological field study.

Sociological hypotheses on the whole explain our data better than psycho-analytic ones. Ullman's hypothesis, that in societies "in which the drinking customs, values and sanctions . . . are well established . . . and are consistent with the rest of the culture, the rate of alcoholism will be low" (Ullman, 1958), if stated as the converse would seem to be true. The Hindus and Moslems brought with them sub-cultures with established drinking customs, values and sanctions which, however, were inconsistent with customs of the society as a whole. Not only do their rates of alcoholism appear to be higher than the rest of the society, but the degree of success achieved with treatment has been less (Table VI).

Summary

An alcoholism treatment programme has been in operation at the St. Ann's Hospital, Port of Spain, Trinidad since March, 1956, combining emetine aversion treatment in groups with milieu therapy and group psychotherapy. In January, 1961, the treatment programme was moved to a separate unit with 20 beds, and the group therapy was handed over to an occupational therapist. An Alcoholism Rehabilitation Officer was appointed who was himself an alcoholic, and A.A. meetings were held on the ward. Patients were followed up at weekly outpatient clinics. The closest collaboration has been maintained throughout with Alcoholics Anonymous, the first group of which was begun in March, 1956. A significant role has been played in Community Education by the Alcoholism Sub-committee of the Mental Health Association.

This collaboration produced a remarkable growth in the number of A.A. groups, which by 1966 numbered 31 in a population of 950,000. The growth of A.A. groups, especially in small rural villages, created a change in the social environment which gave the recovered alcoholic a sense of personal worth. Calypso singers treated at the unit wrote calypsoes about their experience and played a part in promoting community acceptance of the disease concept of alcoholism.

A follow-up study was carried out in 1963 and 1964 on 370 patients, 57 of whom had been treated in 1956 and 313 in 1961. The differences in the characteristics of these two groups indicated an improvement in the community attitude to alcoholism and a greater willingness to seek treatment. The overall outcome was defined in terms of a seven-point scale of abstinence and social functioning with total abstinence of two years or better at one end, and death at the other. The overall success rates were calculated as percentages of the whole, counting those lost to follow-up as failures. Group I (seven-year follow-up of 57 patients) showed 52·6 per cent. successes with 36·8 per cent. totally abstinent for more than two years, 3·5 per cent. (2 patients) having returned to social drinking, and 10·5 per cent. dead, half of them by suicide. These results compared

favourably with the follow-up studies by Davies, Shepherd and Myers and by Wing at the Maudsley Hospital over four years. A further comparison was made with the follow-up study of untreated alcoholics by Kendall and Staton over a period similar to that of Group I of the Trinidad study.

Group II (two-year follow-up of 313 patients) showed 42·49 per cent. successes with a total abstinence of 35·14 per cent. These rates are only apparently lower than those of Group I because of the large group (40·8 per cent.) lost to follow-up. The group lost to trace was, however, not significantly different from the sample as a whole, and there were reasons to believe that in fact Group II had done rather better than Group I. The ratio of successes to known failures improved from 2:1 to 2·5:1.

An attempt was made to break down the number treated in terms of type of treatment. As this was not a planned study no claims were made for the significance of the figures, but the group who elected to have emetine and who went to A.A. on discharge emerged with strikingly better results.

The importance to therapy of obtaining cultural acceptance of the disease concept of alcoholism is stressed. Reasons are sought for the large proportion of East Indians among those coming for treatment. Negroes and East Indians in Trinidad form subcultures of comparable size, yet highest rates of alcoholism seem to come from the Indians with stable family units and male role models, while the matrifocal Negro group seems less vulnerable. This finding is at variance with the expectations of psychoanalytic theory, and sociocultural deprivation seems the likely explanation.

References

BEAUBRUN, M. H. (1957). "Of alcohol and alcoholics." *Caribbean med. Journal*, **19**, 3–4.

—— (1963). "Family relationships and mental health." Winkel, C. M. ed.: *4th Caribbean Conference for Mental Health*. Willemstad, Boek-en-offset Drukkerij der Curaçaosche Courant, 1963 (Summary in McGill Univ. *Transcultural Review and Newsletter*, **15:5**, 53–55).

BORDELAU, J. M., and KLINE, NATHAN S. (1962). "Experience in developing psychiatric services in Haiti." *World Mental Health*, **14**, 4.

BRAITHWAITE, L. (1953). "Social Stratification in Trinidad." *Soc. and Econ. Studies.*, **2**, 5–175.

CLARKE, EDITH (1957). *My Mother who Fathered Me*. London: George Allen and Unwin.

DAVIES, D. L., SHEPHERD, M., and MYERS, E. (1956). "The two years' prognosis of fifty alcoholic addicts after treatment in hospital." *Quart. J. Stud. Alc.*, **17**, 485–502.

DIETHELM, O. (1955). "Research in chronic alcoholism." In: *Aetiology of Chronic Alcoholism*. Diethelm, O. ed. Springfield, Ill.: Thomas.

DOZIER, EDWARD P. (1966). "Problem drinking among American Indians." *Quart. J. Stud. Alc.*, **27:1**, 72–87.

HERSKOVITZ, MELVILLE and FRANCES (1946). *Trinidad Village*. New York. Alfred A. Knopf.

HENRIQUES, FERNANDO (1953). *Family and Colour in Jamaica*. London: Eyre and Spottiswoode.

JELLINEK, E. M. (1960). *The Disease Concept of Alcoholism*. New Haven, College and Univ. Press.

JONES, HOWARD (1963). *Alcoholic Addiction*. London: Tavistock Press.

KENDALL, R. E., and STATON, M. C. (1966). "The Fate of untreated alcoholics." *Quart. J. Stud. Alc.*, **27:3**, 30–41.

KLASS, MORTON (1960). "Cultural complexity in Trinidad." *Annals of the New York Acad. of Sci.*, **83:5**, 855–861.

—— (1961). *East Indians in Trinidad*. Columbia University Press.

LIFTON, ROBERT JAY (1963). *Thought Reform and the Psychology of Totalism*. New York: Norton Library.

MATTHEWS, DOM BASIL (1953). *Crisis in the West Indian Family*. Trinidad Extra Mural Dept. of U.C.W.I.

MILLER, DVORAK, and TURNER (1960). "A method of creating aversion to alcohol by reflex conditioning in a group setting." *Quart. J. Stud. Alc.*, **21:3**, 424–431.

PINTO, HEATHER (1963). "Group therapy among alcoholics." ed. Winkel. C. M. In: *4th Caribbean Conference for Mental Health*. Curacao.

RUBIN, VERA (1962). "Culture, politics and race relations." *Soc. & Econ. Studies*. U.W.I., **11:4**.

SARGANT, W., and SLATER, E. (1954). *An Introduction to Physical Methods of Treatment in Psychiatry*. London: E. & S. Livingstone.

SMITH, RAYMOND T. (1960). "The family in the Caribbean." *Caribbean Studies*. ed. Rubin, Vera, Seattle, Univ. of Washington Press.

TIEBOUT, H. M. (1949). "The act of surrender in the therapeutic process with special reference to alcoholism." *Quart. J. Stud. Alc.*, **10**, 48–58.

ULLMAN, A. D. (1958). "Socio-cultural backgrounds of alcoholism." *Ann. Amer. Acad. pol. soc. Sci.*, **315**, 48–54.

VOEGTLIN, W. L. (1940). "The treatment of alcoholism by establishing a conditioned reflex." *Amer. J. med. Sci.*, **199**, 802–809.

WILLIAMS, ERIC (1962). *History of the People of Trinidad and Tobago*. Port of Spain: P.N.M. Publishing Co.

WING, J. K. (1956). "A four year follow-up of fifty alcohol addicts after treatment in hospital." *Dissertation in Psychological Medicine*. London University.

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