The three faces of alcoholism

by Lloyd Robertson

"Al" was an elected federal politician. He always checked into a motel at 5:30 for about half an hour. He didn't want it known publicly that he needed two shots of Scotch at that time every day or he would become irritable, forgetful and distracted: qualities that make re-election problematic. He also needed two drinks before bedtime so that he could sleep. He died of cirrhosis of the liver at age 71.

"Mary" is intelligent, attractive and, generally, an excellent parent and employee. But when she is on a binge she has none of these qualities. She becomes almost unrecognizable with an animal look in her eyes that tells you that she will do or say anything to obtain alcohol. Lately her binges have become more frequent.

"John" was a bible carrying fundamentalist Christian. He had a problem relating to modern women. He solved this problem by partying about one weekend out of every four. Then he would confess his "sins" before his congregation. He believed he was wrestling with the Devil. He committed suicide at age 22.

During the 1980s I directed a province wide study into alcohol and drug abuse among Amerindian populations in Saskatchewan. The study, Alcohol and Drug Abuse Among Treaty Indians in Saskatchewan was published by the Federation of Saskatchewan Indian Nations and remains the most comprehensive survey of aboriginal abuse patterns ever undertaken in this province.

One of our findings was that, like "Al", 6.3% of both on and off- reserve populations were chronic drinkers. They did not usually get drunk. Often they held responsible positions. But they needed their regular, daily "fix" to keep functioning. For these people, successful treatment involves going to a dry out center and then abstaining from alcohol for the rest of their lives. Interestingly, the same percentage of chronic drinkers is found in non-native populations. This suggests that the old idea that native people have a genetic weakness for alcohol is false.

We found that 11.8% of aboriginal people in Saskatchewan were, like "Mary", binge drinkers. This is roughly twice the non-native binge rate. From my experience, binge drinkers usually face significant mental health issues and that their "binging" may often be viewed as a kind of "self-medication" covering powerful negative emotions. Traditional addiction treatment programs have not had a significant impact on binge drinking and addiction workers are now recognizing that mental health treatment is essential.

At 19.6% the percentage of Amerindian problem drinkers was three times the provincial average. The objective, in this kind of drinking, is to get drunk. Once drunk problem drinkers give themselves permission to do things that they would not do when sober. It may be as simple as overcoming shyness and talking to other people. But problem drinking often leads to breaking and entering, theft, spousal abuse, child neglect and sexual assault.

Fortunately most problem drinkers do not end up like "John". In fact, the majority eventually become social drinkers. To aid in this transition a self-help group calling itself the "Moderation Movement" (M.M.) has organized in the United States and offers group support.

In my own view most problem drinkers will benefit from counselling. I challenge such drinkers to demonstrate that they can handle alcohol responsibly. If they pass their own test, great. If not, then abstinence is the alternative.

At one time addictions counsellors offered the same program to all who abused alcohol. This is a little like a doctor who performs an appendectomy on all patients complaining of stomach pains. The treatment will be effective for those patients suffering from appendicitis but not so great for patients suffering from gall stones.

I believe that treatment for alcohol abuse should be tailored to meet individual needs. Such an approach takes into account the cognitive, emotive and social factors contributing to the addiction.