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JOURNAL INTERVIEW 12

Conversation with Jaroslav Skála

In this occasional series we record the views and personal experience of people who have specially contributed to the evolution of ideas in the Journal's field of interest.

This interview markes the 70th birthday of the Czechoslovak alcoholism specialist Associate Professor J. Skála MD, on 25th May 1986. We wish him many happy returns.

BJA: *When Archer Tongue, director of the ICAA visited Prague in 1957, he had great difficulty in locating the alcoholism treatment centre of the Prague Faculty Hospital Psychiatric Clinic, headed by Dr Jaroslav Skála. When Archer Tongue visted Prague 10 years later, the first taxi driver took him straight to Apolinářská street at the mere mention of Skála's name. That was no coincidence. 'Skála' and 'Apolinář' (the name of the Alcohol Treatment Centre founded by Skála in 1948 and headed by him up to 1982) became widely known terms among the Czechoslovak population. The system of treatment built on the rock of Skála's personality and his professional experience has aroused in the course of years considerable interest, popularity and respect both in his country and abroad. 'Skála' and 'Apolinář' are almost synonymous in Czechoslovakia. First of all we should like to know what Skála had been before the Apolinář. You were born in Pilsen, in the town known for its production of Pilsner Urquell beer. Did you study in Prague?*

JS: I studied medicine at Charles University in Prague and at the same time I attended the Institute of Physical Training and Sports. After graduating from both of these faculties I read psychology and sociology at the university. In 1946 I started to work at the Psychiatric Clinic in Prague.

BJA: *What made you specialize in alcoholism?*

JS: One month after my coming to the clinic Professor Hořejší, chairman of the Czechoslovak Abstinent Union, was looking for a doctor to send to Brussels to the first postwar conference on alcoholism. He chose me. I went there and grasped the size of the problem. After my return I studied the alcoholism literature very thoroughly (including Jellinek, whom I did not meet personally until 1961) and decided to try out emetine therapy, which up to then had not been practised in our country.

BJA: *So it was a coincidence, an external stimulus, a desire to enter an unmapped area? Later you surely asked yourself the question whether behind this conscious motivation there had not been a hidden reason of a more personal nature . . .*

JS: Neither I nor anybody of my family had problems with alcohol dependence, if that is what you have in mind. I personally had been an alcohol consumer but a few years after the beginning of my work with alcoholics I myself started to abstain totally. I did have several experiences with drunkards in my childhood but I do not think they had any decisive influence on my orientation. A greater role was probably played by a certain feature of my character, manifested since my early youth—a tendency to help the weaker not by talking but by acting, energetically, rather directively, like a coach.

BJA: *So you began applying emetine therapy . . .*

JS: We started it with Dr Janda in 1947. We soon flooded the clinic with alcoholics. It was necesary to establish a separate department. At its birth stood another important realization. At that time, in the fifties, the biological therapy of alcoholism soon spread but the patients relapsed a lot. Psychotherapy was being neglected. It was necessary to work deeper and longer with the patients, even after the basic treatment. This gave rise to the sociotherapeutic club TROTTING (Czech abbreviation for 'Club of those Striving for Sobriety' KLUS) which is a few months older than the inpatient treatment in

the Apolinář. It has been meeting ceaselessly every Thursday since 1948—tomorrow I chair its 1845th session.

BJA: *Is it something in the style of AA?*
JS: We were originally inspired by AA but the Club soon acquired its own specific features. I did not want to leave the patients by themselves—besides, the unified system of Czechoslovak health care would have to have a medical worker in charge of such an institution anyway—and so the Club became a platform for cooperation between patients and therapists. That ensured a certain continuity of work and prevented some dangers sometimes encountered in AA, several of whose groups disintegrated or were misled by psychopathic personalities. And then there is another specific trait—the Club meets on the premises of the alcoholism treatment centre, and its participants are the patients under treatment together with those who had gone through it. Thus already during the basic treatment we form a link between the patient and the Club, which can help in the post-treatment period.

BJA: *Were there any foreign models at the birth of the Apolinář—any practical experience with similar therapeutic institutions, or theoretical models?*
JS: I had neither practical experience nor explicit theoretical models. I have a respect for theory but I have always been primarily a man of practice. I think that too much emphasis on theory and too great a link to a certain theoretical model sometimes creates *a priori* approaches and barriers, and somewhat hinders live creative work with patients. I am convinced that it is better to use theoretical knowledge mainly for 'tuning up' a system already working. I was pleased to find repeatedly that theoretical works confirmed what we had already practised before. The Apolinář had for instance many characteristics of a therapeutic community from its very beginning; M. Jones published his works in the second half of the fifties and I was able to get acquainted with them as late as the sixties. It was similar with social learning theory . . . our intuition was not bad.

BJA: *What is your attitude towards the other trends in psychotherapy?*
JS: In the Apolinář system there are many elements of behaviour therapy. I did not like psychoanalysis, though in 1948 in Switzerland I had the opportunity to hear the lectures of Anna Freud. Not until recent years did I somewhat revise my attitude to psychoanalysis; I studied with interest Kernberg, Kohut, Balint, the Blanks. I surely missed a lot and in some respects I did not give the patients their due during my neglect of the analytic approach.

BJA: *Your therapeutic system has its own specific features, some aspects of treatment can be regarded as European and world priorities. Is there anything you would like to add?*
JS: In 1951 our department set up the first 'sobering-up station' (detoxification centre) in the world run as a medical institution. I proposed this move as early as 1949. Acutely intoxicated persons are usually brought to the sobering-up station by the police but from the point of arrival they are solely in the hands of our medical staff. The medical staff are helped by the patients treated in the department and this work in the sobering-up station represents for them one of the psychologically very significant components of their treatment.

We discovered comparatively early the importance of the *length* of the treatment. The 3-week treatment which was—and often still is—common in the world, is in my opinion good for 'standing the patient on his legs'. However, on these legs he often walks only to the nearest pub. After this opening phase of the treatment, concentrated primarily on the basic physical rehabilitation, another couple of weeks must follow which are filled with a demanding therapeutic programme—community therapy, movement therapy, culture therapy, education therapy etc, ended by a 10-day daytime attendance. The basic voluntary treatment in our department takes 13 weeks, relapse treatment 4 to 6 months, compulsory treatment 4 to 11 months.

BJA: *Can you say something more about the Czechoslovak system of alcoholism care in the development of which you played a fundamental role? What precedes the treatment in your department, what follows?*
JS: The basic system was formed in the fifties. Now there are 30 inpatient therapeutic institutions in Czechoslovakia with a capacity of 1 500 beds (Czechoslovakia has 15 million inhabitants). There is a network of more than 200 clinics providing outpatient services. With the help of these centres (especially when the outpatient type of care fails), the patient gets into the inpatient department from where he is later again referred to the outpatient centre care.

The Apolinář developed its own system of post-treatment therapy. In regular intervals the patients return to the inpatient department to undergo one-

week revision treatment sometimes performed in the form of intensive therapeutic stays in the country. They take part in the work of the sociotherapeutic club. In this way the patients can and should, in the course of 10 years after the basic treatment, go through the post-treatment therapeutic programme in the time range equalling the length of the basic treatment.

From among our former patients we have gained a number of efficient co-workers helping mainly with the sociotherapeutic Club work. One of them is the already 20-years abstaining head of the biggest alcoholism treatment centre in Czechoslovakia, which is situated in a beautiful castle in South Bohemia.

BJA: *So the Apolinář kept growing...*
JS: It did not, rather it differentiated and separated into specialized units. For years there were very few of us and even later our numbers did not increase much. I do not envy anybody who has many co-workers at his disposal. For that often leads to the situation where the pivot of the interaction is transferred to the team of the therapists, and the patients are thus deprived of the interaction.

Already in the first years we differentiated three types of treatment: voluntary treatment, compulsory treatment ordered by health authorities, and protective treatment ordered by the court. In 1958 was established a separate therapeutic institution for compulsory treatment and relapses (but the patients start and end their long-term treatment in the Apolinář). Twenty-five beds at the Research Institute of Penology, which came into being in 1967, were occupied by patients who had been sentenced for alcohol related crimes and who were undergoing their alcoholism treatment ordered by the court already during their prison sentence, mainly in the form of evening sessions of the group-psychotherapy type. In this work also some of our former patients participated as lay therapists who often waited at the prison gates for their charges after their release, and helped them with many social problems.

In 1971 a separate therapeutic institution was established for women, containing 32 beds. In 1967 there came into existence the Child, Youth and Family Centre, providing the necessary educative, advisory and psychiatric care for the patients' families. It organizes for instance summer holiday camps for the patients' children who are often physically deprived, holidays for entire families with family therapy done in community and group form; the Centre is regularly visited by school classes who come to listen to talks that are part of health promotion. In 1971 the Drug Dependence Centre was founded, which provides outpatient care and sends its patients to the inpatient department where they are treated together with alcohol-dependent persons.

BJA: *Thus differentiation, specialization, rather than increase of capacity. You evidently and personally wanted to spend your time not mainly managing your subordinates but in contact with your patients.*
JS: That is right. In addition, I did not have the professional and private spheres of my life strictly separated. After my divorce I was in the department practically day and night. I had a pleasant work apartment there. I saw the patients as early as 6 a.m. at the morning gymnastics and I ended the day reading the notes of often all 50 patients, handed in at 9 p.m. At my morning meeting with the staff or with the whole therapeutic community I was informed of what was going on. I also liked to participate in the work therapy with the patients in the garden of our department. I practically did not leave the patients, except for my trips abroad, the longest of which took 6 weeks.

BJA: *Could you say something more about these trips and about your international professional contacts?*
JS: At the beginning there was that conference in Brussels in 1946 and in 1956 I attended the World congress in Istanbul. In 1966 I became a member of the alcoholism advisory board of WHO. In the same year I was in Chile at the WHO conference dedicated to the memory of E. M. Jellinek, in 1968 in Washington, then in Britain, Norway, Yougoslavia... In 1970 I made my longest trip, lecturing in Australia, New Zealand, the U.S.A. and France.

I consider it a great honour to have been able to meet in person such pioneers in alcoholism work as Jellinek, Tongue, Mrs Moser of the WHO, D. Archibald (Canada), Fouquet (France), Glatt & Edwards (Britain), Krauwell (Holland), Strèlčuk (U.S.S.R), von Wartburg (Switzerland) and others. On my trips abroad I gathered information from various sources, but I also tried to offer experiences of my own.

BJA: *So that you applied the system 'take and give' which you enforce in the patient's relation to the therapeutic institution also in international contacts. Are you also engaged in research work, has your system been a subject of research?*

JS: I would mention three research studies that I consider the most significant. In 1976–1980 it was the research of Dr Matějček and Dr Kmošková 'Children of Alcoholic Fathers'. Their findings were confirmed by a later American study with which I became acquainted in Chicago in 1983. Further it was my own study 'Invalidity and Alcohol' which proved that it was primarily alcohol that was responsible for invaliding several thousand people in Czechoslovakia out of work in the course of 5 years. The most extensive research was conducted in the Apolinář in the years 1971–80 (by the authors Kubička and Pintová), analysing in detail our entire therapeutic system from the point of view of the effectiveness of the treatment. It confirmed objectively the long-term therapeutic results we had stated before: 1 year after treatment in the department 45% abstained, after 3 years 35%, after 5 years 25% of all patients—but the results of patients who had *finished* the treatment (there were 72% of those) were always 10% better. It was also shown that the treatment of patients with satisfactory family conditions could be shortened by a few weeks without any harmful effects. I should like to mention that the research itself that was being done in the department had a positive influence on the patients—the patients treated at the time of the research (1971–80) turned out to be the most successful 'Apolinář generation' from the abstinence point of view.

BJA: *I am certain you are engaged in alcoholism prevention in your country. Has this work of yours taken any special form?*

JS: Ten years ago I offered the leader of the Linha Singers Chorus the script of a programme in which music alternated with the words of a doctor and discussion with the audience. In the course of 10 years we gave more than 250 performances of the programme and in this way I talked with more than 70 thousand young people. Now I cooperate in a similar form with the Baroque Jazz Quintet in an anti-smoking programme—all members of the group gradually gave up smoking and they go in for jogging; when performing in the country they organize football matches where they play the listeners—and usually win . . .

BJA: *The lecturing and literary work obviously represents a significant part of your activities after your retirement in 1982, when you handed over the management of your department to Dr Mareček, MD.*

JS: I am finishing several books on alcoholism treatment problems, then the revised 4th edition of a popular booklet, and my part in the collective monograph on alcohol and drug dependence therapy. After handing in all the manuscripts I intend to start writing my memoirs.

However for the last 15 years an important part of my work has been the training of doctors and psychologists in psychotherapy. It has become a sort of my 'second career', to which I now devote the maximum of my time and endeavour. It is long-term training (basic training lasts 400–500 hours followed by supervision), work with groups, communities and clubs. Most of the participants are about 30 years old and so I regard this work as a rare opportunity for a fruitful intergenerational dialogue.

BJA: *The last question—how do you feel on the eve of your seventieth birthday?*

JS: I can honestly say that I feel less 'worn out' than I myself expected. I have invested much in my work, but on the other hand it has given me much in return. This I should like to emphasize for others, as well. You have already mentioned our principle 'take and give'. I have given a great deal to my work but I think I have gained much more from it for myself. That is why I not only want to continue it but I also feel obliged to do so.