DANGERS OF PSYCHOTHERAPY IN THE TREATMENT OF ALCOHOLISM

GEORGE E. VAILLANT

Dynamic Approaches to the Understanding and Treatment of Alcoholism

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Dangers of Psychotherapy in the Treatment of Alcoholism

George E. Vaillant

This chapter is organized in three parts. First, I review the evidence for viewing alcoholism, not as a symptom of emotional illness, but as a disease analogous to hypertension or diabetes. Second. I present a heuristically useful case history. Third, I focus on some of the specific issues that render psychotherapy actually counterproductive in individuals actively struggling with the disease of alcoholism. In doing so, I suggest an alternative model for its care.

But how can alcoholism be called a disease? Indeed, there are at least six reasons for *not* considering alcoholism analogous to medical disease. These objections need to be examined.

First, alcoholism conforms to no Koch's postulates, and there is no known underlying enzymatic defect. Rather, it is multiply determined and the determinants are different in different people. *But* the same can be said of diabetes and hypertension. My thesis is that the continued use of alcohol once an individual has lost the capacity to control how much or how often he drinks is both a necessary and a sufficient cause of the syndrome that we

label alcoholism. In the majority of cases, before patients lose control of their use of alcohol, they are no different from the general population. Once abstinence from alcohol is achieved and a suitable convalescence has passed, they are no longer “ill.” Thus the term “disease” conveys the point that the etiology of alcoholism is uncontrolled drinking, that uncontrolled drinking is not symptomatic of some underlying disorder, and that for most alcoholics return to controlled drinking lies outside an appeal to reason or to a dynamic unconscious. Like the hypertensive or the diabetic, the alcoholic cannot usually cure himself by will power or insight alone.

The second objection to using the medical model in conceptualizing alcoholism is that there is no clear line that separates the alcoholic from the heavy drinker. With diseases, you either have them or you do not. Diagnosis should depend upon signs and symptoms, not upon value judgment. But again consider hypertension or diabetes. We regard them as medical diseases, albeit ones of diverse and often poorly understood etiologies. There is no fixed point when we can decide that “normal” variation in blood pressure has evolved into “abnormal” elevation. Rather, in early stages, the diagnosis of hypertension and diabetes is relative. The more numerous and severe the signs, the more certain the diagnosis. Value judgment is always involved. So it is with alcoholism; normal drinking merges imperceptibly with pathological drinking.

The third objection is that alcoholism is affected by so many situational and psychological factors that the disorder must often be viewed as reactive. Some people drink uncontrollably only after a serious loss or when they are in a specific situation. Again, some alcoholics, by an act of will, return to normal drinking. But these observations are equally true of hypertensives and diabetics. Avoiding specific living situations and exerting will power over salt and caloric intake are sometimes enough to cause the "disease" of diabetes or hypertension to disappear.

The fourth objection to using the term "disease" in the treatment of alcoholism is that for remission alcoholics must learn to assume responsibility for their own drinking. If they were led to believe that alcoholism was a disease, would they not see this label as an excuse to drink or as a reason why they could not be held responsible for their own recovery? *But* in seven years I have suggested to hundreds of alcoholics that their alcoholism was a disease. To my knowledge, not one either was disheartened or used this as an excuse for the next binge. In Alcoholics Anonymous (our staff is required to attend once a month) I have listened to scores of alcoholics discuss their remission. Most of them subscribed to the concept that their alcoholism was a disease *and* that they were responsible for its treatment. Once again, diabetes is a disease, but one for which the individual must assume primary responsibility.

The fifth argument against calling alcoholism a disease is the most compelling. Uncontrolled, maladaptive ingestion of alcohol is not a disease in the sense of biological disorder; rather, alcoholism is a disorder of behavior. According to this argument, there is no more reason to subsume alcoholism under the medical model than to include compulsive fingernail biting, gambling, or child molesting in textbooks of medicine. Alcoholism reflects deviant behavior that should best be classified by sociologists and treated by psychologists skilled in behavior therapy. I would agree *but* for several problems. First, there are insufficient behavior therapists available to even begin to care for the problem of alcoholism; and even if they were available, most alcoholics at present do not possess the social set to seek them out for help. Second, unlike stopping gambling or fingernail biting, stopping alcoholic drinking often requires skilled medical attention during the period of acute withdrawal. Third, unlike gamblers and fingernail biters, most alcoholics as a result of their disorder develop secondary symptoms that require medical care. For example, an estimated 20 to 40 percent of all general hospital patients have a drinking problem, and alcoholism plays a major role in the four leading causes of death in men aged twenty to forty—cirrhosis, suicide, homicide, and automobile accidents. Finally, unlike gambling and fingernail biting, the behavior disorder known as alcoholism leads to such mistreatment of those whom the alcoholic loves that enormous guilt results. As a result, the behavior disorder model (conveying as it does the concept of misbehavior)

generates far more denial in the alcoholic than the disease model (conveying as it does behavior outside of voluntary control). In short, in order to understand and study alcoholism, it behooves us to employ the models of the sociologist and of the learning theorist. But in order to *treat* alcoholics effectively, we need the models of the medical practitioner. In order to be treated, alcoholics require a label that will allow them unprejudiced admission to the emergency rooms and access to medical insurance coverage, to paid sick leave, and to the willing care of medical practitioners—all of which are denied to compulsive gamblers, to child molesters, and currently to a majority of alcoholics. In other words, using the term "*disease*" rather than "*disorder*" becomes a useful device to persuade the alcoholic to admit his alcoholism and a semantic ticket to guarantee the alcoholic admission to the health care system.

The sixth objection to the term "disease" is our deeply ingrained belief that alcoholics are premorbidly different from other people; that alcoholics have personality disorders; that alcoholics have had unhappy childhoods; and that they drink because they are depressed, lonely, and anxious. In short, the sixth objection is that alcoholism is but the tip of the iceberg, a symptom of underlying psychiatric disorder, and that its proper treatment (at least for the rich, well-educated, and highly motivated alcoholic) should be via dynamically oriented psychotherapy. It is to this last objection that this chapter is addressed.

Alcoholism as a Disease

First, if alcoholism is a symptom, there should be an underlying disorder. For example, prospective study of heroin users has suggested that a majority of these individuals have come from relatively disrupted homes and that premorbidly they have been poly-drug abusers (Vaillant, 1966; Robins, 1974). In contrast, there is no good evidence to suggest that heavy cigarette smokers (cigarette abusers) are very different from the general population, at least in their psychopathology. Is alcoholism more like tobacco or heroin abuse?

Retrospective studies have supported the latter view. In the eighth edition of his textbook on psychiatry, Lawrence Kolb writes, "In spite of the conviction of most alcoholics that they would be quite normal if they ceased drinking, psychologically well-adapted personalities are seldom found during periods of sobriety" (Kolb, 1973, p. 205). The majority of retrospective studies suggest that alcoholics are premorbidly passive, dependent, latently homosexual, sociopathic, "oral-dependent," and fearful of intimacy.

At the present time, however, there are at least five prospective studies of alcoholics which suggest these positions are untenable. First, there is the study by Kammeier et al. (1973) of thirty-eight University of Minnesota graduates who were later admitted to Minnesota detoxification centers. At the time of hospitalization for alcoholism this group had significantly

pathological MMPI profiles, with the highest elevations on the scales reflecting depression and sociopathy. However, ten years earlier, when the thirty-eight men were in college, their MMPI profiles were quite normal.

Both Lee Robins and the McCords followed up samples of children at high risk for delinquency and found that, not surprisingly, the alcoholics in these samples had many of the premorbid characteristics associated with predelinquent children; however, the investigations found that the alcoholics' childhood character did not differ dramatically from that of the antisocial nonalcoholics in the group (McCord & McCord 1960; Robins, 1966).

There have also been two prospective studies of premorbidly normal subjects. The first, carried out at the Institute of Human Development at Berkeley, found that premorbidly prealcoholic youths were more active, impulsive, independent, and heterosexual than their high school classmates who on long-term follow-up did not abuse alcohol (Jones, 1968). I reviewed the lives of 268 men from their sophomore year in college until age fifty (Vaillant, 1977). In this study differences were not found that distinguished the premorbid character of alcoholics from the character of nonalcoholics. If anything, the alcoholics were premorbidly more assertive, extroverted, and comfortable with the heterosexual role than nonalcoholics.

Second, if alcoholism is but a symptom of underlying emotional

difficulties, we should expect alcoholics to have had more difficult childhoods. This did not seem to be the case in either the study from Berkeley or in my own follow-up studies. When clinicians blind to the future examined the childhoods of the college sophomores who later became alcoholic, they could not distinguish them from those of nonalcoholics (Vaillant, 1977).

Finally, if alcoholism is just a symptom of emotional distress, we might expect alcohol to be a good tranquilizer. Alcohol should achieve what the alcoholic maintains it achieves: it should raise self-esteem, alleviate depression, reduce social isolation, and abolish anxiety. However, work by Mendelson and colleagues suggests that despite what alcoholics say, objective observation of drinking reveals that chronic use of alcohol makes alcoholics more withdrawn, less self-confident, more depressed, and often more anxious (Tamerin & Mendelson, 1969).

Thus it seems fair to state that what alcoholics tell us and what actually transpires are not congruent. In *retrospect* the alcoholic's use of alcohol seems symptomatic of disordered personality, childhood pain, and the need for a chemical anodyne. But when studied *prospectively*, the loss of control over alcohol comes first and the alcoholic's explanations seem like mere rationalizations. In short, alcoholism may be conceptualized as a disease in the sense that the disordered drinking patterns are for all intents and purposes out of conscious control, and that uncontrolled alcohol ingestion is

both a necessary and a sufficient cause for much of the psychiatric disability associated with so-called “alcoholic personalities.”

If alcoholism is merely a symptom masking underlying conflict, psychotherapy ought to be the approach of choice. But if disordered drinking patterns are the primary problem, if the conflict of which the patient tells us is an unconscious effort to mask his acknowledgment of that problem or “disease,” what then? Might not psychotherapy be plagued by false assumptions? Would not treatment be like treating a patient with hypertensive headaches for unacknowledged anger? One of the great strengths of psychoanalysis is that it has taught us that the past is not always what the patient tells us. If we were to treat a school phobic by trying to unravel what the child found frightening at school, we would be badly misled. We would never discover that a function of school phobias is to displace attention from conflicts at home. Too often psychotherapy of the alcoholic is like taking a phobia literally. Its roots in displacement are forgotten. Let me present a case history. (Certain details are altered to preserve anonymity.)

Case History

1962

When James O’Neill presented himself to a Philadelphia general

hospital, he was a 41-year-old economist for a large industrial firm. He said he had suffered rectal pain on moving his bowels for four days, a complaint he had treated primarily with whiskey. His family history revealed a mother who died at sixty-two of abdominal cancer (untrue) and a father who died at sixty-one of a myocardial infarction. His own past history revealed excellent health except for an eight-month hospitalization in 1957 for "anxiety neurosis." For the past two years he had been in psychotherapy. He was noted to smoke two packs of cigarettes per day and to have "excessive intermittent alcohol ingestion, ? amount." Review of systems revealed tachycardia and hypertension for several years and the fact that he vomited following excessive drinking. His pulse was 120, his blood pressure was 154/102, his liver was down two finger breadths. He had a bilateral inguinal hernia and a rectal abscess. The discharge diagnosis was ischio-rectal abscess and anxiety neurosis. He was to return next month for hernia repair.

When Mr. O'Neill returned, his pulse was 88, his blood pressure was 160/110, and he was described as quite labile. This time the discharge diagnosis was bilateral inguinal hernia and neurogenic hypertension. Significantly, throughout his hospital course, his blood pressure remained 120/80.

1957

Perhaps the details of his 1957 psychiatric hospitalization would cast light on O'Neill's problems. At that time his hospital chart revealed a thirty-six-year-old man, a father of four and a former assistant professor of economics, who was admitted to a Philadelphia psychiatric hospital for the first time. He complained of being a "failure at his marital and professional responsibilities because of drinking and missing teaching appointments." His admission note added, "Present symptoms include excessive drinking, insomnia, guilt and anxiety feeling," and the diagnosis was "behavior disorder, inadequate personality."

Over an eight-month hospital stay, the following history was obtained: "According to the patient's statement, his drinking and gambling began in the summer of 1948 when he became depressed because he did not do well on his Ph.D. generals and was refused entrance into a fellowship organization. At this time his roommate from college did make the fellowship on what the patient described as less merit. The patient at this time began to drink during the day, and to miss teaching appointments; however, he continued to teach and to keep his family together."

He obtained his Ph.D. without difficulty, and in 1955 he transferred from the faculty of Berkeley to the University of Pennsylvania. During the next year and a half he was very unhappy because of "the strict regimentation. " He was dismissed from Pennsylvania with six months to go on his contract and

spent the next nine months until admission doing a great deal of gambling and spending long hours away from home.

One month after O'Neill's admission a psychiatrist contributed the following note to his record: "The patient was glad to see me when I dropped in on him at the hospital 2 weeks ago. However, he did not show up for his appointment. . . and I called him at the hospital to find him sound asleep on his bed. He gives the excuse that it's a little difficult to get a pass. ... He showed little feeling, although he clearly expressed his suspicions and anger through the people he talked about. [In other words, he showed both passive-aggressive and paranoid trends.) His pattern of drinking, sexual infidelity, gambling and irresponsible borrowing led him to recognize from his reading that it adds up to a diagnosis of psychopathic personality—especially since he's experienced no real remorse about it. Since he gave some books to his son to sell, and among them were four books from the University library, he was accused of stealing books and shortly afterwards was discharged for moral turpitude. He claims he did not sell University books knowingly.

"He states emphatically that he is not an alcoholic, but his rather florid face belies this claim. Since he's discontinued his teaching duties, he says he's been drinking every day and has never been more than half an hour away from a shot of whiskey. Even while teaching he would be in a barroom by the middle of the day. In support of the statement that he's not an alcoholic he

points out that he's been taking only one or two drinks each weekend [on weekend passes] since his admission to the hospital.

"During all the time that he was frequenting bars, contacting bookies, and registering in hotels to philander, he always used his own name. It's interesting that when he was carrying on his nefarious pursuits, he got considerable satisfaction out of it being known that he was a professor. There is a difference between his relationship with women and his relationship with men. First of all, when his mother died in 1949 he felt no remorse. He did not remember the year of his mother's death, and in view of the fact that he dates his extracurricular activities as beginning about 9 years ago, this confusion is probably significant. He speaks warmly of his three sons, feeling that they like him although he's not been much of a father. His oldest son has none of his Boy Scout badges, because he's not been able to come to his father for help."

The following history was taken from O'Neill's hospital chart: "The patient is the only child of parents who were in their thirties at the time of his birth. The patient is at the present time married and has four children. His wife is living and well. The patient's mother died in 1949 at age 57 of carcinoma of the uterus. [In fact, the mother had had her uterus removed in 1938.) The patient's mother in the last four or five years of her life refused to allow doctors to attend her because she had turned to the Christian Science faith, although she was an R.N. [So we perceive this alcoholic's mother as

eccentric; the real facts, as we shall see, suggest otherwise.] The patient's father is living and well and is a retired Army officer.

"On admission the patient was placed in group therapy twice a week. During his 8 month hospital stay the patient was taken into individual therapy 3 times a week. In therapy the patient was able to work out a great deal of feelings towards his family, in particular towards his mother and also towards his wife. The patient felt quite hostile and anxious about the fact that he was an Army brat and never had a normal childhood, that his parents were always very cold and grown-up towards him. He harbored many feelings of hostility towards his wife who he feels does not appreciate the fact that she's married to such an intelligent college professor, and all she wants is to have money and bigger homes."

The discharge diagnosis was "anxiety reaction manifested by feelings of ambivalence about his family and his parents and his work." The precipitating stress was considered to be "the death of the patient's mother and a long history of drinking and gambling and going into debt." He was considered to have suffered from "an emotionally unstable personality for the past 20 years."

1962-1968

Between 1957 and his hospitalization for rectal fistula O'Neill had

received over one thousand hours of psychotherapy, months of inpatient treatment, and no real appreciation of his alcoholism by patient or clinician. After 1962 he was fired from three jobs, and then this Berkeley Ph.D. spent the next three years up to 1968 unemployed and living off his wife. Once again, in September 1968, he was admitted to a Philadelphia psychiatric hospital. On admission his chief complaints were “I'm angry at the world, angry at my wife and the kids’ resentment, I'm no damn good.” His record revealed, “Since he’s returned to Philadelphia he’s been drinking heavily, about a quart of whiskey per day. The patient had a history of heavy alcohol intake for the past 20 years. He began to experience auditory and visual hallucinations, paranoid ideas, suicidal thoughts, and he sought hospitalization. The patient also wrote some checks using a bank account that he doesn't have and is fearful about the consequences. The patient claims to have marital difficulties and he’s been separated from his wife on and off. The patient had a history of a previous psychiatric hospitalization. During the course of hospitalization the patient was treated with chemotherapy and intensive group psychotherapy and assigned to milieu activities.”

After a few weeks of hospitalization he was discharged as “not depressed, not suicidal, and with no active psychotic ideation.” He was discharged on 300 mg of chlorpromazine a day and 50 mg of amitriptyline. His discharge diagnoses were “schizophrenic reaction, paranoid type” and “chronic alcoholism.”

Fortunately, this man had been part of the already mentioned prospective study of men chosen as college sophomores for psychological health (Vaillant, 1977). Thus there was in existence a prospectively gathered investigation of James O'Neill. In college he had undergone several psychiatric interviews, psychological tests, and a home interview of his parents by a family worker. Unfortunately, none of this information was ever obtained by his hospital psychiatrists. Psychopaths cannot be expected to belong to studies of healthy male development.

A child psychiatrist in 1974, blind to O'Neill's future after age eighteen, was asked to compare his childhood with those of his peers. She wrote that she would predict that "the young student would develop into an obsessional, hardworking, non-alcoholic citizen, whose work would be related to law, diplomacy, and possibly teaching. He would rely on his intellect and verbal abilities to help in his work. He would probably marry and be relatively strict with his children. He would expect high standards from them. " She summarized the raw data given to her as follows: "The subject was born in a difficult delivery. The mother was told not to have more children. He was bright and learned quickly, he was inquisitive. He played with older children. His attachment to his parents was demonstrated by his difficulty separating from them to go to camp at age 11. He returned home after two weeks. His

parents were reliable, consistent, obsessive, devoted parents. They were relatively understanding; their expectations appear to have been more non-verbal than explicit. The father was characterized as easy to meet, the mother was seen as more quiet; no alcoholism was reported. Warmth, thoughtfulness and devotion to the home were some of the comments. The subject spoke of going to his father first with any problems, and of being closer to his mother than to his father. His peer relations were reported to have been good, and little or no conflict with his parents was reported."

1940-1950

O'Neill's prospectively gathered college record revealed the following: When he was twenty-one, he married his childhood girlfriend. He had been in love with her since age sixteen, and now, six years after they got married, the marriage still seemed solid. Between 1940 and 1950 other observers summed him up as follows: The dean's office of his college ranked his stability as "A." The internist of the college study described him as "enthusiastic, whimsical, direct, confident, no grudges or chips, impressed me as an outstanding fellow. " The social investigator saw him as "hearty, hail-fellow-well-met, describes life as happy, describes home life as happy, and united." The psychiatrist was initially greatly impressed by his "combination of warmth, vitality and personality," and put him in the "A" group. Later the same psychiatrist commented that the subject was "not too sound, showed

mood fluctuations and hypomania." However, upon graduation the staff consensus was that he should be ranked in the top one-third of this group of sophomores already preselected for psychological health. In health, the psychiatrist wished to place him in the middle third. When O'Neill was twenty-three, his commanding officer in the army wrote the following efficiency report on this future "psychopath'' and "inadequate character": "He is able to recognize problems and arrive at sound expeditious solutions." He was thought to give "superior" attention to duty, and the officer wrote that he "particularly desired" his services.

After ten years of prospective observation the study staff's consensus was that they would "place him in the unqualified group in terms of ethical character," and the director of the college health services described him as a "sufficiently straightforward, decent, honest fellow, should be a good bet in any community."

1972

In October 1972, thirty-two years after he entered the study of normal development and twenty-two years after he lost control over his use of alcohol, I met James O'Neill in his one-room efficiency apartment in an expensive Manhattan neighborhood. By the neatness of his grooming, by the number of well-sharpened pencils on his desk, and by his careful ordering of

facts. O'Neill impressed me as an orderly man. There were many expensive accessories in the room that suggested that he had been as prosperous over the past two years as he had claimed.

In appearance he was balding, sported a distinguished mustache, and wore elegant, if worn, clothes. During the interview at first he had a lot of trouble looking at me and seemed terribly restless. He chain-smoked, walked back and forth, lay down first on one bed and then on the other. In avoiding eye contact of me, however, he was still seriously aware of me as a person, and I felt that he was always talking to me. He behaved like a cross between a diffident professor and a newly released prisoner of war. rather than a person truly frightened of human contact. I never got the feeling that O'Neill was cold or self-absorbed. If anything, he suffered from hypertrophy, not agenesis of the conscience.

Nevertheless, he described himself to me as having been “a classical psychopath, totally incapable of commitment to any man alive.” I felt much more he was a lonely but a kindly man. His mental status revealed an energetic man who kept a tight rein on his feelings. As he put it to me, “I’m hyperemotional; I'm a very oversexed guy. The feelings are there, but it's getting them out that's hard. The cauldron is always bubbling. In A.A. I'm known as Dr. Anti-serenity.”

His mental content made frequent reference to Alcoholics Anonymous, which, besides his wife, was clearly the dominant object in his life. I asked him what his dominant mood was, and he said, “Incredulity. ... I consider myself unspeakably lucky; most people in A. A. do. ” He told me of his thousand hours of psychotherapy and said that “the net effect was zero.” Since over the course of therapy his diagnosis had deteriorated from inadequate personality to schizophrenia, I felt that he was probably not being too harsh.

Several revelations emerged from our interview that seemed important to understanding alcoholism.

First, he brought me up to date on his own view of the precipitants of his alcoholism. He said that he had failed to win a coveted fellowship in April of 1948. his son had been born in November in 1948. and his mother had died of cancer in January 1949, after a year of chronic illness. “I watched her die; I visited her daily; I'll never forget the stench.” This sequence of traumatic events, he asserted, led to his alcoholism.

However, from the prospective record, the facts were that in 1948 he had accepted the loss of his fellowship philosophically; to give birth to a son, if you have been well loved yourself, is hardly a psychological disaster; and his mother did not die until August 1949, of an acute perforating ulcer of four days’ duration. She allowed herself to be adequately cared for in a hospital.

Prior to that, as a registered nurse, she had embraced Christian Science; but she suffered from amyotrophic lateral sclerosis of many years' standing, and for a nurse to become a Christian Scientist in order to cope emotionally with that diagnosis is hardly to deny herself the wisdom of the medical profession. It was only in retrospect that O'Neill reconstructed his mother's death as the result of cancer in the uterus that she had had removed eleven years before. This is not to deny that his concern over his mother's growing paralysis did not affect his drinking, but merely to underscore the fact that alcoholics reorder traumatic events to justify their drinking and that psychotherapists believe them.

From the prospective record it was also possible to record a more accurate sequence of O'Neill's feelings about his mother's death. The child psychiatrist of the prospective record had called their mother-child relationship among the best in the study. In 1950, six months after the loss of his mother, a study observer had said that the subject felt the loss of his mother deeply. At the time his mother's physician had remarked that the subject "was devoted and helpful during the illness." It was only seven years later, during his admission to a Philadelphia psychiatric hospital, that O'Neill reported having no feelings toward his mother and maintained that his parents were always very cold toward him.

Second, O'Neill brought me up to date on the progression of his

alcoholism. He had begun drinking heavily in 1948. and by 1950 he had begun morning drinking. By 1951 his wife's uncle, an early member of Alcoholics Anonymous, had suggested the possibility of alcoholism. However, the same year his own university's health services diagnosed him as having "combat fatigue," and his wife had insisted that he was not alcoholic. He admitted that between 1952 and 1955 he had written his Ph.D. thesis while chronically intoxicated and that he had regularly sold university books in order to support his drinking. By 1954 his wife began to complain about his drinking, and by 1955 it was campus gossip, although in his hospital admissions in 1957 and 1962 the diagnosis was not made. During the same weekends in 1957 when the psychiatric hospital had recorded him as having only a couple of drinks, "with my wife on welfare I would go out on weekend pass, get drunk, and gamble," O'Neill told me in 1972. After he was discharged from the hospital in 1968, O'Neill returned to binge drinking over the next fifteen months and finally in February 1970 went on a binge where he drank a case of scotch in five days; he was hospitalized for two weeks, and came into contact with A. A. for the first time. For the next thirty months he had remained sober, except for one three-week lapse. The fact that he was a sophisticated Ph.D. did not prevent him from being the chairman of a blue-collar A.A. group. It is significant that both his self-detrimental gambling and his extramarital affairs stopped as soon as he stopped drinking.

O'Neill's wife, who had become used to taking on a lot of responsibility

over twenty years, told me that in 1972 she still found it hard to see him as a functioning husband. His own perception was that the disagreements between him and his wife could at last be talked about. He cast the current tragedy of his life in terms of not knowing his children and of them not knowing him. “I was a parasite on the whole household for twenty years,” he told me. Thus sobriety does not abolish old wounds, it merely permits the healing process to begin.

Third, a final sequence of events was a shift in O’Neill’s attitude towards religion. At nineteen he had said, “I think that the Bible is the best code of morals there is. ” He did not have a personal God but thought Christianity should be expressed in active commitment to others, not in reflective worship. At age twenty-eight he wrote that he did not go to church but that in his distance from religion “I regret an important type of deeply personal experience which I’ve never known.” After a decade of drinking he never went to church and wrote, “American Protestantism seems barren and bigoted . . . Church means very little.” In 1972 he had returned to church membership and took an active role in its function.

Fourth, upon leaving his apartment, I noted several books related to gambling on his bookshelf and wondered if this remained an interest. He said that he had now sublimated that interest into becoming a consultant to a state government that was setting up a state lottery, a considerably more profitable

occupation. In other words, with the remission of alcoholism his ego functioning had matured. Instead of acting out his compulsive gambling, he had harnessed that interest in a socially and personally constructive way.

In closing, O'Neill told me he could not agree with Alcoholics Anonymous in calling alcoholism a disease. “I think that I will the taking up of a drink. I have a great deal of shame and guilt and remorse and think that’s healthy.” I heartily disagreed; I hypothesized that his shame had facilitated his denial for two decades.

An Alternative to Psychotherapy

My thesis is that the patient who tells us that he drinks because he is depressed and anxious may in fact be depressed or anxious because he drinks. He may draw attention from the fact that it is painful for him to give up alcohol. The alcoholic’s denial may be simultaneously at a conscious, unconscious, and cellular level. In no other mental illness is the deficit state so clearly a product of disordered chemistry and yet the secondary conflicts and associations so dynamically fascinating to psychiatrists. The greatest danger of this is wasteful, painful psychotherapy that bears analogy to someone trying to shoot a fish in a pool. No matter how carefully he aims, the refracted image always renders the shot wide of its mark.

Consider the scenario of *Who’s Afraid of Virginia Woolf*? We see George

and Martha locked in a sadomasochistic marital struggle. Drawing on his protagonists' childhoods, Edward Albee fills his audience in on the complex roots of their current conflict. The therapists in the audience may speculate that if George and Martha could come to terms with their parental introjects and learn openly to love each other through psychotherapy, their need for alcohol would vanish. But let us look at that scenario more closely. In fact, the sadism between George and Martha rises parallel to their rising blood alcohol. People mindlessly torture each other—and their therapists—because they have a disease called alcoholism far more often than people misuse alcohol to punish those they love.

Let me approach the problem from a different tack. Once compulsive drinking is established, any excuse justifies a drink. Consider well- analyzed training analysts who chain-smoke. Despite their access to previously repressed parental introjects and despite deep understanding of their oral needs, analysts continue to smoke. Do they do it from an unconscious death wish or from intractable habit? There is reasonable evidence that premorbidly many alcoholics are no sicker than many heavy smokers. To formulate their habit in terms of their *retrospective* accounts of parental deprivation or psychological conflict would be a grave error.

At this point, I shall describe the Cambridge Hospital program for treating alcoholics. The administrative control of the program is in the

Department of Medicine and in its own nonpsychiatric community board. A cornerstone of this program is to avoid sustaining therapeutic alliances with alcoholics so as to avoid transference; and, it is hoped, thereby to avoid the lion's share of the ensuing countertransference. The staff has been deliberately recruited from the psychodynamically naive. The reason for this philosophy is that even if alcoholics can learn to tolerate their transference, therapists of alcoholics seem to have extraordinary difficulty in tolerating theirs. For example, for years I was associated with two psychoanalytically oriented, sophisticated, humane community mental health centers. In both there was an unwritten sign over the entrance to inpatient and outpatient services. The sign said, "Alcoholics need not apply." This stemmed from senior staff's countertransference, not from the needs of the community.

In contrast, if the Cambridge Hospital alcohol program shuns psychotherapy, if it phobically avoids transference, it also treats more alcoholics than any other program in Massachusetts. It has a walk-in service sixteen hours a day, seven days a week; patients are seen without appointment. The staff has learned to accept, not reject, the twenty-time repeater; to offer hope and experience to the ten-time repeater; and to offer education and treatment to the one thousand alcoholics who are seen each year for the first time. Alcoholics' needs for welfare, shelter, detoxification, and referral are met day and night. Getting alcoholics to return for subsequent visits is not a problem.

However, when an alcoholic comes for a return visit, he sees whatever counselor is on duty. This could be any one of ten individuals. Even group leadership is on a rotating basis so that patients will come to groups to work on their problem of alcohol, not out of alliance to an individual. Again, on the detoxification unit, a patient is welcome to return as many times as he needs detoxification, but on every admission the patient is assigned a new counselor. The focus of the program is to produce alliance first to the institution Cambridge' Hospital and from there through stepwise progression to encourage the patient to move on to an alliance with Alcoholics Anonymous. This organization, by its very emphasis on anonymity, strives to avoid sustaining individual alliances. A member is taught to ally himself with his peers' ego strengths—not with those of his therapist.

Let me explain this unusual approach: Why does it help treatment to regard alcoholism as a disease, not a psychiatric disorder? Why does it help to violate the usual principles of doctor-patient alliance?

First, alcoholism is a disorder with unexpected relapses and intense needs for help at unexpected times. The alcoholic, like the unconcious, has little sense of time. Unexpected relapses tend to be destructive to any ongoing relationship, and this includes the most selfless therapeutic alliance. The patient literally is not under his own control. One of the advantages of a walk-in clinic, a hot line, and A.A. is that they do not expect the patient to be in

control. If we treat alcoholism by trying to sustain a therapeutic alliance, we expect the alcoholic's symptoms to be dynamically determined, controllable through insight, and affected by the state of the transference. However, once we feel that there is a dynamic relationship between our response and the patient's drinking, we develop superstitious and magical ideas about our powers, and this leads to hypervigilance, then mistrust, and finally rupture of the alliance. It is no accident that the first step of Al-anon, as well as A.A., is "We admitted we were powerless over alcohol." Rather than engender therapeutic nihilism, the Cambridge Hospital program paradoxically has this motto as its cornerstone. Our treatment staff are asked to attend Al-anon regularly. The whole treatment philosophy is designed to alleviate the enormous staff guilt generated by the seemingly inexplicable failure of some alcoholics to recover. Teaching staff to "let go" of patients when they leave allows them to welcome those who may return.

Similarly, we try to involve the closest family member of every patient admitted. But the task of family therapy is not just to view the patient's alcoholism in the context of his ongoing family relationships but also to view his ongoing familial battles from the perspective of the "disease," alcoholism.

The second reason for avoiding psychotherapy is that if the onset of alcoholism is facilitated by object loss, it is even truer that alcoholism causes object loss. There is probably no group of people more exquisitely lonely than

chronic alcoholics. They have replaced virtually every meaningful person in their lives with inanimate bottles. The temptation of the sensitive therapist to step in and try to fill that loneliness leads to overwhelming demands, e.g., crises on weekends, Christmas, or in the early hours of the morning. The therapist withdraws, and the alcoholic's misperception that his loneliness is too great to bear is confirmed. So, again, it is important to avoid therapeutic relationships leading to intense transference and countertransference.

The third reason for the Cambridge Hospital's philosophy is a paradox of alcoholism. Dynamic treatment can serve to increase, rather than lessen, the patient's denial that he has a problem with alcoholism. For if alcoholism is regarded as a symptom, then misunderstood relapse only increases the patient's guilt toward his therapist. If alcoholic sadism is regarded as dynamically, not chemically, engendered, shame is immense. But if the patient's rages and relapse to alcohol are a symptom not of his unacceptable ambivalence, but of his matter-of-fact illness, then the patient's guilt is reduced and he can keep his alcoholism in consciousness. Not only can he remember that his marriage and childhood were *allegedly* intolerable; also, he can see as intolerable the *fact* that he now truly has difficulty controlling his drinking.

The fourth reason for avoiding psychotherapy is that alcoholism is sometimes preceded and is always followed by profoundly low self-esteem.

By definition, a sustained therapeutic relationship and its accompanying transference present the therapist as a powerful and reliable figure enhancing the alcoholic patient's low self-esteem and exacerbating his contempt for his own incomprehensible unreliability. Alcoholics learn to displace this rage at self to contempt for the reliability, the tolerance, and the sobriety of their long-suffering therapists. A therapist can only experience this as ingratitude. In response, the patient can only conclude that his ego strengths can never be allied with his therapist's.

In contrast, the anonymous peer groups in Alcoholics Anonymous ask only that the patient accept help from those who are as vulnerable as himself; and equally important, of course, A. A. allows him to help in return. An alliance is forged and self-esteem goes up. True, A.A. has a system of "sponsors" and "pigeons," but one definition of a pigeon is "someone who keeps the sponsor sober"! Thus we have another paradox. Psychotherapy asks that the patient admit helplessness to his doctor, encourages him to say how little he has to be grateful for, but insists that he be independent enough to pay for that privilege. A. A. costs the patient nothing but shows him that he is independent enough to help others and encourages gratitude for the smallest blessings. That such an approach involves denial of emotional suffering is true; but research into serious medical illness is slowly teaching us that selective denial can be lifesaving.

Fifth, there is also evidence that a small group of alcoholics have been so profoundly deprived in childhood that the reliving of early rejections in psychotherapy may be unbearable. If most alcoholics are not premorbidly sociopathic, a very high percentage of sociopaths are alcoholic. Thus a significant fraction of alcoholics *have* had early childhoods similar to those of severe delinquents and poly-drug users. Some alcoholics have suffered early maternal neglect which may impair their capacity to care for themselves. However, the yearnings involved make their appearance in the transference, and *that is where the danger lies*. The fact that the subject never had an adequate mother becomes amplified by the transference rather than relieved. Psychoanalysis helps us love the parents that we have had but does not provide the parents that we never had. Doctors, wishes aside, are not mothers, and the analyst's couch is no bassinet. There are times in life when the affects associated with early abandonment may best be left alone. And the period during which an alcoholic gives up alcohol is one such time.

Indeed there are precious few ways that adults acquire sustaining parental introjects. There are few ways that an adult can truly find a mother substitute. One way is by loving group membership, for example, in A.A. or the church; another is becoming a mother substitute himself, for example, being a matron in an orphanage or a twelfth-stepper in A. A.

The sixth and final justification for the Cambridge Hospital philosophy is

the worthy psychodynamic goal that alcoholics must be taught "the inviolable unity of their own selves." I think that to achieve that goal, alcoholics must learn that their drinking behavior is *not* a reflection of their dynamic unconscious, but just the reverse. Often what emerges in the therapy of an alcoholic is psychological confabulation in order that the patient can continue his chronic addiction. The chief complaint "I drink because my wife left me" masks the fact that "my wife left me because I drank," and the self-loathing that derives from the secret belief "My wife left me because I am bad because I could not stop drinking" hides the more bearable and admissible fact that "my wife left me because I could not stop drinking because I was powerless over a disease."

Psychotherapists encourage and focus upon the affects of anger and sadness, but in chronic alcoholism interest in the patient's "poor me's" and "resentments," instead of uncovering old wounds, merely brings forth reflex confabulation to explain unconsciously conditioned relapse to alcohol. But as the case history illustrates, without prospective study appreciation of this fact is immensely difficult and the alcoholic's anger and depression become major foci of psychotherapy.

To conclude, once an alcoholic has achieved stable sobriety, he will have the same needs for and capacity to benefit from psychotherapy as would any other member of the population. But bald facts from the lives of 268 men,

prospectively followed from their sophomore year in college until age fifty, underscore the theoretical points of this chapter. Twenty-six of these men at some point lost control over their use of alcohol. One-half sought psychotherapy and on the average received about two-hundred hours of psychotherapy. With time, one-half of these men have achieved stable remission from their alcoholism—usually through abstinence. In only *one* case did psychotherapy seem to be related to the remission; in many cases it seemed to deflect attention away from the problem.

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