DENIAL AND THE PSYCHOLOGICAL COMPLICATIONS OF ALCOHOLISM

MARGARET H. BEAN

Dynamic Approaches to the Understanding and Treatment of Alcoholism

Denial and the Psychological Complications of Alcoholism

Margaret H. Bean

e-Book 2015 International Psychotherapy Institute

From *Dynamic Approaches to the Understanding and Treatment of Alcoholism* by Margaret H. Bean, Edward J. Khantzian, John E. Mack, George Vaillant, and Norman E. Zinberg

Created in the United States of America

www.freepsychotherapybooks.org
ebooks@theipi.org

Table of Contents

About the Author

Margaret H. Bean is the Harvard Medical School Career Teacher in Substance Abuse at The Cambridge Hospital and a faculty member of the Harvard Medical School. She has published several professional articles on the use of intoxicants, in particular a series on Alcoholics Anonymous.

Denial and the Psychological Complications of Alcoholism

Margaret H. Bean

It is not yet possible to predict of individuals whether they will or will not become alcoholic. Once dependence is established, however, its consequences are predictable, though patterns of development vary.

This chapter will describe the psychic disruption that results from the experience of alcoholism. It will attempt to trace linkages between the physical experiences of repeated loss of control and intoxication and the emotional consequences of being alcoholic. What develops, concurrently with mild central nervous system impairment and a system of defenses based on denial, is a clinical state which has been called the alcoholic personality and often assumed to antedate the alcoholism.

The chapter will suggest that the so-called “alcoholic personality” is partly a complication of alcoholism. By “alcoholic personality” I mean the distortions in personality functioning commonly seen in drinking alcoholics such as impulsivity, self-centeredness, self-destructiveness, irresponsibility. poor judgment, regression, irritability, labile mood, and the defense system based on primitive denial, rationalization, projection, and minimization.

I will argue that substantial personality dysfunction is directly caused by both physical events and the experience of being alcoholic, and will attempt to show how. Once the dysfunction has developed, it sustains and entrenches the alcoholism. When the alcoholism is in remission, many of the personality disturbances recede as well.

This approach differs from those of Mack and Khantzian in this book, who try to define what deficit in psychic structure produces the alcoholism. Although, as they show, psychopathology may antedate or contribute to the establishment of alcoholism, this chapter ignores etiology, and describes what happens after alcoholism begins.

The personality disruption described does not replace the character of the sufferer. Rather, it overlies and may partially obscure the original personality, which will reemerge when the alcoholism is treated, with two other developments possibly added. The alcoholic may have permanent or temporary personality destruction on a neurological basis, and he may have massive repair and relearning to do to restore his psychic integrity after the devastating experiences that occur in the lives of alcoholics, much as a stroke victim or concentration-camp inmate will be affected by his experience.

The experience of being an alcoholic is complex and extremely painful to the sufferer. It begins gradually. The person rarely realizes that he has

symptoms of early alcoholism. Instead he is likely to be both bewildered and frightened.

Social and medical myths about the disease intensify fear, shame, and isolation. People with alcoholism face prejudice and contempt. Families and employers are bewildered and angry with them. Many doctors and health professionals are not trained to diagnose or treat them and instead react with avoidance of diagnosis or confirmation of despair and rejection of the person.

The disorder may begin subtly but moves along and usually worsens over time along three channels. The first is loss of physical health, safety, and comfort. The second is psychological damage. The third is resulting losses and destruction of the things the person loves in his life: relationships, career potential and achievement, economic status, and legal identity as a citizen in good standing. These events, quite characteristic in alcoholism, cause intense and increasing suffering. As any such process occurs in a person's life, he reacts to it.

The idea of psychopathology produced by trauma during adulthood is not new. It has been described in life-threatening and crippling disease, and a range of human catastrophes such as knowledge of impending death (Becker, 1973; Kubler-Ross, 1969), combat (Brill & Beebe. 1955), natural disasters (Lindemann, 1944; Rangell, 1976; Titchener & Kapp, 1976), and incarceration

in a prison camp (Frankl, 1959). Just as it is possible to generalize about the psychology of disaster or concentration-camp victims despite the obvious fact that each has a unique personality and defensive style and might react to the trauma in idiosyncratic ways, with alcoholism there will be wide variation according to what the person brings to the experience, but the experience is so powerful that it is possible to describe a general response to it.

In all these other events the painful process is experienced as unavoidable and overwhelming. There seems to be no explanation for it and no help for it. The psychological reactions to these traumas usually include a period of shock, decompensation, and regression. Then the person makes a variety of efforts to control, master, cope with, and later to bear, understand, and transcend the suffering. That a person faced with the experience of alcoholism would react like other human beings faced with trauma seems obvious. That such a psychology of response to suffering must be understood to work effectively with alcoholics also seems clear.

It is practical to speak of the "phases" of alcoholism, which can be identified as early alcoholism, with such experiences as blackouts and loss of control of drinking; a middle stage, with growing psychological dependence; development of tolerance to alcohol, and then frank addiction and withdrawal; remission and relapse; and finally deterioration. It is natural to discuss these phases in a chronological order, though individual alcoholics

may not progress predictably from phase to phase. Reversal of direction, telescoping, and skipping phases are common. Each phase may be complicated by psychological disruption and the consequences of impaired function on social, economic, legal, and physical wellbeing.

This concept of alcoholism borrows from many other thinkers in the field (Jellenik, 1952, 1960; Goodwin, 1971; Goodwin et al., 1973; Eddy et al., 1965; Seevers, 1968; Wikler, 1970; Nathan & Bridell, 1977; Rado, 1933; Glover, 1928, 1932; Simmel, 1948; Hartmann, 1935, 1951; Krystal & Raskin, 1970; Wurmser, 1974; Ablon, 1976; Calahan & Cisin, 1976; Chafetz and Demone, 1962; Chafetz & Yoerg, 1977; National Commission on Marihuana and Drug Use, 1973; Pattison et al., 1977; Kissin, 1974). Though some models clearly acknowledge the importance of subjective factors—"motivation," "craving," and "psychological dependence"—in the *establishment* of abnormal drinking patterns, many of them cease to interest themselves in the behavior and psychology of the drinker *after* the development of alcoholism, in the response to what is happening, how the alcoholic acts, and the way he or she seems to feel.

In the development of alcoholism, different physical and psychological factors are paramount at different stages. I have not found it practical to discuss these factors separately, in isolation; for treatment purposes, it is more useful to examine them in interaction. Other chapters of this book

discuss drinking as a social phenomenon, the vulnerable personality, and the applicability of psychoanalytic methods in treatment. All these subjects have bearing on mine, but my central purpose is to link the alcoholic's subjective experience with the way he presents clinically.

However we may refine upon it (Keller & McCormick, 1968; Keller, 1977), alcoholism means repeated harmful drinking. As a working definition of harm I will use "serious problems related to drinking in any of these areas: physical, emotional, social, vocational, financial, or legal." A working *description* of alcoholism, since research in the field is spotty though extensive, and since patients' own perceptions are distorted, must draw on other fields of experience. To know "what it feels like," for instance, it is useful to compare the experience of alcoholism to other traumas, to look at brain-damaged patients and refer to drug addiction. A few vignettes, rather than formal case histories, have been drawn from clinical work with patients.

I admit to a strong positive bias. Alcoholics can get well, even on their own. Studies exist, though of small samples, that show a recovery rate for untreated alcoholics of from 17 to 24 percent over a two-year period (Imber et al., 1976; Kendall & Staton, 1966; Lemere, 1953; and Orford & Edwards, 1977), suggesting that over a lifetime recovery rates are much higher.

Alcoholism treatment programs including A.A. have differing

assumptions, though much understanding could be shared. Some patients enter the treatment system more comfortably via their physician or psychotherapy than via A.A., but their drinking is often neither understood nor addressed. People are often fearful and depressed about entering A.A. or an alcoholism treatment program, but get more reliable help in staying sober there. They may not be able to learn how to take care of their disorder until their minds clear. They may require a period free of alcohol to begin to understand how to go about recovering.

A part of the alcoholic's resistance to treatment has often been the negative and rejecting reaction he encounters among caregivers who. themselves pessimistic, are apt to collude in his denial. Just as the diagnosis of alcoholism is painful to accept, so it is painful to make without therapeutic optimism, as in the following story:

Katharyn P. aged 60, came into my awareness with a family history of nearly every member being alcoholic. The patient herself had drunk nearly continuously for over thirty years. When I was called to see her. she had chronic liver disease, lung disease, and heart disease, and had been in a confused state with mild disorientation and inability to remember more than two of five objects at three minutes for the eight weeks she had been in the hospital. Fortunately, her neurological impairment eventually cleared. During the three years preceding our contact, her need for medical admissions for

pneumonia, head trauma, and fractures from falls due to drinking had doubled every year, until in the year before I saw her she had had a dozen admissions. Her physicians had meticulously cared for the complications of her alcoholism without seeking treatment for the alcoholism itself. The reasons they gave for this were doubt that there was any treatment for alcoholism, uncertainty about how to find it, and a strong if misplaced sense of tact. When they attempted to bring up the matter of her drinking, she became upset, and since she seemed unable to bear to talk about it, they usually avoided the subject of alcoholism.

When I confronted her about her drinking and how it was endangering her, she was embarrassed and furious. She hated me, for I had humiliated her beyond endurance by lifting off her defenses and exposing her to the life she had to look back on of years of drinking. Shame was intense even though she had been a quiet, generally secret drinker who had her liquor sent to her home and drank it there, offending no one except her own conscience. The humiliation, depression, and guilt unleashed by breaching her denial were more than she could stand, and as soon as she could, she signed herself out against medical advice from an attractive, kindly alcoholism rehabilitation unit. She rejected A.A., but she was willing to come to see me weekly and to attend an occasional rehabilitation program meeting and has not had a drink for over 3 years. During this time she has required hospitalization for her frail medical condition, but only for a total of a few weeks per year, as opposed to

seven months of the year previous to the beginning of her alcoholism treatment.

For many years this woman did not get help for her alcoholism. It was not that she did not realize what was happening to her. She did. She simply, understandably, could not bear to face it without help, and the process of helping her face it was an excruciating and demanding therapeutic event. In this case her problems were compounded by the fact that her numerous medical caretakers shared in her denial.

It seemed to me that this sixty-year-old woman, in breaking the addiction, the habit, and indeed the way of life that had been entrenched for thirty years, showed extraordinary strength of character. As her mind cleared, her stubbornness and tenacity came to the fore. The obstinacy of her fight against me could be channeled into the fight against her craving for alcohol, a fight which initially she had to carry on at every moment of every day. Whatever may have been her original reasons for drinking, they had long since receded into forgetfulness, and she was able to see that the craving was outweighted by the dire consequences of drinking. It was possible to divert her thinking into envisioning the possibility of recovery. She liked a fight, and she liked winning it.

Eventually, she simply summed herself up as “one of those people who

just can't drink." She needed no deeper psychological insight. "From the first drink," she said, "I guess I was an alcoholic." Since she had usually drunk alone, it is clear that she did not drink for ordinary social reasons. Possibly she was vulnerable to alcohol from the beginning; her family history did suggest both inherited and environmental predispositions.

As a background to the description of the development of alcoholism, we will look at healthy and heavy drinking.

Healthy Drinking

Although it is not simple to define healthy drinking, we may briefly say that it is usually drinking in company, and that its extent is defined by each culture and established by custom, influenced by age and the availability of alcohol. Generally, behavior is consistent with self-esteem and does not produce trouble in the drinker's health, his relationships, or his economic and legal status; it does not cause pain and deterioration in his mental life. Drinking is within range of voluntary modification or self-control. And some healthy people choose not to drink at all.

Healthy adolescent drinking in our culture is usually motivated by curiosity, a wish to become adult, and peer pressure; adult social drinking, at least partly, by the pleasures of conviviality. The simple act of pouring and holding a drink has a symbolic significance, like changing to slippers after

work: a cue to relaxation. Though the taste is often an acquired one, alcohol tastes good to most people, smells good, feels warming. Subjectively, in healthy drinkers its effect is to produce relaxation, regression, decreased inhibition, and euphoria. These are cheerful effects: pleasure that can be deliberately sought and unfailingly obtained.

Heavy Drinking

It is striking that most adults drink moderately, while only a small fraction become heavy drinkers or alcoholics. Some healthy drinkers can ingest relatively large amounts with no resulting trouble. Some healthy drinkers drink alone; some heavy drinkers drink only socially. Most healthy drinkers have at least once or twice become drunk; some heavy drinkers never have. Some drinkers become alcoholics overnight; some heavy drinkers continue for a lifetime without ever becoming alcoholics. Drinking to avoid pain is more common to heavy than to healthy drinkers.

Heavy drinking is defined by quantity, not by its dangerous effects. We classify this group as not alcoholic because the drinking does not produce harmful consequences. The person may be on a continuum moving toward alcoholism, and some heavy drinkers will probably become alcoholic. But despite increasing amounts of alcohol taken, increasing frequency of drinking, more frequent drunkenness and hangovers, and perhaps some blackouts, the

diagnosis of alcoholism does not yet apply (Bacon, 1973).

A drinker may drink to calm his anxiety or to conceal it, and may find the alcohol "works" so well that he comes to resort to it before, or in, any threatening situation or at any time when painful feelings surface. Or he may drink only during a period of stress or loss, such as divorce.

Control factors may include ethnic patterns of moderate use or abstinence. Families may act as models for healthy or abusive drinking or may protect the drinker from the consequences of his drinking (Ablon, 1976; Calahan & Cisin, 1976). After the unpleasant experience of hangovers and perhaps some blackouts, the drinker may moderate his intake or stop.

Alcoholism is partly a learned habit, with reinforcement producing and maintaining the drinking. Many independent factors reinforce drinking. One is the psychological effect of the act itself separate from the chemical effect. This is analogous to a repetition compulsion, and is seen in alcoholics who drink despite taking Antabuse, who know that if they drink they will experience not the usual chemical effect, but instead dangerous sickness. Another factor is direct oral gratification from drinking, tasting, and swallowing. This resembles compulsive eating. Probably most important is the pharmacological effect of alcohol on the brain with its corollary change in sensory and emotional experience.

Heavy drinking may begin as a symptom, to mute conflict or get rid of intolerable affect. But as often as the symptom is repeated it produces reinforcement, so that it is powerfully learned.

Another reinforcing characteristic of alcohol use is its value as a defense in avoidance learning. Just as a rat will press a lever to prevent shocks, an anxious shy person may drink before a job interview to reduce anxiety. The reinforcement is that the interview is then less painful. This learning is particularly resistant to extinction because it is never tested. There may also be a positive operant conditioning learning pattern in people who drink to produce pleasure or get "high."

The psychological factors related to heavy drinking will include the factors that characterize any behavior. Alcohol use, like eating, is likely to have meanings and uses according to individual psychological style and pathology. The neurotic may use alcohol as a chemical equivalent for a psychological defense (see the chapters by Mack and Khantzian in this book, and Khantzian et al., 1974). A person with a hysterical personality may use it to reduce conflict during a sexual experience. The abuse of alcohol in depressions of all kinds is well known. The depressed person may use alcohol for anesthesia and relief, or to express self- destructiveness or devaluation. In a person with oral character traits alcohol may, like food, be used in place of people as an object for satisfaction and comfort. A schizophrenic may

incorporate alcohol into a delusional system. One man became convinced that the "Greater Power" relied upon in A.A. to maintain sobriety was forcing him to drink against his will. Or the heavy drinker may use alcohol to mask unacceptable feelings or to get in touch with inaccessible ones. Some schizophrenics appear to attempt to ward off psychosis with alcohol.

The Distinction Between Heavy Drinking and Alcoholism

This is a partly psychogenetic model for heavy drinking, but not for alcoholism. The question remains why some heavy drinkers become alcoholic, and others do not. Psychopathology can contribute to abnormal use of alcohol and heavy drinking, as described above. There are clear situations in which each choice to drink is a response to a separate feeling state or conflict and is chosen. Like other symptoms, such drinking is designed to relieve the conflict or pain. This situation may be in effect in heavy drinking, but in alcoholism, as in heavy cigarette smoking, *these rules no longer apply*. Once alcoholism begins, each drink is not a separate choice in response to a feeling state. When there is physiological dependence, drinking may be determined by the length of time since the last drink, not unresolved oral needs or unconscious suicidal tendencies. Even before the establishment of physiological dependence, psychological dependence and the establishment of a learned habit of drinking may augment or supplant classical symptom formation in the production of drinking.

In alcoholism drinking becomes an epicycle which is self-sustaining. In order to interrupt it, it is not enough to remove the factors which led to excessive drinking. For example, treatment of depression which may have preceded the alcoholism is necessary but not sufficient. The autonomous cycle of addictive drinking must also be broken. A psychogenetic model of symptom formation is clearly active at some points in some drinkers and is clearly buried under and superseded by other factors at other times. Clinicians need to know when it is making a contribution and when other factors are paramount.

A causal link between alcoholism and some forms of mental illness may be established. There is evidence for at least association in some genetic studies (Goodwin. 1971). But prospective studies have not clearly demonstrated a "prealcoholic personality" (Vaillant, 1980 and in this book). Early reviews of research studies which tried to determine a set of character traits typical of the alcoholic or "causing" alcoholism found few reliable characteristics (Lisansky, 1967; Sutherland et al., 1950; Syme, 1957).

More recent studies using more sophisticated methods have shown some subtypes among alcoholics (Skinner et al., 1974; Whitelock et al., 1971; Williams, 1976), but since the studies are retrospective, these findings might equally well support the hypothesis argued here, that there are differences between alcoholics and nonalcoholics, but some of these may be *produced* by

the disorder and not found before its onset.

Several studies suggest that psychopathology follows the onset of alcoholism. In a prospective study of a group some of whom later developed alcoholism, general maladjustment and especially depression, health concern, and guilt increased between the original testing and the alcoholic stage (Hoffman et al., 1974).

Another prospective study of the causal relation between drug abuse and psychiatric disorders followed a group of drug abusers for six years. Initially there were no significant symptom differences between the groups. At six years eight of fourteen depressant users had serious depression, five of eleven stimulant users had psychoses, and the twenty-six narcotic users showed no change in psychopathology. It is possible that different preexisting personality disorders determined drug selection, but at the beginning of the study symptom levels in all three groups were low (McLellan et al., 1979). The study did not specify whether alcohol was one of the drugs the depressant group used, and it would be important to study alcohol separately, but the clear intergroup differences are provocative.

Every alcoholic has a character structure which may be predisposing *or not* before the alcoholism, but whoever experiences alcoholism will undergo characteristic psychological damage. This damage will be grafted on to the

original psychological organization and intertwined with it. The alcoholic will then present clinically as more or less psychologically impaired depending on stage and complications of alcoholism as well as on initial strengths and weaknesses of character.

Early Alcoholism

Heavy drinking may persist indefinitely, maintained by familial and social forces, by psychological factors, or as a learned response. But in some drinkers and perhaps even some people picking up their very first drink, another set of developments occurs.

This group is distinguished from the group I have called heavy drinkers because the drinking, whatever amount, causes harm. The person is alcoholic. The symptoms vary, but many include blackouts, hangovers, solitary drinking, morning drinking, and sneaking drinking, antisocial acts while drinking, and experiences of loss of control (Bacon, 1973).

The patient may have come to this stage down any path, over any length of time. He may have begun to drink regularly to the point of stupor, or he may not always or even very often drink to excess. But his “meter” is out of order. When he decides not to drink, he may find himself drinking anyway; when he does drink he doesn’t know what will happen, how much he will drink or how he will act. After a few blackouts, hangovers, and embarrassing

recollections, he will try to control his drinking, will almost certainly fail, and will try again repeatedly. Should he be seen clinically, he will probably not be correctly diagnosed.

Unless he has been drunk very recently, he has no physiological symptoms. He may be well dressed, satisfactorily employed, and entirely presentable. No one wants to admit that he is out of control, and few doctors want to confront a patient with such a suspicion. It is easier to assume that loss of control is an unusual event than to inquire searchingly about previous episodes. Early alcoholics who have prepared themselves to ask for help with their drinking may thus find themselves subtly discouraged. Of all alcoholics early ones are the most neglected, least understood, most frequently undiagnosed, and easiest to treat. It is unusual for them to seek help, but if they do, a single interview may begin recovery, though they need more help than that.

The early alcoholic has little or no impairment in his physical functioning, except for the memory loss of blackouts and the discomfort and slowed thinking of hangovers. He has no withdrawal symptoms, though his drinking has unpleasant consequences, such as upsetting people who care about the drinker.

He may be aware of his unusual drinking, anxious about it, and ashamed

and depressed when he drinks too much. But what may be evident to outside observers is often opaque to him. He has little idea that he has an abnormal response to alcohol, or what that means.

What he notices is that he repeatedly loses control of his behavior. He realizes, and others realize, that this is not like social drinking. Why does he not act on this knowledge and stop?

Instead, he does two other things. He does not accept his loss of control as fixed. He does not give up hope that he can drink socially and safely. Like a child learning to walk, he tries over and over again to master the drinking. He begins a determined, doomed struggle against his loss of control. He continues to lose control. His thinking begins to shift in reaction to these repeated experiences. Denial, rationalization, and projection appear in relation to drinking.

The next case shows how denial appears in relation to drinking:

Peter L. is a 30-year-old professor of design raised in many countries by diplomat parents. He first came to treatment with me after his wife separated from him because of his drinking. He was referred by a physician, his prep school roommate, who had been worried about his drinking for several years; he had always refused treatment until his wife made good on her threat to move out.

He was young, gifted, rich, handsome, and depressed. He wanted psychotherapy for his depression. He denied having any difficulty related to drinking. He gave a history that he

sometimes drank too much at parties, only drank on social occasions, never at work or in the mornings, had no severe hangovers, and denied memory blackouts. He did not drink every day. He found the idea that he could not control his drinking infuriating and stigmatizing.

He saw me as a judge who, if he could figure out how to conciliate me, would benignly allow him to drink, or who, threateningly, might deprive him of his drinking. He had intense feelings about alcohol. He thought that if he was alcoholic he was degraded and defective. Coming to therapy was proof of his defect, and was regarded as punishment, and penance. He distracted attention from his shame by fighting about scheduling and about the fee. He had trouble accepting the idea that his decision to drink or not was an issue of his safety and comfort. He felt that if he could not drink socially he was morally inferior.

I told him I was not sure he was alcoholic, since he had no addiction or withdrawal symptoms, but that he reported damage to his relationships and to his self-esteem from drinking, and his wife and friends were concerned. He now admitted to blackouts, but felt he chose to get drunk.

He desperately hoped that if only we could treat his depression, he would be changed in some way and would then be able to drink. He was sure his drinking was out of control because of some psychological disturbance. (This much longing for alcohol is not characteristic of social drinking and indicates that he was psychologically dependent.)

He was determined to prove that he was not alcoholic. He stopped drinking altogether for three weeks. As soon as he stopped drinking, he spent much less time in therapy arguing that he was not alcoholic. His depression lifted. He talked about the comfort of knowing that if he did not drink, he could not get into danger. He was amazed at his previous insistence that he could control his drinking, and appalled at the risks he had taken with his career and marriage. Sober, he was soon talking about what happened to him when he drank, telling me that he had nearly weekly blackouts, insulted and assaulted friends at parties, drank much more than his friends, and spent time with a couple he neither liked nor respected but enjoyed because they were very

heavy drinkers, probably alcoholic. That is, sober, he was able to talk about the frightening and painful aspects of drinking which he previously denied.

After several weeks the desire to drink returned. He began to feel that he had proved he was not alcoholic and to deny trouble with drinking. He came to an appointment half an hour late, saying that he didn't want any more treatment, that it made him depressed. By the end of the session he acknowledged that he had started drinking again and did not want to feel bad about it, which would happen if he came to treatment. He denied being worried or guilty, but protested too much. Because of his distress he decided to continue therapy.

The next few weeks he avoided the topic of alcohol and denied that he was having trouble. He insistently defended his right to drink and his self-respect, threatening to break treatment if I continued to ask about the drinking. One day he came in depressed and full of self-hate. He had lost control of his drinking and while drunk and in a blackout had driven a carload of friends into a post. Some of them were injured. He was furious with me, saying that if I had not undermined his self-confidence, he would not have lost control and drunk too much in the first place. Now full of remorse, he described the previous few weeks in which his daily alcohol consumption had been slowly rising, from two drinks to six or more. Because of his shame, he had needed to lie about this in therapy. As the guilt and embarrassment about his blackout episode overwhelmed the denial, he described real damage caused by his drinking. He was able to make the causal link between his pain and his drinking.

He was also able to make a plan to get sober. He stopped drinking again, and this time he was depressed and angry about not drinking. He reluctantly agreed to go to A. A. He returned from one meeting feeling that he was different from the people in A. A., that he was superior. He was confirmed in his belief that he was not alcoholic. But he was possessed and pursued by craving for alcohol, wrestling with the desire to drink at parties, dinners, and business lunches. He was as preoccupied as a dieter longing for chocolate, and hopeless about the craving ever abating.

He stayed sober five weeks. During this time his wife moved back in. His spirits rose and he started drinking immediately. He drank attempting to control it but in increasing amounts and with increasing denial for eight weeks before he had another episode of loss of control. This time he got drunk at a party for the chairman of his department, destroyed a room, and had to be arrested, spending the night in jail. His wife moved out again. He had an acute ‘‘cure.” Miserable, full of self-reproach and remorse, frightened about endangering his career, furious with me that I had not taken away his alcoholism, he stopped drinking again. He joined A.A. and this time he loved it. He fervently followed instructions, went to many of the meetings, and felt it was better than therapy, which only caused depression. He left treatment. Two days later he went on a three-day bender, which ended when he smashed up another car. He came back to therapy tired, sick, disgusted with himself, humiliated, and admitting, with gritted teeth, that he was alcoholic.

His experiences illustrate graphically what a painful process it is to accept the diagnosis of alcoholism, a process which is necessary to begin recovery. Now, with his denial collapsed, he admitted that in the past he had had alcoholic hepatitis and had several arrests for drunken driving.

He has been sober in A.A. nearly a year. He goes to A. A. meetings every week, a brief period of daily attendance. His depression is improved, and he has reduced therapy to check-in visits though he may return for more treatment later. His wife, who had come in to talk a few times, goes to Al-anon occasionally, and they are together. He is not obsessed with the question of whether he can control his drinking. He finally ‘‘let go” the struggle for control and once he realized he could not drink safely had little trouble staying sober. He overcame a block to his creative production at work which had lasted for most of this year of treatment, and recently won a travel fellowship.

This patient has early alcoholism. He had the entire system of denial, psychological dependence, rejection of diagnosis, attributing pain and danger

to other causes, and fight for control. He was not yet completely demoralized and hopeless about recovery. He was hopeful instead that he could drink safely. He hated his disease and diagnosis. Once he could give up the denial, he could choose whether he wanted to drink or not. Weighing the risks against his love of the idea of drinking, he chose to stop. He is typical in that when he was drinking and fighting to control it, he needed denial; when he stopped, he could acknowledge the painful consequences of drinking, soften his rejection of diagnosis, and make use of treatment.

Denial of alcoholism was present before addiction had developed and drastically decreased within a short time whenever he stopped drinking. While it might be argued that this obsessive denial was always present, he and his wife say that it began when he started drinking heavily and only occurred around the issue of drinking. He can describe how as he begins to want to drink his thinking twists in order to allow him to do so, and how the denial is decreased when he is sober, and he cannot understand how he could have been so self-destructively irrational. He now knows how he must think to take care of his drinking problem.

I was not sure at first that this patient was alcoholic. He had no physical addiction, and his denial was very convincing. We initially decided to wait and see if he had any more dangerous and humiliating blackouts and losses of control. These did not occur immediately after he started “controlled

drinking," but in each case he ended by loss of control. This, combined with his intense denial related only to drinking, made the diagnosis.

His alcohol problem had been worsening steadily over several years, and while one cannot predict what would happen to him next, if he continued drinking, he would appear to have been at very high risk of addiction and other complications. In A.A. people describing their early drinking often report similar experiences. His behavior and reactions are nearly universal among alcoholics. In A.A. newcomers are told, "Identify, don't compare, and sooner or later you'll hear your own story."

The "Middle" Phase

As the early alcoholic continues to drink, tolerance develops, so that he needs more alcohol to achieve the same subjective change. Even if he increases the dose, the desired relief may elude him. This, in fact, is what alcoholics frequently report: "It just didn't work the same way any longer"; and the observational studies likewise describe in drinking alcoholics an increase in psychic pain, depression, and anxiety (Capell & Herman, 1972; Mendelson et al., 1964; Tamerin et al., 1976; Vanicelli, 1972; Warren & Raynes, 1972; Mendelson & Mello, 1979). Insofar as alcohol was used as a pharmacological defense, it is no longer effective. So other defenses must be substituted to protect the ego from being overwhelmed.

One would think that by this time the alcoholic would surely want to stop. He wants to want to. But if he *really* wanted to, he thinks, why then of course he could control the drinking: this, he has to believe. One may ask whether the unconscious or repressed knowledge that he is, in fact, helpless to control the drinking may not underlie the clinging, dependent behavior so commonly seen in alcoholics at this stage and thereafter.

They experience intense need for people, though people are offended or feel rejected by their destructive behavior, rationalizations, and growing childish self-centeredness. At this phase, alcoholics are less likely to stop or try stopping, risking another failure, than they are to become passive. Cognitive changes result from repeated failures. Negative self-perceptions which are relatively inaccessible to corrective feedback lead to giving up (Kovaks & Beck, 1978). The person learns that his efforts are useless, and he stops struggling. Treatment from this point on must not only point out the harm from drinking. It must help to reverse the learned helplessness (Seligman, 1975).

Often the alcoholic has or finds reason to seek help, however; the complications of alcoholism can mimic almost any form of mental illness, leading him to think he needs a psychiatrist, or a fall or accident may give him an acceptable cause to present himself to a general physician. He both seeks and fears intervention with his alcoholism. He often cannot relate his pain to

drinking. Whenever the diagnosis is suspected, the physician must aggressively pursue it since the patient can rarely make it for himself.

Alan T. was a middle-aged, red-faced, well-dressed white-collar worker with a bluff manner who came to the clinic complaining of depression, anxiety, sleeplessness, and inability to concentrate on his work. He denied any problems with drinking. His family also doubted that he had an alcohol problem. He had no signs of endogenous depression. He complained of increasing difficulty getting work done over about eighteen months. On close questioning about the nature of his difficulty at work, he admitted to confusion and lethargy. Further neurological examination gave no more information, but finally, on repeated concerned questioning about the confusion, he admitted to drinking at work. When it was explained that sometimes people felt bad about their drinking and found that they could not tell the whole truth about it at first, he readily admitted drinking a quart of bourbon a day by himself plus heavy social drinking, for three or four years. His denial was countered by empathy.

After about an hour of ventilation, support, reassurance, clarification, and intensive alcoholism education chiefly consisting of suggesting that his depression might be caused by the alcohol, that I thought it was, that I could help him with this, and that we could not tell if he needed psychotherapy or other help until he had been sober for a while, he agreed to attempt to stop drinking, see me weekly, and try A.A. Here denial was opposed by hope and information. He attended his sessions regularly, had no physical withdrawal or craving when he stopped drinking, and invested himself increasingly in A.A. At the end of the twelve-week period without alcohol which I had asked him to complete, his depression and sleep disorder had remitted completely, though he still had difficulty making himself do his work. At this time he related this to not liking his work and not wanting to work at all rather than to the confusion, lethargy, and guilt that crippled him when he was drinking. He has continued A.A., contacts me from time to time, and has been sober for several years.

Since this patient was able, with help, to admit how much he drank, and

was able to countenance the thought that drinking in itself might be doing him harm, his denial system was in an early flexible stage of development.

Writings on Denial

For the practical purpose of this chapter I will use "'denial'' in the broad colloquial sense to include all the alcoholic's defenses which have a denying quality, or serve to protect his drinking behavior or his self-esteem. This is clearly different from the word's strict and careful use in psychoanalytic thinking, which will be described below.

Psychoanalytic studies of theories of defense, including studies of denial, scarcely mention alcoholism; psychoanalytic studies of alcoholism have little to say about denial (Glover, 1928, 1932; Rado, 1933; Simmel, 1948).

The literature on the psychology of the alcoholic is voluminous, and has been reviewed elsewhere (Armotang, 1958; Barry, 1974; Blane, 1968; Sutherland et al., 1950; Syme, 1957).

The papers that mention denial in alcoholism make some interesting points. Alcoholism is a chronic behavior that cannot be maintained and supported without organization and work (Paredes, 1974). Denial in alcoholism serves as a kind of functional deafness, the keystone of the

pathological defense system of the alcoholic. It is reinforced by rationalization and defends against profound insecurity and low self-esteem (Twerski, 1974). According to Tamerin the appearance of denial is associated with active drinking (Tamerin & Neuman, 1974). In contrast, Hartocollis (1968. 1969), Gomberg (1968), and Vaillant (1976) treat denial as a character trait of the alcoholic, noting that denial of personal problems may precede alcoholism and be shared by the whole family. They do not specify how the onset of alcoholism was determined, and this would be important because denial is one of the early symptoms or complications of alcoholism, beginning well before the establishment of addiction, but consequent to symptoms of early alcoholism, as in the case of Peter L.

Psychoanalytic Papers on Drug Abuse

The scarcity of psychiatric writing on the psychology of alcoholism contrasts with the situation with drug abuse. Psychodynamic understanding of drug dependence generally assumes that the role of physiology in maintaining drug use is minimal. This is not true in alcoholism.

This work may be particularly helpful in understanding the relapse in an alcoholic who has been sober and for whom, at this point, withdrawal and confused thinking are not paramount.

Wurmser's (1978) is a fascinating discussion. He begins by casting aside

the early psychoanalytic literature on the subject. He believes that drug use is psychically determined and that drug dependence has little physical basis.

He describes drug use as a defense against the problems produced by the ego defect of affect defense. Drug use is an attempt at self-treatment, an artificial defense against overwhelming affects, rather than a wish fulfillment or escape. The defense is against internal rather than external threats. The affects that cannot be tolerated are rage, shame, and hurt or abandonment. Wurmser believes that intense craving for the drug after withdrawal is related to upsurge of these affects, with a kind of narcissistic decompensation and ego fragmentation, which the drug reverses. That is, the drug is used as a replacement for a defect in psychological structure. He expands the characterization of the dynamic functions of drug use to help with several other converging problems—superego pathology, rudimentary ability to form symbols and use fantasy, archaic passive dependence, self-destructiveness, regressive wishes, and narcissistic crisis.

Krystal and Raskin's (1970) work is along the same lines, saying that the drug user is grappling with affects which have never been moderated or neutralized, so are dedifferentiated, archaic, and excruciating. They also emphasize the disturbance in object relations in drug-dependent people, their need for supplies and for object substitutes to take in. Drug users inevitably fail to achieve lasting satisfaction, with intense disappointment and rage, the

ambivalence being handled by ego splitting and impoverishment. In any case, the use of drugs is seen as an effort to adapt and survive in the face of these serious problems.

Denial and Mechanisms of Defense

Defenses are processes which are a function of ego organization, and which regulate instincts and serve the integrity of the ego. The intention of the defense, to decrease pain and avoid anxiety, should be distinguished from the results of the use of the defense, which may be destructive to the ego, for example when denial of illness blocks treatment (Hoffer, 1968).

Freud's most extensive discussion of denial is in *An Outline of Psycho-Analysis*. He saw disavowal of external reality as the first stage of psychosis, and opposed it to repression, a rejection of the internal demands of the id. Denial, or disavowal, was the primal defense mechanism against external reality (Freud, as noted by Laplanche & Pontalis, 1973).

In his paper on fetishism (1927) he noted that in denial two contradictory elements occurred simultaneously, one taking account of reality and the other denying it, instead expressing a wish. He clarified that perception was intact, and that what was denied was the significance of the perception.

Anna Freud did not include denial in her list of defense mechanisms in *The Ego and the Mechanisms of Defense* (1966). She defined defense mechanisms as the means by which the ego wards off pain and anxiety from internal sources and controls impulses and affects. She continued Freud's distinction that denial was used against external rather than internal threats to the ego.

> The method of denial upon which is based the fantasy of the reversal of real facts into their opposite, is employed in situations in which it is impossible to escape some painful external impression. (A. Freud, 1966, p. 93)

Denial is a normal mechanism early in development, a preliminary stage for maturer defenses, from which it is distinguished by the fact that denial is not entirely intrapsychic since it protects against experience of real external danger (A. Freud, 1966).

Jacobson clarified how denial could occur when the distinction between internal and external was lost. This could take place if the ego regressed to the point where self and object, internal and external, were treated in the same manner. The process was regression, not projection (Jacobson, 1957).

Denial places two ego functions, the defense and the ability to test reality, at odds. During normal development it can be limited and gradually relinquished in favor of reality sense and maturer capacities to delay, deflect,

regulate, and master tension (A. Freud, 1966).

In alcoholism denial is used in exactly the same types of conditions which Anna Freud described to evoke it in the first place, situations of helplessness against painful reality from which the person cannot escape.

Semrad and Vaillant have observed that recovery from schizophrenia and drug addiction reversed regression with sequential substitution of maturer defenses. Primitive projection, denial, and distortion are followed by affective, then neurotic, and finally healthy defenses (Semrad, 1967; Vaillant, 1971).

Recently some have abandoned S. and A. Freud's clear usage and employ the term “denial” in a less clear expanded way to include rejection not only of external perceptions but also of unacceptable internal reality, painful affects, and even instinctual drives (Moore & Rubenfine, 1969). Despite this semantic problem, their descriptions of the clinical uses of denial are helpful.

Denial has its origins in early attempts of the organism to obtain relief from painful external stimuli or the painful affects generated by them. The painful stimuli include objects evoking aggression, hence threatening object loss, and events which threaten the ego with danger. The denial mechanism, effective at first in conserving objects, in used later against painful percepts of the self, external trauma, and the punitive superego (Moore & Rubenfine,

1969).

Denial may be both adaptive and pathological:

> The adaptive function of denial is the avoidance of painful affects evoked by percepts which arouse signal anxiety basically related to the continuum of threats encountered by the developing ego: danger of loss of object, danger of loss of love, castration, superego disapproval, and loss of self esteem. [Moore & Rubenfine, 1969, p. 33]

In situations of extreme danger denial may be the most adaptive defense mechanism available, in temporary adaptation protecting the ego from being overwhelmed. The person accurately perceives the trauma and appreciates its implications, but maintains an unconscious unrealistic idea that the trauma has not taken place; then he gradually, stepwise, resynthesizes the ego split. Pathology results only when the ego split is not repaired, though denial may also be associated with more severe pathology. The ego split may be maintained by a fantasy, for instance of invulnerability, or specialness, which allows the person to disregard his perceptions (Trunell & Holt, 1974). The equivalent in the alcoholic is the fantasy that he can drink normally, moderately, and in a controlled way. This is one of the major obstacles to recovery.

Denial may be used to attempt to secure instinctual gratification as a special function of the pleasure ego important in id factors and wishes (Moore & Rubenfine, 1969). This is of special note considering the role of denial in

alcoholism to preserve drinking.

Other defense mechanisms may be used to reinforce denial (Jacobson, 1959). Threat of breakthrough of denied material may lead to marshaling of adjunctive defenses, or acting out. These are invoked to protect the ego from being overwhelmed by the task of adapting to a loss too great to bear. Failure of adjunctive defenses along with the original denial would lead to experience of the pain which the defenses had been used against, such as depression, or other symptoms.

In alcoholism this occurrence of denial in association with clusters of related supporting defenses is very common, and bears testimony to the extent of the threat to the integrity of the ego.

How Denial Is Understood by Alcoholism Specialists

Denial is defined for psychoanalytic usage as a defense, a psychological mechanism to protect against pain. When contemporary alcoholism workers use the concept of denial, they mean something quite different. It is used broadly to mean the denial of obvious reality, but also to cover a whole range of alcoholic tactics to justify, hide, or protect drinking, to block treatment, and to deny responsibility for the consequences of behavior.

Denial as a Response to Trauma

The “denial system” in alcoholism is a set of psychological changes that occur as a reaction to alcoholism, a sort of psychological complication. The cases show the maladaptive effects of denial, especially the defensive resistances which block recovery and access to treatment.

What generates the psychological position which the drinker takes? The person who develops an addiction is faced with a strange subjective experience. Addiction is an organic assault on the physical and psychological integrity of the person.

He has repeated experiences of painful consequences of drinking. He ought to make the terrifying discovery that he cannot control his drinking, but he resists and denies it. He realizes that a catastrophe is afoot, and is bewildered and afraid. But he does not know what has happened to him. He does not say, “I drink because I have no control over alcohol use, withdrawal makes me sick, and drinking has been repetitively reinforced.” He instead explains his experience in ordinary psychological terms, like the hypnotized person who closes the window and then rationalizes his action. He says, ”1 drink because my wife doesn’t understand me” or ”1 drink when I feel depressed.”

His usual intellect and judgment are not available to help him understand what is happening to him because alcohol has often impaired

them.

When the alcoholic begins drinking, he does so in response to social and psychological forces. In alcoholism drinking shifts partly out of voluntary control, though it can still be modified voluntarily to an extent. The shift occurs without announcement or explanation, so it is experienced as continuing under voluntary control, while in reality it is not.

The impact of this experience cannot be overestimated. It is like the loss or reversal of the person's mastery and maturation in the acquisition of bowel and bladder control. These functions were originally under automatic physiological regulation and with development were brought into voluntary and social control. (This is not to specify the nature of alcoholic loss of control, which I do not claim to understand, but it is a good metaphor for the *experience* of loss of control.)

Because of the experience of loss of control, the despair that he cannot stop, the lack of understanding how to stop, and the terror of the consequences of stopping, the alcoholic sets up an elaborate psychological protective structure to preserve his drinking, a system of denial. His creative efforts to explain his experience to himself and master it, while they have disastrous consequences, are extraordinary and fascinating.

The alcoholic begins to react, by fighting to regain control, and to

explain to himself and others why he is behaving so badly. Repeated attempts to recover control repeatedly, predictably fail. This gradually destroys hope. Alcoholism destroys the person's belief that he is a normal, worthwhile person, for he finds himself repeatedly behaving destructively. Self-esteem deteriorates. The experience forbids the normal social wish to be able to drink socially. The alcoholic becomes guilt-ridden. He is demoralized in his attempt to solve his problem with drinking, although alcoholics almost invariably make repeated constructive efforts before they give up in despair.

He does not respond to his failures by saying that he needs help because of denial, shame, fear, and confusion. The failures humiliate him, and he is afraid that if he talks about what is happening to him he will be stigmatized and his despair will be confirmed. Most people experience a diagnosis of alcoholism as a tragedy. By the time someone makes it, their hope is usually gone.

Growing helplessness, like the neurological effects of alcohol, engenders regression. Efforts at mature grasp of the situation and problem solving fail and are given up. The alcoholic no longer believes in the possibility of a solution, and he retreats to the undifferentiated responses of regression, avoidance, magical thinking, and denial.

As drinking increases, complications extend and intensify, efforts to

control drinking fail, and simultaneously the alcoholic realizes that he cannot stop drinking; he becomes frightened and hopeless, and even more dependent on drinking. He is terrified of stopping, knowing that he would be faced with emptiness and sickness from the loss of drinking though he would also be relieved and feel better. He would also be faced with his shame and guilt, which are so intense that they are hard for most nonalcoholics to comprehend, and faced with the ruin of part of his life and other consequences of his drinking. When he does want to stop, which occurs when his contact with reality, and hence level of pain, is high, and occurs because of his self-respect and wish to recover, he does not think he can, and does not know how to.

One of his choices is to continue to drink while admitting that his drinking is bad, out of control, hostile, destructive, disgusting, and dangerous. To the alcoholic this appears untenable, like embracing the gutter, though there are some alcoholics who assume this attitude. Another of his choices is to give up drinking, which may be all that he feels that he has, and while its gratifications are not what they were when he started drinking, his need for it, symbolically, symptomatically, as an overlearned pattern, and to stave off withdrawal, is intense and unremitting. He does not believe that he is able to stop. He feels that this option is closed to him.

He chooses, instead, a third alternative, which to nonalcoholics appears

incomprehensible, but in view of this discussion is seen to have a compelling internal logical necessity of its own. He denies his alcoholism. If one is alcoholic and denies it or fails to "know," realize, or acknowledge it, one is spared the staggering blow to self-esteem of the stigma of alcoholism, and one may drink, not because it is safe or acceptable, but because one can then rationalize that it is. He increasingly centers his attention on alcohol and dedicates his whole thinking to explaining, justifying, and protecting his drinking and attempting to compensate for the catastrophic problems in his life that result from drinking.

Denial of illness in this situation is different from anosognosia, denial of illness based on neurological defect, and different from psychotic delusion, though it borders on this extreme. Delusion is a positive created belief substituted for reality. In alcoholism denial is more like a rejection of reality or clinging to an old, wished-for reality than a creation of alternative reality.

Clinical Examples

Here is a case of a man who had never had treatment and had no hope. Jimmy R. was an elderly man, terrified, lonely, terribly sad, and full of self-hatred. "I'm nothing but a bum." But he made a valiant effort to pretend that he had no alcohol problem. He blamed the beginning of his problems on his service hospitalizations and the resulting bills. He did admit to memory

problems, but they were “from working with carbon tetrachloride in World War II.” He vomited in the morning, but that was “from nerves,” which also rationalized his having to have a drink in the morning. He got rolled on the street, but that was “because kids have changed today.” He was “anemic” but not alcoholic.

His life today is very sad. Scarcely anyone cares about him. He feels hopeless about getting any help from anyone. He believes that he is dying, having “lived three score years and ten,” and is extremely isolated. He has health problems but “not a booze problem.”

This man has a dual system, with excruciating reality acknowledged on one track and simultaneously denied on the other. He refuses to, or is unable to, bear the horror of his life, so he uses denial extravagantly in the face of obviously contradicting reality. It would seem that his denial of his alcoholism, while admitting all these other tragedies, is used here to protect the last tenuous shred of his self-respect, and that in this man denial is part of a primitive desperate scramble to protect himself against desolation and despair of towering proportions. Denial of his alcoholism may also serve to protect his drinking, but it had the feeling of a pathetic and ineffective attempt to preserve his last shred of dignity as a human being. He might be a bum, but he was not an alcoholic.

As a general formula, this holds: the greater the pain and the less the hope, the more rigid the denial, and thus, as Moore and Murphy (1961) point out, the less likelihood there is of successful treatment. This patient used massive astonishing denial to try to protect against despair, but without success. When denial is so dysfunctional, it must be regarded as almost psychotic.

Adjunctive Defenses

Denial is only effective temporarily. Work must constantly be expended to sustain it in the face of contradicting reality. The alcoholic fights to keep his distortions separated from realistic perception.

The methods include avoidance, delaying, minimization, projection, and rationalization. In avoidance, the person removes himself from situations where he will be confronted, or diverts attention or changes the subject. In delaying, the alcoholic denies facts despite knowing that information to prove him wrong is close at hand. A temporary stalling tactic, it is not based on long-term hope of convincing anyone to the contrary, but avoids for the present moment some painful realization or admission. In minimization, the person cannot stand to tell the whole of what he is doing, but is able to hint or tell part. Projection and rationalization externalize responsibility or make the drinking seem plausible.

Suppose the person has been denying his drinking to his child, who then says, “But I saw you.” Defensively the parent has several options. He can continue to use denial, matching his story against the child’s by saying “No, you didn't, I wasn’t drinking.” Or he can take one step backward, acknowledging the reality of the child’s perception but defining himself as innocent of the action, since it was caused by evil outside himself. “Well, what do you expect with a bunch of stupid yelling kids? That’s the only way I can ever get any peace around here.” This is a case of a shift to projection, externalizing responsibility for the *motivation* while acknowledging the *act*.

Or he can acknowledge the reality of the action, and not blame others for it, but redefine the action as harmless, or himself as not alcoholic. “Yes, but it was only a short one, and one little drink never hurt anyone. Besides, I can control it.” In this case he has chosen denial, rationalization, and minimization.

The literature of Alcoholics Anonymous abounds with clinical examples and ways to relinquish these defenses. Anyone interested need only look in the index of “*As Bill Sees It*, published by A.A. (Alcoholics Anonymous, 1967), under “rationalization,” “honesty,” and “alibis” for examples. For instance:

> The perverse wish to hide a bad motive underneath a good one permeates human affairs from top to bottom. This subtle and elusive kind of self-righteousness can underlie the smallest act or thought. Learning daily to spot, admit, and correct these flaws is the essence of character-building

> and good living. [Alcoholics Anonymous, 1967. p. 17]

And there are pamphlets such as *Alcoholism: A Merry-Go-Round Named Denial* (Kellerman, 1969) and *Dealing with Denial* (Hazelden Foundation, 1975).

All of these subordinate techniques in the alcoholic are usually directed toward the same two major goals as the use of denial: justification of continued drinking, and restoration of self-esteem in the face of the destructive consequences of drinking.

Organic Factors in the Psychology of Alcoholism

> It is faulty in principle to try to make a distinction between so called organic and functional diseases as far as symptomatology and therapy are concerned. (Goldstein, 1952, p. 245)

To be drunk is to suffer impairment of the central nervous system, which gradually is reversed as the hangover wears off. Staying drunk, or getting drunk repeatedly, may eventually produce permanent damage to the brain. A model of neurological dysfunction cannot be applied without modification to explain the findings in alcoholism, both because the brain injury in alcoholism is characteristic and different from other forms of injury and because it coexists with numerous other factors which make the clinical picture more complex. But the literature on brain damage, most importantly

Kurt Goldstein's classic paper (Goldstein, 1952), is useful in explaining the alcoholic's psychological experience, responses, defenses, and restitutive efforts.

Post-Detoxification Dementia

The active alcoholic repeatedly enters an intoxicated state with alteration of consciousness, to the point of stupor or coma, disturbed sensorium and affect, and impaired memory, both in the form of "blackouts," periods during drinking when the person was able to function but for which he or she has either partial memory or none at all, and in the form of recent memory difficulties persisting after the intoxicated episode.

In addition to acute intoxication and post-detoxification delirium (d.t.'s) there is a separate and clinically important disorder—postdetoxification dementia.

> For a few days to weeks after their last drink patients who had been drinking heavily will exhibit a mild dementia or "wet brain." This condition can be distinguished from the memory defect of Korsakoff's psychosis because in mild dementia the memory and orientation defects are relieved by offering the patient clues. [Vaillant, 1978. p. 574]

This state may be chronic and mild but it is very important, since it reduces the individual's ego competence, self-protectiveness, and ability to respond to treatment.

The handling of affect is markedly changed. There may be loss of affective regulation, with intense waves of feeling often disconnected from external causes, fleeting and labile. Extremes of feeling follow each other unpredictably.

Clinical findings of mood lability, irritability, and dulled affective reactivity may be explained by damage to areas around the ventricular systems at the base of the brain, where drugs producing dependence, including alcohol, tend to accumulate preferentially (Rankin, 1975).

Several other types of affective disturbance are seen in alcoholism. The affective changes of withdrawal are regular and characteristic. The person is in an agony of physical sickness, ashamed, guilty, remorseful, fearful, and depressed. In addition to the physical component there is usually a reactive depression. Even if the alcoholic represses and denies the discovery that his life is out of control, some awareness of this breaks through, causing depression. And the frequent coexistence of affective disorder and alcoholism suggests that some depressed alcoholics may have major affective illness in addition to alcoholism.

Even more striking than the impact on affect is the change in the operation of the personality. This is not universal. It may be mild, and may only be clear-cut in advanced alcoholism. What is seen is a deterioration in

the highest capacities of human functioning. Judgment, planning, abstract reasoning, and ethical concerns are all impaired. Memory is usually affected in special and separate ways. Use of language becomes more concrete and rudimentary. Emotional preoccupations show the intense self-absorption of the very small child, or the senile person. The personality regresses to an infantile id-dominated level of functioning with pronounced impulsivity and use of primitive defenses such as denial and projection. During drinking the person is overwhelmed and preoccupied with inner experience. Ego functioning is primitive and ineffectual. The person looks, feels, and acts helpless. The superego also regresses to a primitive punitive archaic mode. The person experiences intense guilt and simultaneous loss of effective impulse control.

Research on neuropsychiatric measures of subclinical brain damage in alcoholics shows two major findings. Alcoholics lose the abstract attitude, and complex perceptual-motor abilities are impaired (Kleinknecht & Goldstein, 1972; Rankin, 1975). “There is considerable electroencephalographic and pneumoencephalographic evidence of prolonged brain impairment and damage in alcoholics” (Parsons & Freund, 1973). “Perhaps individuals with a strong susceptibility to blackouts may have a subclinical, very mild form of Korsakoff syndrome which may or may not progress with further drinking and time” (Goodwin et al. in Edwards et al., 1977, p. 109).

Premature Aging

The physical findings resemble premature aging (Illis, 1973). Alcohol can produce brain cell death or injury such as accumulation of "wear and tear" pigment and vascular lesions (Roizin et al., 1972). Cerebral atrophy in alcoholics has been demonstrated by pneumoencephalography and computerized axial tomography (Brewer & Perrett, 1971; Roizin et al., 1972; Tumarkin et al., 1955). During active drinking, delta wave sleep is decreased, as it is in older persons, a finding considered to represent diffuse cortical damage (Smith et al., 1971). Fronto-limbic and nondominant hemispheric functions may be impaired (Edwards et al., 1977; Parsons, 1975).

Extreme events, such as frontal lobe atrophy and Korsakoff's syndrome, though infrequent, may occur in deteriorated alcoholics. Such damage is permanent. Though there is controversy about these findings, some of the damage caused by alcohol may be reversible after substantial sobriety (Plum & Posner, 1966; Adamson & Burdick, 1973; Rankin, 1975; Kapur & Butters, 1977; Albert et al., 1979).

Nutritional deficiencies (Victor et al., 1971), hepatic dysfunction, and sleep deprivation, especially of REM sleep (Freedman et al., 1975) are complications of alcoholism which affect the brain. Nor can one ignore remoter physical complications, such as concussions, broken bones, and other results of alcohol-induced falls and accidents (as with the woman described

on page 58).

While these conditions are likely to be marked and severe in chronic deteriorated alcoholics, it is important not to neglect their effect in early alcoholics. It may be difficult for a person without alcoholism to grasp that this disordered state with disturbed consciousness, arousal, affect, memory, confusion, irrationality, and helplessness is a repeated prolonged experience in the drinking alcoholic. Some form of it, attenuated or severe, may totally dominate his conscious experience.

What is the meaning of this for alcoholics? The alcoholic's experience is equivalent to what it would be like for healthy people to have partial general anesthesia to the point of stupor regularly several times a week, and be expected to function normally, for example go to work, drive, and so on, a few hours afterward. This explains some of the abnormalities in the mental status of the active alcoholic, even when briefly sober. The repeated failures at work and in social situations are likely to produce humiliation and anxiety, and it is characteristic of the alcoholic, as of the patient with brain damage, to produce defensive thinking and behavior.

In the early stage alcoholics, like other patients with depressed cortical functioning, may not be aware of loss of function, but instead experience mood swings, a sense of inadequacy, and a sense of increased effort required

for work. They may complain that too much is expected of them and feel overwhelmed. They may lose interest in cultural, intellectual, and aesthetic matters and show coarsening of interpersonal relations, outbursts of anxiety, anger, and excessive need to be reassured and cared for (Gardner, 1975; Redlich & Freedman, 1966).

At a more advanced stage, failure to complete a task evokes excuses or alibis, a refusal to see failure. The person avoids challenging situations. Further deterioration produces more obvious inefficiency and failure, and more excessive emotional compensatory devices.

Both alcoholics and brain-damaged people show clinically not only the organic deficit but the person's feelings in response to the deficit (anxiety, distress, frustration, and regression) and efforts to adapt to the situation such as social withdrawal, and use of rationalization and denial (Goldstein, 1952).

Alcoholism has physical and neurological components. It makes people sick, helpless, and out of control. The prognosis is generally thought to be poor. It is terrifying. The person's response to it shares much with the response to dreaded physical disease.

Many writers have pointed to the use of denial of illness by patients with serious illness, impending death, and brain damage (Becker, 1973; Dudley et al., 1969; Fulton & Bailey. 1969; Flackett & Weisman. 1969; Kubler-

Ross. 1969; Weisman. 1972).

Weinstein and Kahn (1953) point out that denial is used more in stroke than in cancer or heart patients, whose sense of self and adequacy is less at stake than in stroke victims, and suggest that this may be related to the inability to think, use language, and control feelings, which can be as devastating even as bodily pain, limitation of function, and fear of death. This would apply in alcoholism.

Levine & Zigler (1975) extend this idea that denial is related to the psychological impact of the disability or illness. They noted that the greater the threat to the self, the greater the refusal to come to terms with the illness. They examined denial that there was any difference in the real and ideal self before and after illness, and suggested that patients could choose one of two paths in this dilemma. They could use successful denial, inflating the real image back up to match the ideal, or they could lower their aspirations for themselves as stroke victims often seemed to do. Alcoholics tend to use both of these mechanisms. The first is denial that anything is the matter. The second is noted in A.A. in the phenomenon of "settling for less," or lowering expectations or aspirations.

The brain-damaged person, who is prevented from grasping his plight because of his impaired capacity to abstract, or disordered perception of his

defect, is faced only with the situation of frustration and distress when he cannot perform an expected task. Other persons with defects such as stroke, or expressive aphasia, or drunkenness in alcoholism, are faced not only with the experiences of their impaired functioning but also with its meaning for them: that they are impaired or diminished persons. They are faced with the problem of restoration of their profoundly threatened psychological integrity and self-esteem.

Physical Dependence

Addiction is the final common path which results from repeated high doses of alcohol, taken for whatever reason. The neurons acclimate to the presence of alcohol, and when it is removed, the acclimated neurons rebound to overactivity. This appears clinically as withdrawal. While drinking no longer makes the alcoholic feel good, stopping makes him sick.

Psychological dependence on alcohol increases with physiological dependence, or frank addiction. With advanced alcoholics, the clinical picture increasingly shifts toward withdrawal symptoms as producing the wish to drink; the importance of drug effect as a pharmacological defense becomes less, as does the symbolic psychodynamic meaning of the agent or the act of using it.

The alcoholic reports that he is depressed and drinks in response to

this. The psychic state results from physical withdrawal and perhaps a reactive depression. Drinking does relieve the distress, but this feeling and his action bear little relation to psychological factors leading to drinking.

Episodes of drunkenness before and after development of addiction appear confusingly similar. Both the heavy drinker and the addicted one say they are tense or depressed before they drink. The fact that a profound and dramatic change in regulation or control of drinking has occurred is obscured by its subtle and gradual development, by the fact that the drinker still experiences his behavior as psychologically controlled, and by his denial. The change is not appreciated because the shift is never formally announced. Failure to grasp this central point about the regulation of drinking in alcoholism has led to all manner of mismanagement and misunderstanding of the alcoholic.

A Clinical Example

Most of the patients described in this chapter have been middle-aged or elderly people, poorly able to envision a future without alcohol— depressed, guilty, and afraid. “Mental health is not dull” (Vaillant, 1977), though mental illness and alcoholism, which has succeeded syphilis as the great mimic of emotional disorder in every form, have been absurdly romanticized. Though the patient in the following story led a life of B-movie intensity, she never for

a moment was able to escape her own unhappiness and sense of futility, her feeling that nothing added up. Given her youth, her intelligence, and her extravagant good looks, given that she should have felt equipped in every way to enjoy life, we at first suspected that some emotional disorder, probably borderline personality organization, must account for her long self-destructive history.

Marcia S., aged twenty two, came to the hospital after a moderately serious overdose of pills which she took at the height of a fracas with her boyfriend, with whom she had had a long, stormy, mutually torturing relationship.

There was no history of alcohol abuse, though the patient did acknowledge social drinking and heavy recreational use of drugs. She was coherent and oriented in mental status with no evidence of thought disorder, hallucination, or delusion. Although there was no press of speech, flight of ideas, or hyperactivity, she did complain of racing thoughts and confusion. She showed rapid, somewhat tumultuous shifts in affect from tears to guilt to self-hatred to rage to anxiety. Though she complained of difficulty sleeping, mostly restless sleep with no early morning waking, she had no appetite disorder. She was admitted to the hospital for evaluation of her depression and suicidal ideation.

Her last ten years had been tumultuous and chaotic with impulsive decision making, abusive drug use, much self-destructive behavior, dropping out of school, and a long history of psychiatric treatment of both conventional and counterculture styles.

During her evaluation, because of some discrepancies and evasions, drinking history was taken several times. She persistently denied difficulty with drinking. Suddenly she left the hospital, leaving the staff a note to inform us of her decision. A champagne bottle was found in her room.

When she turned up again, it was once more with complaints of depression due to trouble with a boyfriend. As before, she was anxious and desperate, complaining of trouble marshaling her thoughts, and denying difficulty with drinking. Her drinking histories varied with different questions, and she began to acknowledge that she was drinking heavily. She still considered her symptoms to be psychological in origin. She was contemptuous and repelled by the idea that she had a drinking problem. She was too young, vividly good looking, and streetwise to have alcoholism.

I told her that we could talk weekly regardless of the cause of her troubles, but that we could not be sure of the cause unless she could stay sober for a while. It seemed likely, I thought, that alcohol might be causing some of her pain: alcohol alone could do this to people. If that was the case, stopping drinking would make her feel better, besides strengthening her to cope with any other problems. If there was no change, she could drink again. After six weeks of explanations about alcohol, she made several attempts to get sober. To her panic and astonishment she could not. She was addicted and had withdrawal. With considerable urging and support she signed into an alcoholism treatment facility. She stayed five days, euphoric about how much better she felt physically. She now had the answer, needed no more treatment. She remained sober for a couple of months “on her own.” She felt so much better, she couldn’t believe it had been as bad as all that, and she was convinced that she could control it. So she began drinking again.

Shortly after she started, she appeared for an appointment, angry and reproachful, saying “You've spoiled my drinking,” but it took several more attempts to stop on her own before she was willing to return to the treatment center. This time she was slightly depressed, sad about not being able to drink but too committed, too hopeful, to need to resurrect her denial. She became actively involved in several aspects of the rehabilitation program and A.A., quit her job in a liquor store, and made some sober friends. She did not return to see me for several months.

When she came, there was no more confusion, poor judgment, lability, anxiety, or sleep failure. She was still dramatic and charming and vulnerable to depression. She was furious to

have alcoholism, embarrassed, and reluctant to engineer a total revision of her former jazzy lifestyle. She was living in a stable situation, had friends, a carpentry workshop, a garden, and a boyfriend who was a sober alcoholic. She was generally "pretty comfortable with myself for the first time in ten years." This time she could clearly see that when she drank she became depressed, impulsive, confused, regressed, helpless, and prone to desperate clinging relationships. When she stopped, her mood lifted and her controls improved; when she drank again her impulsivity and depression returned. She repeated this cycle several more times before she finally stayed stably sober.

In A. A. she found people who could help her make sense out of her chaotic experience. She described her blackouts to them, and they recognized and explained them to her. Alcoholics often think they are losing their minds and seek psychiatric help, and she found that more than half the A.A. members in the group she joined had seen at least one psychiatrist, often several, who missed the diagnosis of alcoholism. One of her psychiatrists had diagnosed her blackouts as hysterical amnesia. Another had called the tremulousness and insomnia of withdrawal anxiety neurosis. Another had noted her impulsive self-destructive behavior while she was drinking and concluded that she was character-disordered. Her other four psychiatrists added borderline personality organization, major affective disorder, depressed, with hypomania, and adjustment reaction of adolescence. None diagnosed her alcoholism. These were not poorly trained psychiatrists. Most had teaching appointments at prestigious medical schools. They were not incompetent or negligent. The diagnosis of alcoholism is often elusive and difficult to make.

Ten years, seven psychiatrists, several other therapists, six diagnoses: she had been in psychiatric treatment for half of her life and no one made the diagnosis of her most life-threatening difficulty. No wonder she was skeptical when I recommended further therapy after she had established sobriety and begun healing safely from the turmoil of repeated drunkenness. That she had alcoholism does not exclude the possibility of coexisting emotional disturbance. The most dangerous disorder should be addressed first, and when the patient has been abstinent for some time, psychiatric status can more easily be assessed.

This patient's denial obscured the diagnosis. So did my reluctance to accept her having addictive alcoholism barely out of her teens. It was easy to interpret her symptoms as psychological, but in fact she was, in terms of her age, surroundings, and general personality functioning, a typical alcoholic. Her denial system, in its obduracy and ingenuity, was characteristic of the addictive phase of alcoholism, a natural and predictable set of defenses.

If this girl had continued to drink much longer, her awareness of loss of control would probably have become less accessible; as it was, her denial struck me as to some extent conscious. Even in more deteriorated alcoholics, the "self" is always present, however submerged. Whether she would not or could not acknowledge her condition, she felt as helpless at realizing she was out of control as if she were paralyzed or incontinent, humiliated and shocked, demoralized and disorganized. Alcoholism threatens the sufferer's core sense of physical integrity and mastery.

With this patient, denial served principally to protect her self-esteem. Her reaction to the diagnosis of alcoholism had more of shock and injured vanity, I think, than fear. Since she didn't "know" that she couldn't live without alcohol, she did not dread the thought of sobriety, and the diagnosis was more of an insult than a threat. She did not foresee the miseries of withdrawal: the weakness, sickness, agitation, and insomnia she would feel as her depressed central nervous system rebounded, the longing for the alcohol

that had always disposed of these symptoms before, and the painful, unanesthetized guilt and humiliation that would flood her as her consciousness cleared. When she relapsed after two months, she reinvoked denial to protect her self-esteem, and extended it to protect her right to drink; but the system never became entrenched and could not prevail against her hope.

Working with Patients Who Deny Their Alcoholism

This patient is typical: with further progression, with loss of hope and damage done, denial is strengthened, varied, and extended. The alcoholic's remarkable ingenuity in protecting his drinking is well countered by A.A., whose members clearly recognize the tactics of denial, rationalization, minimization, etc., and know when to confront, empathize, or compare from their own experience.

They explain to the alcoholic that much of his subjective distress is “part of the disease” or “from drinking.” They label these painful affective states “resentments,” “the poor me’s,” “the fears,” or “the remorse.” In this way they are able to acknowledge the alcoholic’s psychological experience as real and painful, but do not allow it to distract from the task of getting sober. These feelings they see as potentially dangerous excuses for drinking.

Alcohol workers know the dangers of traversing the swamp of a

recently drinking alcoholic's psychology without beacons and guideposts. They have chosen, by and large, to select and simplify by some sensible rules what they will focus on and what they will ignore, contradict, and play down. Therefore they tend to minimize or confront rather than explore the alcoholic's moods, dynamics, and defenses. A whole massive area of the alcoholic's personality functioning must be discounted. They leave aside large areas of the alcoholic's experience as unworkable, or worse, seductively distracting attention from the fight against drinking into blind alleys of rationalization. They simply ignore some sources of affective distress, since they know from experience that much of it will abate if the alcoholic only stays away from alcohol. They succeed in using this simplified map of alcoholic psychology because they have grasped the combined physical and psychological nature of the phenomena they are grappling with.

But in so doing they reject the content of the alcoholic's experience and psychology as though it had no meaning and interest. His special griefs are not directly addressed. Little attention is paid to the use of the denial system as a defensive construction generated to protect against fear, pain, or psychological collapse. This is practical, but makes it difficult to understand the alcoholic fully, and to follow what is happening to him as his disorder develops, or during recovery.

The failure to empathize with the entire experience of the alcoholic and

respect it as having meaning may contribute to failure to *engage* the alcoholic in treatment in the first place, though it facilitates working with him once he is engaged.

Progression

Surprisingly, addiction is usually not the end of the development of alcoholism. Further processes ensue, produced by physiological dependence and acting to reinforce and sustain the drinking. Although some alcoholics progress no further and others improve, these processes in some alcoholics produce complications and the phenomenon of deterioration. This is what is known in Alcoholics Anonymous as "progression."

Deterioration

In addition to the dementia and personality impairment, alcoholism may be complicated by loss of social, legal, financial, and emotional resources. The alcoholic may lose friends, family, marriage, job. He may be arrested, lose a license or repeatedly find himself in a detoxification center or mental hospital. At a time when the alcoholic most needs the pleasures and rewards of sobriety to oppose his drinking, these are progressively demolished.

A Clinical Example

Mario P.. an elderly immigrant man with a forty-year history of drinking lived with his daughter, who protected him from the consequences of his drinking. He was rarely admitted to the hospital alcohol center, and when he was admitted, he readily acknowledged that he had alcoholism but denied that there was any reason for him to stop drinking. He was guilty and worried about his daughter's anger at his alcoholism—"She's right; I'm wrong"—but he felt drinking was not bad for him, and he saw no reason to stop. At this stage he used denial only to protect his drinking, not to deny that he had alcoholism.

Suddenly he began to appear frequently at the center. This turned out to be a result of his daughter's marriage and her move to another state. He was now evicted, living on the streets, for which he was totally unprepared and unskilled, and in serious difficulties with his health.

At this point he totally denied his alcoholism, or any difficulties from it. This apparently odd shift can be understood if denial is seen in the first instance as limited to protecting his right to drink. Later he needed to defend against physical and psychological pain and danger. While he was protected by his daughter, he was willing to acknowledge that he had alcoholism. But without her to protect and cover for him, knowing the risks he ran every day, aware that his life was in ruins, he now needed a much more global and rigid kind of denial, and of two kinds.

This patient's life, like most alcoholics', was full of deprivation, danger, and suffering. He did not complain of these things, or of the losses, resulting from his alcoholism, of all the activities and undertakings which are foundations of self- respect. In this he was not unusual. Complaints of pain and demands for relief are sparse in the clinical picture of alcoholism.

Perhaps this patient was "settling for less," as A. A. puts it. Believing he has brought his pain upon himself and deserves to be punished, the alcoholic acquiesces in his deprivation. Denial, then, does not extend to cover his sense of guilt.

There may be something comparable in Goldstein's (1952) observations

of advanced deterioration in brain-damaged patients. Faced with a task they cannot fulfill, they become dazed, agitated, fumbling, unfriendly, evasive, or aggressive—in Goldstein's interpretation, this is a response to inner experience, not a fear of outside danger. To get rid of their anxiety, such patients withdraw to diminish exposure to threatening situations, and stay alone, liking the familiar, obsessively orderly, upset by any change (just as this patient lived unobtrusively with his daughter).

Deterioration produces more excessive emotional compensatory devices. Goldstein mentioned frequent paranoia and megalomania. These "total" compensations bring to mind the total denial of another patient.

Enoch T., a middle-aged man who had been unable to complete first grade, was brought by the police to the detoxification center. He said they had picked him up after he had drunk "one or two beers," and that they picked on him because he was a "retard." He told us he worked regularly in a sheltered workshop, and showed us how he carefully carried out the trash and lined up the chairs in the cafeteria. He liked to put them all in a row; when he took too long, they yelled at him. A lot of people picked on him. He occasionally drank one or two beers but "never hard stuff. It makes you crazy like them in there [pointing to the ward|. They say they drink and can't stop."

Perhaps because "them in there" were tremulous, sick, and helpless and we were reluctant to place this earnest innocent among them, and surely because of our own wish to believe that he had only one tragic problem instead of two, we made a diagnosis of intellectual retardation and failed to make one of alcoholism. He sat quietly in a comer, knees pressed together, leafing through a picture magazine, until we could reach his family. They informed us that he had been a chronic unemployed street alcoholic for thirty years, in addition to being retarded, and that when

he drank he often fought with policemen. When we asked him about this, he grinned slyly and said he guessed his family might be wrong.

This patient's total disavowal of his miserable circumstances need not be attributed to his retardation. I have seen blanket denial of equal extent among addicted alcoholics of average and above-average intelligence. It is understandable as a response to alcoholism as a catastrophic experience—terrible losses, deprivations, the sense of being at hazard, shame and the certainty one can never atone, the ruin of self-esteem, the utter loss of hope. The alcoholic's circumstances are now wholly traumatic, and he must make a desperate effort to create a psychology for emotional survival. Denial under these conditions is a primitive defense invoked to stave off psychological collapse.

Whatever the patient's original psychopathology, most alcoholics use these psychological mechanisms. If the disease progresses, patients with diverse character styles become more and more alike. Most advanced alcoholics come to resemble each other, and demonstrate what is called “the alcoholic personality.”

Treatment

Because denial protects against unbearable pain, no one using it will give it up without a struggle, and without being offered something to take its

place. Expecting it to disappear on request is like expecting a psychotic to stop hearing voices when one informs him that they are not real.

If a person is to be expected to relinquish his denial, or some of it, and become accessible to treatment, several things must happen.

Denial will give way when the pain increases so massively that the defense breaks down and pain and depression rush in. It is not coincidental that so many alcoholics get sober at a time of despair, losing a spouse or a job for example. This is called “hitting bottom.” The internal shift that takes place when denial gives way is called in A.A. a spiritual awakening.

Alternatively a person may give denial up if the pain against which it protects decreases, or he can find another way to cope with and tolerate the pain. Something must be offered to decrease the pain, such as hope. The crucial transactions which launch an alcoholic toward sobriety include an intervention in, and revision of, the denial system and an attack on despair, which allows the alcoholic to begin to relinquish some of his denial.

The therapeutic approach in all these cases emphasizes the modification of the denial system, by two techniques. It is most effective to empathize with the pain that generated the defense, and to relieve the pain by acknowledging it, offering help, instilling hope, and contradicting despair. When the pain decreases, the defense mechanism can be abandoned. In addition, denial of

the dangers of drinking must be confronted, and the patient's need for safety stressed.

Getting sober means facing the full impact of one's pain while renouncing the central means to cope one has learned to use. One interrupts, moreover, a whole way of life, a complete set of well-learned habits that include a way of perceiving, thinking, and feeling. One frustrates intense craving and rejects what may have been the prime mover of one's existence.

Some alcoholics will go hungry and expose themselves to extreme danger in order to drink. To stop is, for them, a loss comparable to never eating again, and a violation of the only form of self-preservation they know. Such alcoholics are unable to imagine what life would be like without alcohol, profoundly dependent on the knowledge that alcohol is accessible, and terrified of its loss.

Treatment of alcoholism hurts. One can only applaud the courage of those alcoholics who recover on their own, untreated, and of those who come voluntarily for help—and then use it. Most alcoholics who come to treatment facilities are coerced there, or at least persuaded, and most come with a negative attitude. Addicted drinkers cannot comprehend the idea that by taking systematic steps it is straightforwardly possible to get free of the problem. Many have experienced their failure at controlled drinking as

inexplicable, perhaps as punishment for fundamental badness. Their repeated failures, along with neurological impairment, have made them feel helpless, engendering regression and giving up. No longer grasping the possibility of recovery, they cannot see that alcoholism is an understandable, treatable disease resulting from a complex pathological process.

Once detoxification is past, the mood of the newly sober alcoholic will depend on many factors. He may be elated by the relief from the chemical and reactive depression, by recovery of self-esteem from being able to stop, and by relief from the climate of terror which resulted from his repeated experience of loss of control. But he may also have a major depression in reaction to the loss of the alcohol, just as some obese people become depressed when beginning a diet, or in reaction to confronting the reality of the consequences of his drinking, staring back into the ruin of his life, sometimes for the first time. No one could be expected easily to face the difficulties left by many years of drinking, so he will still need defenses such as denial to help him with the pain at least until such time as he has built a more mature structure of sheltering defenses in his new life. He will relinquish his defenses slowly as he works through and integrates his losses and reestablishes self-esteem. He may continue to need denial to help him with stigma, shame, and humiliation from his new conscious acknowledgment of his alcohol problem. He is very likely to continue to deny his alcoholism publicly as a protection against stigma from peers and employers, often real

though sometimes exaggerated.

A.A. wisely permits this, expecting the recovering alcoholic to be able to "admit" his alcohol problem only after some work against denial, and only much later to "accept" it, that is, to have dealt with the pain entailed, to have worked through and undone enough to diminish pain, fear, and shame, and to be able to face and tolerate the feelings directly.

Relapse

The use of denial in relation to the relapse is an intriguing phenomenon. When the person has been sober but is moving toward a relapse, he is faced with a difficult psychological problem. From whatever sources, possibly biological, possibly social, possibly from reasons described by learning and conditioning theory, or as a symptom, the impulse to drink is upon him (Bandura, 1969). It drives and pressures him. Perhaps he has maintained his sobriety out of a fantasy that good behavior would bring some special rewards, which he now recognizes, with disappointment and anger, are not forthcoming. Perhaps he is depressed or in other distress of the same nature as generated his early symptomatic use of alcohol. Perhaps he is longing and wishing to be a normal person, who is allowed the pleasures of moderate drinking, while he hates the idea that he is an outsider, excluded. Perhaps he is disappointed and angry with the people who have been helping him with

his controls. He is so sensitive, and they are, after all, only human. When his feelings are hurt, he turns away from them and yearns to drink. Most often, movement toward relapse is unconsciously motivated, and the reasons the person gives are rationalizations.

The difficulty that faces him is that the impulse that besets him is forbidden. He knows he must not drink. Old-fashioned conflict theory may help us understand what happens.

He visualizes the idea of drinking in his mind. It is deeply seductive, for he knows that it will relieve his sickness, and, at the same time, it is forbidden. He experiences a choice between deprivation, which is equated with behaving well, and relief, or gratification, which is equated with being bad, or doing the forbidden. As in neurotic conflict the impulse, because it is forbidden, is to some extent kept out of awareness by repression and denial, while the prohibitions are more often conscious. He begins a struggle with his superego, ego ideal, ego, inner controls, self-respect, and self-preservation, all of which oppose his drinking, on the one hand, and the drive to drink, on the other. One must remember that he is regressed, mildly confused, and in despair, so these personality agencies are not functioning very well. This is where the denial system is called into operation. He will not be able to obey the drive to drink until he can quell the forces of mature personality functioning. So he must erect a whole castle of protections and supports

around the idea of drinking. This is an example of denial as an agent of wish fulfillment.

Usually the first line of defense in this dilemma is to repress and deny the impulse, intensify reaction formation, and invoke added controls such as increased attendance at A. A. meetings. If these efforts are successful, the impulse will remain in check and the person will remain sober. Every recovering alcoholic has variations on this struggle thousands of times in his establishment of sobriety. If he loses one struggle once, he is likely to relapse.

Although the impulse is under cover and in check, it may continue to press for release and expression in action. The energy driving toward the expression of the impulse will align itself with every element of the personality or psychology which comes to hand to use as a weapon against the controls and prohibitions that block it. What happens is that the denial system used before to protect drinking is resuscitated to permit it again. In order for drinking to be permitted, the ego and superego forces against it must be met and mastered. In order to permit drinking, which is dangerous, the signal anxiety alerting the ego must be put aside. Superego prohibitions must be silenced, and the danger of failure to meet the ego ideal, with resulting loss of self-esteem and depression, must be prevented. All these ends are achieved by regeneration of the denial system. If the person denies that he is alcoholic, that there is a disorder in his ability to use alcohol

moderately, the ego alert system saying that drinking is dangerous will be baffled by the negation "I can drink safely," the superego will be silenced, since social drinking is permitted and only alcoholics are prohibited from drinking, and self-esteem will be safe, since the ego ideal allows social drinking. The final technique permitting the alcoholic to pick up a drink is disavowal of the impulse by projecting blame for it around himself, onto what A.A. lumps together as "people, places, and things."

In A.A. this phenomenon, called "budding" (building up to a drink) or "stinking thinking," is well known, and there are clear safeguards against it, usually in the form of increased controls, including association with people who will recognize the purpose of the perversion of the defense system to allow drinking and who will confront the denial and rationalizations and empathize with the feelings.

Once the denial system has permitted the discharge of the impulse into action, a relapse usually occurs. Then denial will need to be retained as a facilitator of drinking while the alcoholism reestablishes itself, then as a protector of the drinking, and again to protect against all the kinds of pain produced by the alcoholism, as a defense against despair, shame, fear, pain, and loss.

When the person gets sober again, denial ebbs away, as it did when

sobriety was first established, possibly faster because of learning from previous sobriety, because it is no longer needed. (See case on p. 84.)

To help the alcoholic out of such a complicated impasse, we have to grasp the relentlessness of the impulse to drink. It may be a long time before the recovering alcoholic can concentrate on anything else. Whatever its sources—and it helps to remember how various they can be—the drive does not rest. Like hunger or thirst it may abate, but eventually reasserts itself. No one, probably, can understand it who has not felt it. This is one great strength of A.A., that all its members have been there too. The craving for alcohol is comparable in intensity and intractability with an instinct. We can only measure it by its results.

No one claims that all recovered alcoholics can be restored to full functioning. The knowledge of time wasted must alone be a source of depression. Reparative, and then later restorative, efforts can be made at undoing the damage done, as in A.A.'s twelfth step, in which the recovered alcoholic actively helps to retrieve and reeducate other sufferers.

Whether or not the original personality predisposed him to drinking, the recovered alcoholic is not the person he was. He may be a better one, but in any case his experiences have affected him. He may need help with staying sober, and he will need help with integrating his experience.

Clinicians may choose not to work intensively with people with alcoholism, but must encounter alcoholics in their work. They should be able to make the diagnosis, confront the alcoholic, and refer the patient for treatment with some comfort, tact, and respect. The alcoholic's experience is so alien to the ordinary person that people often belittle it. not realizing that it is overwhelming to the sufferer.

The development of physiological dependence is imperceptible to the alcoholic, and often to the clinician; both of them are likely to see the excessive drinking as psychologically driven. Both physical and psychological pressures to drink may be present at once. When the person drinks heavily but not alcoholically, he may need clarification, controls, and sanctions, or treatment for the underlying psychological or social problem. When he is alcoholic, he needs an external intervention, medical treatment, often structure, support, and help with controls, and then reeducation, help with reintegrating his life and relearning, and psychological work to repair the damage done by the alcoholism.

When the phase of alcoholism is not correctly identified, the temporary balance between physical and psychological factors is easily misassessed, and the constantly metamorphosing denial system may be approached from the wrong side. Different modes of treatment have more to offer at different phases. While the clinician's first object is to get the patient sober and keep

him that way until the chemical is no longer active in his system, the patient may need still further support before he is able to transcend and master his problem.

It is not enough to breach the denial system. Unless its workings and its time course are understood, intervention may be futile. This time course is contrapuntal to the phases of alcoholism and recovery. One cannot overstate the value of the denial system to the alcoholic, or the protean and yet tenacious obstacle it presents to the clinician. It provokes the frustration and contempt of many caregivers; it does much to explain the confusion and ambivalence of political bodies asked to support alcoholism treatment programs. Worst of all, it invites the despairing collusion of too many families, employers, and therapists.

Unless the denial system is successfully breached, and the physical impact of alcoholism understood, efforts to intervene with the alcoholic will repeatedly founder. In addition, work with alcoholics will be unpleasant and bewildering, dominated by magical thinking and hunches and wishes. Helpers will resort to scare tactics, coercion, indulgence, beseeching, and avoidance. It will be impossible to devise a clear program for the patient's recovery, and the result will be needless relapses and pain, frustration, inefficiency, and almost inevitable treatment failure.

Alcoholics are commonly thought to be the most unrewarding of all patients. I have not found them so. Increasing awareness that alcoholics can recover has been an encouragement. Despair blocks recovery, but recovery is possible, with hope and skill.

Conclusion

The goal of this chapter has been to describe the subjective world of the alcoholic in tandem with his clinical presentation and the psychological functions of denial during progression, recovery, and relapse. Perhaps such concepts will make it easier to develop treatment approaches elegantly fitted to the needs of the individual alcoholic, his stage of development, the nature of his restitutive denial, and its modifications by previous treatment.

References

Ablon, J. Family structure and behavior in alcoholism: A review of the literature. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 4. *Social aspects of alcoholism*. New York: Plenum, 1976.

Abraham, K. The psychological relation between sexuality and alcoholism. In Se*lected papers on psychoanalysis*. New York: Basic Books, 1960. (Originally published, 1908.)

Adamson, J. A.. & Burdick, J. A. Sleep of dry alcoholics. *Archives of General Psychiatry*. 1973.28. 146-169.

Albert, M. S., Butters. N., & Levin, J. Temporal gradient in the retrograde amnesia of patients with alcoholic Korsakoff's disease. *Archives of Neurology*. 1979, 36. 211-216.

Alcoholics Anonymous. *Alcoholics Anonymous*. New York: Alcoholics Anonymous World Services, 1939 (1st ed.), 1976 (3rd ed.), & 1978 (4th ed.).

Alcoholics Anonymous. *As Bill sees it: The A.A. way of life*. New York: Alcoholics Anonymous World Services, 1967.

Alcoholics Anonymous. *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services, 1955 and 1977.

Allman, L. R., Taylor, H. A., & Nathan P. E. Group drinking during stress: Effects on drinking behavior, affect and psychopathology. *American Journal of Psychiatry*, 1972, 129. 669-678.

Armor, D. J., Polich, J. M., & Stambul H. B. *Alcoholism and treatment*. Santa Monica. Calif.: Rand Corporation, 1976.

Armotang, J. D. The search for the alcoholic personality. *Annals of the American Academy of Political and Social Science*, 1958, 315, 40-47.

Bacon, S. D. The process of addiction to alcohol. *Quarterly Journal of Studies on Alcohol*, 1973, 34, 1-27.

Baekeland, F. Evaluation of treatment methods in chronic alcoholism. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 5. *Treatment and rehabilitation of the chronic alcoholic*. New York: Plenum Press, 1977.

Bailey, M. B., & Leach, B. *Alcoholics Anonymous: Pathways to recovery—a study of 1058 members of the A. A. fellowship in New York City*. New York: National Council on Alcoholism. 1965.

Bales, R. F. Cultural differences in rates of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1945, 6, 480-499.

Bales, R. F. The "fixation factor" in alcohol addiction: An hypothesis derived from a comparative study of Irish and Jewish social norms. Unpublished doctoral dissertation. Cambridge, Mass.: Harvard University, 1944a.

Bales, R. F. The therapeutic role of Alcoholics Anonymous as seen by a sociologist. *Quarterly Journal of Studies on Alcohol*, 1944b, 5, 267-278.

Balint, M. *The basic fault*. London: Tavistock Publications, 1968.

Bandura, A. Social learning and moral judgments. *Journal of Personality and Social Psychology*. 1969. 11, 275-279.

Barry. H. B., III. Psychological factors in alcoholism. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 3. *Clinical pathology*. New York: Plenum Press, 1974.

Basch. M. The concept of affect: A reexamination. *Journal of the American Psychoanalytic Association*, 1976, 24, 759-777.

Bateson, G. The cybernetics of "self": A theory of alcoholism. In *Steps to an ecology of mind.* New York: Ballantine Books, 1972, pp. 309-337.

Bean, M. H. Alcoholics Anonymous: A.A. *Psychiatric Annals*, 1975, 5, 3-64.

Bean, M. H. Denial and the psychological complications of alcoholism. This volume.

Becker. E. *The denial of death*. New York: Free Press, 1973.

Behar, D., & Winokur, G. Research in alcoholism and depression: A two-way street under construction. In R. W. Pickens & L. H. Heston (Eds.), *Psychiatric factors in drug abuse.* New York: Grune & Stratton, 1979.

Blane. H. T. *The personality of the alcoholic: Guises of dependency*. New York: Harper & Row, 1968.

Blane, H. T., Overton, W. F., & Chafetz, M. Z. Social factors in the diagnosis of alcoholism. *Quarterly J. of Studies on Alcohol*. 1963, 24. 640.

Bliding. A. Efficacy of anti-anxiety drug therapy in alcoholic post-intoxication symptoms: A double-blind study of chlorpromazine, oxazepam and placebo. *British Journal of Psychiatry*. 1973, 122. 465-468.

Blum, E. M. Psychoanalytic views of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1966, 27, 259-299.

Blum, E. M., & Blum, R. H. *Alcoholism*. San Francisco: Jossey-Bass, 1967.

Brenner, C. On the nature and development of affects: A unified theory. *Psychoanalytic Quarterly*, 1974, 43, 532-556.

Brewer, C., & Perrett, L. Brain damage due to alcohol consumption: An air encephalographic, psychometric, and electroencephalographic study. *British Journal of Addictions*, 1971,66, 170-182.

Brill, A. A. Alcohol and the individual. *New York Medical Journal*, 1919, 109, 928-930.

Brill, N. W., & Beebe, G. W. *A follow-up study of war neurosis*. Washington. D.C.: U.S. Government Printing Office, 1955.

Burnett, G. B. Common alcohol-related disorders: Recognition and management. *South Medical Journal*, 1978, 71, 561-565.

Butler, S. "*Erewhon" and "Erewhon revisited*." New York: Modem Library, 1955. (Originally published, 1872 and 1901.)

Butterworth, A. T. Depression associated with alcohol withdrawal: Imip- ramine therapy compared with placebo. *Quarterly Journal of Studies on Alcohol*, 1971, 32, 343-348.

Cahalan, D., & Cisin, I. Drinking behavfor and drinking problems in the United States. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 4. *Social aspects of alcoholism*. New York: Plenum Press, 1976.

Cahalan, D., Cisin, I., & Crossley, H. M. *American drinking patterns: A national study of drinking behavior and attitudes*. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1969.

Cahalan, D., & Room, R. *Problem drinking among American men*. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1974.

Calder, K. Psychoanalytic knowledge of group processes: Panel report. *Journal of the American Psychoanalytic Association*, 1979, 27, 145-156.

Camps,, F. E., & Dodd, B. E. Increase of the incidence of ABH blood group substances among alcohol patients. *British Medical Journal*, 1967, 1, 30.

Canter, F. M. The future of psychotherapy with alcoholics. In *The future of psychotherapy*. Boston: Little, Brown. 1969.

Capell,, H., & Herman, C. P. Alcohol and tension reduction: A review. *Quarterly Journal of Studies on Alcohol*, 1972, 33, 33-64.

Chafetz, M., Blane, H. T., Abram. H. S., et al. Establishing treatment relations with alcoholics. *Journal of Nervous and Mental Diseases*, 1962, 134, 395-409.

Chafetz, M., & Demone, H. W., Jr. *Alcoholism and society*. New York: Oxford University Press, 1962.

Chafetz, M., & Yoerg, R. Public health treatment programs in alcoholism. In Kissin & H. Begleiter

(Eds.), *The biology of alcoholism.* Vol. 5. *The treatment and rehabilitation of the chronic alcoholic*. New York: Plenum Press, 1977.

Chalmers, D., & Wallace, J. Evaluation of patient progress. In S. Zimberg, J. Wallace, & S. B. Blume (Eds.), *Practical approaches to alcoholism psychotherapy*. New York: Plenum Press, 1978.

Coc hin, J. The pharmacology of addiction to narcotics. In G. J. Martin & B. Kisch (Eds.), *Enzymes in mental health*. Philadelphia: Lippincott, 1966.

Cruz-Coke, R. Colour blindness and cirrhosis of the liver. *Lancet*. 1964 , 2, 1064-1065.

Cummings, N. W. Turning bread into stone: A modem anti-miracle. *American Psychologist*. 1979, 34, 1119-1129.

Davies, D. L. Normal drinking in recovered alcoholic addicts. *Quarterly Journal of Studies on Alcohol*, 1962, 23, 91-104.

Dews, P. Comment on D. Robinson, The alcohologist's addiction: Some implications of having lost control over the disease concept of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1972, 33, 1045-1047.

DiCicco, L., Unterberger, H., & Mack, J. E. Confronting denial: An alcoholism intervention strategy. *Psychiatric Annals*, 1978, 8, 54-64.

Dif.senhaus, H. Current trends in treatment programming for problem drinkers and alcoholics. Unpublished paper prepared for the National Institute on Alcohol Abuse and Alcoholism, 1980.

Dudley, A., Verheg, J., Masnola, M., Martin, C., & Holmes, T. Longterm adjustment prognosis, and death in irreversible diffuse obstructive pulmonary syndrome. *Psychosomatic Medicine*, 1969, 31, 310-325.

Eddy, N. B., Halback, H., Isbel, H., & Seevers, M. H. Drug dependence: Its significance and characteristics. *Bulletin, World Health Organization*, 1965, 32, 721-733.

Edwards, G., Gross, M. M., Keller, M., Moser, J., & Room, R. (Eds.) *Alcohol-related disabilities*. Geneva: World Health Organization, 1977.

Erikson, E. H. Identity and the life cycle. [*Psychological Issues*, Monograph 1] New York: International Universities Press, 1959.

Erikson, E. H. Identity: *Youth and crisis*. New York: Norton, 1968.

Ewing, J. A., Rouse, B. A., & Pellizzari, E. D. Alcohol sensitivity and ethnic background. *American Journal of Psychiatry*, 1974, 131, 206-210.

Frankl, V. *Man's search for meaning*. New York: Pocket Books, 1959.

Freedman, A. M., Kaplan, H., & Sadock, B. J. *Comprehensive textbook of psychiatry*. (2nd ed.) Baltimore: Williams & Wilkins, 1975. Chaps. 19.3 & 23.2.

Freud, A. The ego and the mechanisms of defense. In *The writings of Anna Freud*, Vol. 2. New York: International Universities Press, 1966.

Freud, S. An autobiographical study. In *Standard edition*. Vol. 20. London: Hogarth, 1959. (Originally published, 1925.)

Freud, S. Civilization and its discontents. In *Standard edition*, Vol. 21. London: Hogarth, 1961. (Originally published, 1930.)

Freud, S. The claims of psychoanalysis to scientific interest. In *Standard edition*, Vol. 13. London: Hogarth, 1955. (Originally published, 1913.)

Freud, S. Fetishism. In *Standard edition*, Vol. 21. London: Hogarth. 1961. (Originally published, 1927.)

Freud, S. The future of an illusion. In *Standard edition*. Vol. 21. London: Hogarth, 1961. (Originally published, 1927.)

Frf.ud, S. Group psychology and the analysis of the ego. In *Standard edition*. Vol. 18. London: Hogarth, 1955. (Originally published, 1921.)

Freud, S. Inhibitions, symptoms and anxiety. In *Standard edition*, Vol. 20. London: Hogarth, 1959. (Originally published, 1926.)

Freud, S. Instincts and their vicissitudes. In *Standard edition*, Vol. 14. London: Hogarth, 1957. (Originally published, 1915.)

Freud, S. Introductory lectures on psychoanalysis. In *Standard edition*. Vol. 16. London: Hogarth. 1963. (Originally published, 1916-1917.)

Freud, S. An outline of psycho-analysis. In *Standard edition*. Vol. 23. London: Hogarth, 1964. (Originally published, 1940.)

Freud, S. Three essays on the theory of sexuality. In *Standard edition*, Vol. 7. London: Hogarth, 1955. (Originally published, 1905.)

Fulton, J., & Bailey, P. Tumors in the region of the third ventricle. *Journal of Nervous and Mental Diseases*, 1969, 69, 1-25, 145-164,261.

Gardner, H. *The shattered mind: The person after brain damage*. New York: Knopf, 1975.

Gerard, D. L., & Saenger. G. *Outpatient treatment of alcoholism*. Toronto: University of Toronto Press, 1966.

Gitlow, S. Review of G. A. Marlatt & P. E. Nathan, (Eds.), Behavioral approaches to alcoholism. *American Journal of Psychiatry*, 1979, 136, 1108-1109.

Glover, E. G. The etiology of alcoholism. *Proceedings of the Royal Society of Medicine*, 1928,21, 1351-1355.

Glover, E. G. On the etiology of drug addiction. *International Journal of Psycho-Analysis*, 1932, 13, 298-328.

Goldberg, A., et al. (Eds.) *The psychology of the self.* New York: International Universities Press, 1978.

Goldstein, D. B., & Goldstein, A. Possible role of enzyme inhibition and repression in drug

tolerance and addiction. *Biochemistry and Pharmacology*, 1961, 8, 48.

Goldstein, K. The effect of brain damage on the personality. *Psychiatry,* 1952, 15, 245-260.

Gomberg, E. S. Etiology of alcoholism. *Journal of Consulting and Clinical Psychology*, 1968, 32, 18-20.

Goodwin, D. W. Is alcoholism hereditary? *Archives of General Psychiatry*, 1971, 25, 545-549.

Goodwin, D. W., & Guze, S. B. Heredity and alcoholism. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 3. *Clinical pathology*. New York: Plenum Press, 1974.

Goodwin, D. W., Hill, S. Y., & Hopper, S. Alcoholic blackouts and Korsakoff's syndrome. In M. M. Gross (Ed.), *Alcohol intoxification and withdrawal: Experimental studies II*. New York: Plenum Press, 1975.

Goodwin, D. W., Schulsinger, F., Hermansen, L., Guze, S. B., & Winokur, G. Alcohol problems in adoptees raised apart from alcoholic biological parents. *Archives of General Psychiatry*, 1973, 28, 238-243.

Gottheil, E., Alterman, A. I., Skoloda, T. E., & Murphy, B. F. Alcoholics' patterns of controlled drinking. *American Journal of Psychiatry*, 1973, 130, 418-422.

Green, A. Conceptions of affect. *International Journal of Psycho-Analysis*, 1977, 58, 129-156.

Green, J. R. The incidence of alcoholism in patients admitted to a medical ward of a public hospital. *Medical Journal of Australia*, 1965, I, 465-466.

Greenblatt, D. J., & Shader, R. I. *Benzodiazopines in clinical practice*. New York: Raven Press, 1973.

Grunebaum, H., & Solomon, L. F. Toward a peer theory of group psychotherapy I: On the developmental significance of peers and play. *International Journal of Group Psychotherapy*, 1980, 30, 23-49.

Gustafson, J. The mirror transference in the psychoanalytic psychotherapy of alcoholism: A case report. *International Journal of Psychoanalytic Psychotherapy*, 1976, 5, 65-85.

Haberman, P. W., & Baden, M. M. Alcoholism and violent death. *Quarterly Journal of Studies on Alcohol*, 1974, 35, 221-231.

Hackett, T., & Weisman, A. Denial as a factor in patients with heart diseases and cancer. *Annals of the New York Academy of Sciences*, 1969, 164, 802- 817.

Hamm, J. E., et al. The quantitative measurement of depression and anxiety in male alcoholics. *American Journal of Psychiatry*, 1979, 136, 580-582.

Harris, I. B., & Westermeyer, J. Chemical dependency education within medical schools: Supervised clinical experience. *American Journal of Drug and Alcohol Abuse*, 1978, 5, 59-74.

Hartmann, H. Ich-psychologie und das anpassungs problem. *Internationale Zeitschrift fuer Psychoanalyse*, 1935, 24, 62-135. (Translated and condensed with comments by D. Rapaport in Organization and pathology of thought. New York: Columbia University Press, 1951. Pp. 363-396.)

Hartmann, H. Technical implications of ego psychology. *Psychoanalytic Quarterly*, 1951, 20, 31-43.

Hartocollis, P. Denial of illness in alcoholism. *Bulletin, Menninger Clinic*, 1968, 32, 47-53.

Hartocollis, P. A dynamic view of alcoholism: Drinking in the service of denial. *Dynamische Psychiatrie*, 1969,2, 173-182.

Hazelden Foundation. *Dealing with denial*. The Caring Community Series, No. 6. Center City, Minn.: Hazelden Foundation, 1975.

Hellman, A. D. *Laws against marijuana: The price we pay*. Urbana: University of Illinois Press, 1975.

Hendrick, I. Work and the pleasure principle. *Psychoanalytic Quarterly*, 1943, 12, 311-329.

Heyman, M. M. *Alcoholism programs in industry: The patient's view*. Monograph 12. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1978.

Hill, M., & Blane, H. T. Evaluation of psychotherapy with alcoholics: A critical review. *Quarterly Journal of Studies on Alcohol*, 1967,28, 76-104.

Hoffer, W. Theory of defense. *Psychoanalytic Study of the Child*, 1968, 23, 178-188.

Hoffman, H., Loper, R. G., & Kammier, M. L. Identifying future alcoholics with MMPI alcoholism scales. *Quarterly Journal of Studies on Alcohol*, 1974, 35, 490-498.

Horton, D. The function of alcohol in primitive societies: A cross-cultural study. *Quarterly Journal of Studies on Alcohol*, 1943,4, 199-230.

Illis, L. S. Regeneration in the central nervous system. *Lancet*, 1973, I, 1035-1037.

Imber, S., Schultz, E., Funderburk, F.. Allen, R., & Flamer, R. The fate of the untreated alcoholic. *Journal of Nervous and Mental Diseases*, 1976, 162, 238-247.

Imboden, J. B., et al. Alcoholism. Part 9 of the series Practical psychiatry in medicine. *Journal of Family Practice*, 1978, 6, 685-686, 688, 691.

Jackson, J. K. Alcoholism and the family. In D. J. Pittman & C. R. Snyder (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Jacobson, E. Denial and repression. *Journal of the American Psychoanalytic Association*, 1957, 5, 61-92.

Jacobson, E. Depersonalization. *Journal of the American Psychoanalytic Association*, 1959, 7, 581-610.

Jellinek, E. M. *The disease concept of alcoholism*. New Haven, Conn.: College & University Press, 1960.

Jellinek, E. M. Heredity of the alcoholic. *Quarterly Journal of Studies on Alcohol*, 1945, 6, 105-114.

Jellinek, E. M. Phases of alcohol addiction. *Quarterly Journal of Studies on Alcohol*, 1952, 13, 673-684.

Jones, M. C. Personality correlates and antecedents of drinking patterns in adult males. *Journal of Consulting and Clinical Psychology*, 1968, 32, 2-12.

Kaiser, H, The problem of responsibility in psychotherapy. *Psychiatry,* 1955, 18, 205-211.

Kammeier, M. L., Hoffmann, H., & Loper, R. G. Personality characteristics of alcoholics as college freshmen and at time of treatment. *Quarterly Journal of Studies on Alcohol*, 1973, 34, 390-399.

Kapur, N., & Butters, N. Visuoperceptive defects in long-term alcoholics and alcoholics with Korsakoff's psychosis. *Quarterly Journal of Studies on Alcohol*, 1977, 38, 2025-2035.

Kazin, A. The giant killer: Drink and the American writer. *Commentary*, 1976, 61, 44-50.

Keeler, M. H., Taylor, 1. C., & Miller, W. C. Are all recently detoxified alcoholics depressed? *American Journal of Psychiatry*, 1979, 136, 586-588.

Keller, M. Alcohol consumption. In *Encyclopaedia Britannica*, Vol. I. Chicago: Encyclopaedia Britannica, Inc., 1973.

Keller, M. The definition of alcoholism and the estimation of its prevalence. In D. J. Pittman & C. R. Snyder (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Keller, M. A lexicon of disablements related to alcohol consumption. In G. Edwards, M. M. Gross, M. Keller, J. Moser, & R. Room (Eds.), *Alcohol- related disabilities*. Geneva: World Health Organization, 1977.

Keller, M., & McCormick, M. *A dictionary of words about alcohol*. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1968.

Kellerman, J. L. *Alcoholism: A merry-go-round named denial*. New York: Alcoholics Anonymous Family Group Headquarters, Inc., 1969.

Kendall, R. E.. & Stanton, M. C. The fate of untreated alcoholics. *Quarterly Journal of Studies on Alcohol*, 1966, 27, 30-41.

Kernberg, O. F. *Borderline conditions and pathological narcissism*. New York: Aronson, 1975.

Kernberg, O. F. Large group processes: Psychoanalytic understanding and applications. Paper presented at the panel on "Psychoanalytic knowledge of group processes," American Psychoanalytic Association, New York, Dec.

1977.

Khantzian, E. J. Some treatment implications of the ego and self disturbances in alcoholism. This volume.

Khantzian, E. J. The alcoholic patient: An overview and perspective. *American Journal of Psychotherapy*, 1980, 34, 4-19.

Khantzian, E. J. The ego, the self and opiate addiction: Theoretical and treatment considerations. *International Review of Psycho-Analysis*, 1978, 5, 189-199.

Khantzian, E. J. Impulse problems in addiction: Cause and effect relationships. In H. Wishnie & J. Nevis-Olesen (Eds.), *Clinical approaches to impulsive patients*. New York: Plenum Publishing Corporation. 1979a.

Khantzian, E. J. On the nature of the dependency and denial problems of alcoholics. *Journal of Geriatric Psychiatry*, 1979b, 11, 191-202.

Khantzian, E. J., Mack, J. E., & Schatzberg, A. F. Heroin use as an attempt to cope: Clinical observations. *American Journal of Psychiatry*, 1974, 131, 160-164.

Kissin, B. The pharmacodynamics and natural history of alcoholism. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 3. *Clinical pathology*. New York: Plenum Press, 1974.

Kissin, B., & Gross, M. M. Drug therapy in alcoholism. *American Journal of Psychiatry*, 1968, 125, 31-41.

Klein, D. F. Psychopharmacology and the borderline patient. In P. Hartocollis (Ed.), *Borderline states in psychiatry*. New York: Grune & Stratton, 1975.

Kleinknecht. R. A., & Goldstein, S. Neuropsychological deficits associated with alcoholism: A review and discussion. *Quarterly Journal of Studies on Alcohol*, 1972, 33, 999-1020.

Klein, N. S., Wren, J. C., Cooper, T. B., Varga, E., & Canal, O. Evaluation of lithium therapy in chronic and periodic alcoholism. *American Journal of Medical Science*, 1974,268, 15-22.

Knight, R. P. The dynamics and treatment of chronic alcohol addiction. *Bulletin, Menninger Clinic*, 1937a, 1, 233-250.

Knight, R. P. Psychodynamics of chronic alcoholics. *Journal of Nervous and Mental Diseases*, 1937b, 86, 538-548.

Kobi.er, J. *Ardent spirits: The rise and fall of prohibition*. New York: Putnam, 1973.

Koffend, J. The case for alcohol. *Atlantic Monthly*, 1979, 244, 66-70.

Kohut, H. *The analysis of the self.* New York: International Universities Press, 1971.

Kohut, H. Forms and transformations of narcissism. *Journal of the American Psychoanalytic Association*, 1966, 14, 243-272.

Kohut, H. Preface. In *Psychodynamics of drug dependence*. Research monograph 12. Rockville, Md.: National Institute on Drug Abuse, 1977a. Pp. vii-ix.

Kohut, H. *The restoration of the self.* New York: International Universities Press, 1977b.

Kohut, H., & Wolf, E. S. The disorders of the self and their treatment: An outline. *International Journal of Psycho-Analysis*, 1978, 59, 413-426.

Koi.b, L. C. *Modern clinical psychiatry*. Philadelphia: Saunders, 1973.

Kovaks, M., & Beck, A. T. Maladaptive cognitive structures in repression. *American Journal of Psychiatry*, 1978, 135, 525-533.

Krout, J. A. *The origins of prohibition*. New York: Knopf, 1925.

Krystal, H. Self- and object-representation in alcoholism and other drug dependence: Implications for therapy. In *Psychodynamics of drug dependence*. Research monograph 12. Rockville, Md.: National Institute on Drug Abuse, 1977. Pp. 88-100.

Krystal, H., & Raskin, H. A. *Drug dependence: Aspects of ego functions*. Detroit: Wayne State University Press, 1970.

Kubler-Ross, E. *On death and dying*. New York: Macmillan, 1969.

Lapi.anche, J., & Pontalis, J. B. *The language of psychoanalysis*. Translated by D. Nicholson-Smith. New York: Norton, 1973.

Leach, B. Does Alcoholics Anonymous really work? In P. Bourne & R. Fox (Eds.), *Alcoholism: Progress in research and treatment*. New York & London: Academic Press, 1973.

Leach, B., Norris, J. L., Dancey, T., & Bissell, L. Dimensions of Alcoholics Anonymous. *International Journal of the Addictions*, 1969, 4, 507-541.

Lemere, F. What happens to alcoholics? *American Journal of Psychiatry*, 1953, 109, 674-682.

Lester, D. A biological approach to the etiology of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1960, 21, 701-703.

Levine, J., & Zigler, E. (Eds.). Denial and self-image in stroke, lung cancer and heart disease patients. *Journal of Consulting and Clinical Psychology*, 1975, 43, 751-757.

Lindemann. E. Symptomatology and management of acute grief. *American Journal of Psychiatry*, 1944, 101, 141-148.

Lisansky, E. Clinical research in alcoholism in the use of psychological tests: A re-evaluation. In R. Fox (Ed.). *Alcoholism: Behavioral research, therapeutic approaches*. New York: Springer, 1967.

Loewald, H. *Psychoanalysis and the history of the individual*. New Haven. Conn.: Yale University Press, 1978.

Logue, P. E., Gentry, W. D., Linnoii.a, M., & Erwin, W. C. Effect of alcohol consumption on state anxiety changes in male and female nonalcoholics. *American Journal of Psychiatry*, 1978, 135, 1079-1082.

Ludwig, A. M. On and off the wagon: Reasons for drinking and abstaining by alcoholics. *Quarterly Journal of Studies on Alcohol*, 1972,33, 91-96.

Mack, J. Alcoholism, A.A., and the governance of the self. This volume.

MacKay, J. R. Clinical observations on adolescent problem drinkers. *Quarterly Journal of Studies on Alcohol*, 1961,22, 124-134.

Maddox, G. L. (Ed.) *The domesticated drug: Drinking among collegians*. New Haven, Conn.: College and University Press Services, 1970.

Mardones, J. On the relationship between deficiency of B vitamins and alcohol intake in rats. *Quarterly Journal of Studies on Alcohol*, 1951, 12, 563-575.

Mathew, R. J., Claghorn, J. L., & Largen, J. Craving for alcohol in sober alcoholics. *American Journal of Psychiatry*, 1979, 136, 603-606.

McCord, W., & McCord, J. *Origins of alcoholism*. Stanford, Calif.: Stanford University Press, 1960.

McLearn, G. E., & Rodgers, D. A. Differences in alcohol preferences among unbred strains of mice. *Quarterly Journal of Studies on Alcohol*, 1959, 20, 691-695.

McLellan, A. T., Woody, G. E., & O'Brien, C. P. Development of psychiatric illness in drug abusers. *New England Journal of Medicine*, 1979, 301, 1310-1314.

Meissner, W. W. Psychoanalytic aspects of religious experience. *Annual of Psychoanalysis,* 1978, 6, 103-141.

Mello, N. K. Behavioral studies of alcoholism. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 2 Physiology and behavior. New York: Plenum Press, 1972.

Mello, N. K., & Mendelson, J. H. Drinking patterns during work: Contingent and non-contingent

alcohol acquisition. *Psychosomatic Medicine*, 1972, 34, 139-164.

Mendelson, J. H., LaDou, J., & Solomon, P. Experimentally induced chronic intoxication in alcoholics: Psychiatric findings. *Quarterly Journal of Studies on Alcohol*, 1964, 25, 40-52.

Mendelson, J. H., & Mello, N. K. Biological concomitants of alcoholism. *New England Journal of Medicine*, 1979, 301, 912-921.

Menninger, K. *Man against himself*. New York: Harcourt, Brace, 1938.

Merry, J., Reynolds, C. M., Bailey, J., & Coppen, A. Prophylactic treatment of alcoholism by lithium carbonate. *Lancet*, 1976, 2, 481-482.

Mitscherlich, A. Psychoanalysis and the aggression of large groups. *International Journal of Psycho-Analysis*, 1971,52, 161-168.

Moore, B. E., & Rubenfine, D. L. *The mechanism of denial*. Monograph. Kris Study Group of the New York Psychoanalytic Institute, 1969, 3, 3-57.

Moore, R. A. The problem of abstinence by the patient as a requisite for the psychotherapy of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1962, 23, 105-111.

Moore, R. A., & Murphy, T. C. Denial of alcoholism as an obstacle to recovery. *Quarterly Journal of Studies on Alcohol*, 1961, 22, 597-609.

Mottin, J. L. Drug-induced attenuation of alcohol consumption. *Quarterly Journal of Studies on Alcohol*. 1973, 34, 444-463.

Nathan, P. E., & Bridell, D. W. Behavioral assessment and treatment of alcoholism. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 5. *The treatment and rehabilitation of the chronic alcoholic*. New York: Plenum Press, 1977.

National Commission on Marihuana and Drug Abuse. *Drug use in America: Problem in perspective*. 2nd report of the Commission. Washington, D.C.: U.S. Government Printing Office, 1973.

National Council on Alcoholism. *What are the signs of alcoholism*? New York: National Council on Alcoholism. 1975.

National Council on Alcoholism, Criteria Committee. Criteria for the diagnosis of alcoholism. *American Journal of Psychiatry*, 1972, 129, 127-135.

Novick, D. M., & Yancovitz, S. R. Library resources in alcoholism. *Annals of International Medicine*, 1979, 91, 325.

Onions, C. T. (Ed.) *Shorter Oxford English dictionary on historical principles*. (3rd ed.) London: Oxford University Press, 1952.

Orford, J., & Edwards, G. *Alcoholism*. London: Oxford University Press, 1977.

Osi.er, W. *Principles and practice of medicine*. New York: Appleton, 1928.

Overall, J. E., Brown, D., Williams, J. D., & Neill, L. Drug treatment of anxiety and depression in detoxified alcoholic patients. *Archives of General Psychiatry*, 1973, 29, 218-221.

Paredes, A. Denial, deceptive maneuvers and consistency in the behavior of alcoholics. *Annals of the New York Academy of Sciences*, 1974,233, 23-33.

Parsons, O. Brain damage in alcoholics: Altered states of consciousness. In M. M. Gross (Ed.), *Alcohol intoxification and withdrawal: Experimental studies II*. New York: Plenum Press, 1975.

Parsons, O., & Freund, G. Chronic central nervous system toxicity of alcohol. *Annual Review of Pharmacology*, 1973, 13, 217-227.

Pattison, E. M. A critique of abstinence criteria in the treatment of alcoholism. *International Journal of Social Psychiatry*, 1968, 14, 268-276.

Pattison, E. M. The rehabilitation of the chronic alcoholic. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 2. *Physiology and behavior*. New York: Plenum Press, 1972.

Pattison, E. M. Nonabstinent drinking goals in the treatment of alcoholism. *Archives of General Psychiatry*, 1976, 3, 923-930.

Pattison, E. M., Sobell, M. B., & Sobell, L. C. *Emergency concepts of alcohol dependence*. New York: Springer, 1977.

Pearlin, L. E., & Radabaugh, C. W. Economic strains and the coping functions of alcohol. *American Journal of Sociology*, 1976, 82, 652-663.

Plum, F., & Posner, J. B. *The diagnosis of stupor and coma*. Philadelphia: Davis, 1966.

Pokorny, A., Putnam, P., & Fryer, J. Drug abuse and alcoholism teaching in U.S. medical and osteopathic schools. *Journal of Medical Education*, 1978, 53, 816-824.

Popham, R. E. A critique of the genetrophic theory of the etiology of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1947, 7, 567-587.

Quitkin, F. M., Rifkin, A., Kaplan, J., & Klein, D. F. Phobic anxiety syndrome complicated by drug dependence and addiction. *Archives of General Psychiatry*, 1972, 27, 159-162.

Rado, S. The psychoanalysis of pharmacothymia (drug addiction). *Psychoanalytic Quarterly*, 1933, 2, 1-23.

Randolph, T. G. The descriptive features of food addiction: Addictive eating and drinking. *Quarterly Journal of Studies on Alcohol*, 1956, 17, 198-224.

Rangell, L. Discussion of the Buffalo Creek disaster: The course of psychic trauma. *American Journal of Psychiatry*, 1976, 133, 313-316.

Rankin, J. G. (Eds.) *Alcohol, drugs, and brain damage*. Toronto: Addiction Research Foundation of Ontario, 1975.

Redlich, F., & Freedman, D. *The theory and practice of psychiatry*. New York: Basic Books, 1966.

Richter, C. P. Loss of appetite for alcohol and alcoholic beverages produced in rats by treatment with thyroid preparations. *Endocrinology*, 1956, 59, 472- 478.

Rizzuto, A-M. The patient as a hero. Unpublished manuscript, 1976.

Robins, L. N. *Deviant children grown up*. Baltimore: Williams & Wilkins. 1966.

Robins, L. N. *The Vietnam drug user returns*. Special Action Monograph, Series A, No. 2. Washington, D.C.: Special Action Office for Drug Abuse Prevention, May 1974.

Robins, L. N., Bates, W. M., & O'Neal, P. Adult drinking patterns of former problem children. In D. J. Pittman & C. R. Snyder (Eds.), *Society, culture and drinking patterns*. New York: Wiley, 1962.

Robinson, D. The alcohologist's addiction: Some implications of having lost control over the disease concept of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1972, 33, 1028-1042.

Rodgers, D. A. Factors underlying differences in alcohol preferences among unbred strains of mice. *Psychosomatic Medicine*, 1966, 28, 498-513.

Roizin, L., FIalpern, M.. Baden, M. M., et al. Neuropathology of drugs of dependence. In S. J. Mule & M. Brill (Eds.), *Chemical and biological aspects of drug dependence*. Cleveland: C.R.C. Press, 1972.

Room, R. Comment on D. Robinson, The alcohologist's addiction: Some implications of having lost control over the disease concept of alcoholism. *Quarterly Journal of Studies on Alcohol*, 1972, 33, 1049-1059.

Rosenfeld, H. A. The psychopathology of drug addiction and alcoholism: A critical review of the psychoanalytic literature. In *Psychotic states*. London: Hogarth, 1965.

Rosett, H. L. Alcohol, brain physiology and ego function: Implications for psychotherapy. Unpublished paper.

Roueche, B. *The neutral spirit: A portrait of alcohol*. Boston: Little, Brown, 1960.

Scheidlinger, S. Identification: The sense of belonging and of identity in small groups. *International Journal of Group Psychotherapy*, 1964, 14. 291-306.

Scheidlinger, S. On the concept of the "mother-group. " *International Journal of Group Psychotherapy*, 1974, 24, 417-428.

Schuckit, M. A., Goodwin, D. A., & Winokur, G. A study of alcoholism in half-siblings. *American Journal of Psychiatry*, 1972, 128, 1132-1136.

Schur, M. *The id and the regulatory principles of mental functioning*. New York: International Universities Press, 1966.

Seevers, M. H. Psychopharmacological elements of drug dependence. *Journal of the American Medical Association*, 1968,206, 1263-1266.

Seligman, M. E. P. *Helplessness: On depression, development, and death*. San Francisco: Freeman, 1975.

Semrad, E. The organization of ego defenses and object loss. In D. M. Moriarty (Ed.), *The loss of loved ones*. Springfield, Ill.: Charles C Thomas, 1967.

Shapiro, R. Psychoanalytic knowledge of group processes. Presented at the panel on "Psychoanalytic knowledge of group processes," American Psychoanalytic Association, New York, Dec. 18, 1977.

Shimano, E. Y., & Douglas, D. B. On research in Zen. *American Journal of Psychiatry*, 1975, 132, 1300-1302.

Silber, A. An addendum to the technique of psychotherapy with alcoholics. *Journal of Nervous and Mental Diseases*, 1970, 150, 423-437.

Silber, A. Rationale for the technique of psychotherapy with alcoholics. *International Journal of Psychoanalytic Psychotherapy*, 1974, 28, 47.

Simmel, E. Alcoholism and addiction. *Psychoanalytic Quarterly*, 1948, 17, 6-31.

Sinclair, A. *Prohibition: The era of excess*. Boston: Little, Brown, 1962.

Skinner, H. A., Jackson, D. N., & Hoffman, N. H. Alcoholic personality types: Identification and

correlates. *Journal of Abnormal Psychology*, 1974, 83, 685-696.

Smith, J. W., Johnson, L. C., & Burdick, J. A. Sleep, psychological and clinical changes during alcohol withdrawal in NAD-treated alcoholics. *Quarterly Journal of Studies on Alcohol*, 1971, 32, 932-949.

Solomon, H. C. Foreword. In M. Chafetz & H. W. Demone (Eds.), *Alcoholism and society*. New York: Oxford University Press, 1962.

Spruiell, V. Three strands of narcissism. *Psychoanalytic Quarterly*, 1975, 44, 577-595.

Stewart, D. A. The dynamics of fellowship as illustrated in Alcoholics Anonymous. *Quarterly Journal of Studies on Alcohol*, 1955, 16, 251-262.

Straus, R. Alcohol abuse and physicians' responsibility. *Archives of Internal Medicine*, 1977, 137, 1513-1514.

Sundby, P. *Alcoholism and mortality*. Oslo, Norway: Universitets-Forlaget, 1967.

Sutherland, E. H., Schroeder, H. G., & Tordella, O. L. Personality traits of the alcoholic: Critique of existing studies. *Quarterly Journal of Studies on Alcohol*, 1950, 11, 547-567.

Syme, L. Personality characteristics and the alcoholic: A critique of current studies. *Quarterly Journal of Studies on Alcohol*, 1957, 18, 288-302.

Tamerin, J. S. The psychotherapy of the alcoholic woman. In S. Zimberg, J. Wallace, & S. B. Blume (Eds.), *Practical approaches to alcoholism psychotherapy*. New York: Plenum Press, 1978.

Tamerin, J. S., & Mendelson, J. H. The psychodynamics of chronic inebriation: Observations of chronic alcoholics during the process of drinking in an experimental setting. *American Journal of Psychiatry*, 1969, 125, 886-899.

Tamerin, J. S., & Neuman, C. D. Psychological aspects of treating alcoholism. *Alcohol Health and Research World*, Spring 1974, Experimental Issue, 14-18.

Tamerin, J. S., Weiner, S., & Mendelson, J. H. Alcoholics' expectancies and recall of experiences during intoxication. *American Journal of Psychiatry*, 1976, 126, 1697-1704.

Tiebout, H. M. Alcoholics Anonymous: An experiment of nature. *Quarterly Journal of Studies on Alcohol*, 1961, 22, 52-68.

Tiebout, H. M. Therapeutic mechanisms of Alcoholics Anonymous. *American Journal of Psychiatry*, 1943-1944, 100, 468-473.

Titchener, J. L., & Kapp, F. J. Family and character change at Buffalo Creek. *American Journal of Psychiatry*, 1976, 133, 295-299.

Tomkins, S. *Affects, imagery, and consciousness*, Vol. 1. New York: Springer, 1962.

Touch of Evil. Universal International. Alfred Zugsmith, producer, 1958.

Trice, H. M. A study of the process of affiliation with Alcoholics Anonymous. *Quarterly Journal of Studies on Alcohol*, 1957, 18, 39-54.

Trunell, E., & Holt, W. E. The concept of denial or disavowal. *Journal of the American Psychoanalytic Association*, 1974, 22, 769-784.

Tumarkin, B., Wilson, J. D., & Snyder, G. Cerebral atrophy due to alcoholism in young adults. *U.S. Armed Forces Medical Journal*, 1955, 6, 67-74.

Twerski, A. J. Alcologia: A "logical" paralogia. *American Journal of Psychoanalysis*, 1974, 34, 257-261.

Unterberger, H. Personal communication, Aug. 14, 1978.

Vaillant, G. E. *Adaptation to life*. Boston: Little, Brown, 1977.

Vaillant, G. E. Adaptive ego mechanisms. *Archives of General Psychiatry*. 1971, 24, 108.

Vaillant, G. E. Alcoholism and drug dependence. In A. M. Nicholi (Ed.), *The Harvard guide to modern psychiatry.* Cambridge, Mass.: Belknap Press of Harvard University Press,

1978.

Vaillant, G. E. Dangers of psychotherapy in the treatment of alcoholism. This volume.

Vaillant, G. E. *The natural history of alcoholism*. In preparation, 1981.

Vaillant, G. E. Natural history of male psychological health: V. The relation of choice of ego mechanisms of defense to adult adjustment. *Archives of General Psychiatry*, 1976, 3d, 535-545.

Vaillant, G. E. Natural history of male psychological health: VIII. Antecedents of alcoholism and "orality." *American Journal of Psychiatry*, 1980, 137, 181-186.

Vaillant, G. E. Personal communication, April 1979.

Vaillant, G. E. A twelve-year follow-up of New York narcotic addicts: III. Some social and psychiatric characteristics. *Archives of General Psychiatry*, 1966, 15, 599-609.

van Dijk, W. K., & van Dijk-Kofferman, A. A follow-up study of 211 treated alcohol addicts. *British Journal of Addictions*, 1973, 68, 3-24.

Vanicelli, M. I. Mood and self-perception of alcoholics when sober and intoxicated. *Quarterly Journal of Studies on Alcohol*, 1972,55, 341-357.

Viamontes, J. A. Review of drug effectiveness in the treatment of alcoholism. *American Journal of Psychiatry*, 1972, 128, 1570-1571.

Victor, M., Adams, R. D., & Collins, G. H. *The Wernike Korsakoff syndrome: A clinical and pathological study of 245 patients, 82 with postmortem examinations*. Philadelphia: Davis, 1971.

Vischi, T. R., et al. *Alcohol, drug abuse, and mental health national data book*. Rockville, Md.: Alcohol, Drug Abuse, and Mental Health Administration, 1980.

Waeldf.r, R. The principle of multiple function: Observations on over- determination. *Psychoanalytic Quarterly*, 1936, 5, 45-62.

Waldorf, D., & Biernacki, P. The natural recovery from heroin addiction: A review of the incidence literature. *Journal of Drug Issues*, 1979, 9, 281–289.

Wallace, J. Behavior modification as adjunct to psychotherapy. In S. Zimberg. J. Wallace, & S. D. Blume (Eds.), *Practical approaches to alcoholism psychotherapy*. New York: Plenum Press, 1978.

Waller, J. A , & Turkel, H. W. Alcoholism and traffic deaths. *New England Journal of Medicine*, 1966 , 275 , 532-536.

Warren, G. H., & Raynes, A. E. Mood changes during three conditions of alcohol intake. *Quarterly Journal of Studies on Alcohol*, 1972, 33, 979-989.

Weil, A. T. *The natural mind*. Boston: Houghton Mifflin, 1972.

Weinstein, B., & Kahn, R. *Denial of illness*. Springfield, Ill.: Charles C Thomas, 1953.

Weisman. A. D. *On dying and denying*. New York: Behavioral Publications, 1972.

Weisman, M. M., & Meyers, J. K. Clinical depression in alcoholism. *American Journal of Psychiatry*, 1980, 137, 372-373.

Weisman, M. M., Meyers, J. K., & Harding, P. S. The prevalence rates and psychiatric heterogeneity of alcoholism in a United States urban community. *Quarterly Journal of Studies on Alcohol*, 1980, 41, 672-681.

Whitelock, P. R., Overall, J. E., & Patrick, J. H. Personality patterns and alcohol abuse in a state hospital population. *Journal of Abnormal Psychology*, 1971, 78, 9-16.

Wilder, H , & Kaplan, E. H. Drug use in adolescents: Psychodynamic meaning and pharmacogenic effect. *Psychoanalytic Study of the Child*, 1969, 24, 399-431.

Wikler. A. Conditioning factors in opiate addiction and relapse. In D. M. Wilmer & G. G. Kassenbaum (Eds.), *Narcotics*. New York: McGraw-Hill, 1970.

Williams, A. The student and the alcoholic patient. *Nursing Outlook*, 1979, 27, 470-472.

Williams, A. F. The alcoholic personality. In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism.* Vol. 4: *Social aspects of alcoholism*. New York: Plenum Press, 1976.

Williams, R. B.. Russell, R. M., Dutta, S. K., & Giovetti, A. G. Alcoholic pancreatitis: Patients at high risk of acute zinc deficiency. *American Journal of Medicine*, 1979, 66, 889-893.

Williams, R. J. *Alcoholism: The nutritional approach*. Austin: University of Texas Press, 1959.

Williams, R. J. The etiology of alcoholism: A working hypothesis involving the interplay of hereditary and environmental factors. *Quarterly Journal of Studies on Alcohol*, 1947, 7, 567-587.

Winokur, G., Clayton, P. J., & Reich, T. *Manic depressive illness*. St. Louis: Mosby, 1969.

Winokur, G., Reich, T., Rimmer, J.. & Pitts, G. Alcoholism: III. Diagnosis and familial psychiatric illness in 259 alcoholic probands. *Archives of General Psychiatry*, 1970, 22, 104-111.

Wolff, P. H. Ethnic differences in alcohol sensitivity. *Science*, 1972, 175, 449-450.

Woodruff, R. A., Guze, S. B., Clayton, P. J., & Carr, D. Alcoholism and depression. *Archives of General Psychiatry*, 1973, 28, 97-100.

Wren, J., Kline, N., & Cooper, T. Evaluation of lithium therapy in chronic alcoholism. *Clinical Medicine*, 1974, 81, 33-36.

Wurmser, L. *The hidden dimension: Psychodynamics in compulsive drug use*. New York: Aronson, 1978.

Wurmser, L. Psychoanalytic considerations in the etiology of compulsive drug use. *Journal of the American Psychoanalytic Association*, 1974, 22, 820- 843.

Yorke, C. A critical review of some psychoanalytic literature on drug addiction. *British Journal of Medical Psychology*, 1970,43, 141.

Zaleznik, A. Psychoanalysis and organization theory. Presented at the panel on "Psychoanalytic knowledge of group processes," American Psychoanalytic Association, New York,

Dec. 18, 1977.

Zetzel, E. R. Anxiety and the capacity to bear it. *International Journal of Psychoanalysis*, 1949 , 30, 1-12.

Zetzel, E. R. On the incapacity to bear depression. In M. Schur (Ed.), *Drives, affects and behavior*, Vol. 2. New York: International Universities Press, 1965.

Zimberg, S. Psychiatric office treatment of alcoholism. In S. Zimberg, J. Wallace, & S. B. Blume (Eds.), *Practical approaches to alcoholism psychotherapy*. New York: Plenum Press, 1978a.

Zimberg, S. Treatment of socioeconomically deprived alcoholics. In S. Zimberg, J. Wallace, & S. B. Blume (Eds.), *Practical approaches to alcoholism psychotherapy*, New York: Plenum Press, 1978b.

Zinberg, N. E. Alcohol addiction: Toward a more comprehensive definition. This volume.

Zinberg, N. E. Alcoholics Anonymous and the treatment and prevention of alcoholism. *Alcoholism: Clinical and Experimental Research*, 1977, 1, 91- 101.

Zinberg, N. E. Medical education and intoxicant use. In J. Lowinson (Ed.), *Proceedings of National Drug Abuse Conference*, New York, 1976.

Zinberg, N. E., & Bean, M. H. Introduction: Alcohol use, alcoholism, and the problems of treatment. This volume.

Zinberg, N. E., & Fraser, K. M. The role of the social setting in the prevention and treatment of alcoholism. In J. H. Mendelson & N. K. Mello (Eds.), *The diagnosis and treatment of alcoholism*. New York: McGraw-Hill, 1979.

Zinberg, N. E., & Robertson, J. A. *Drugs and the public*. New York: Simon & Schuster, 1972.

Zuska, J. J. Beginnings of the Navy program. *Alcoholism: Clinical and Experimental Research*, 1978, 2, 352-357.