ALCOHOLISM IN A SHOT GLASS

WHAT IS ALCOHOLISM?

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What Is Alcoholism?

One reasonable conclusion that can be drawn from a perusal of the literature on alcoholism is that nobody knows what alcoholism is. An equally reasonable conclusion is that everybody knows what alcoholism is, but that they just happen not to agree. It is as if alcoholism were the elephant and the researchers the blind men in the parable of the blind men and the elephant. Depending on where they make contact with the beast, the researchers define it as trunklike, earlike, or taillike, when it is really a large thick-skinned mammal with a trunk, ears, and tail. People have argued, and still argue, whether alcoholism is a form of moral turpitude, a bad habit, a disease, or a symptom of an underlying emotional or psychological disorder. Depending on their perspective, they see it as a product of the devil, of the culture, of the genes, of the body, or of the mind. All of these positions have their defenders. Believers in the moral turpitude theory are still with us. The story comes to mind of the fundamentalist preacher who was giving a hell-and-brimstone sermon. As his preaching reached a crescendo, he bellowed out, "Tell me if anyone here is in favor of sin?" A little old lady in the back of the church stuck up her hand. "What! you're in favor of sin?" screamed the preacher. "Oh no," said the little old lady, "I thought you said gin." For her, sin and gin belonged to different categories, but this is not so for many of her fellow Americans. Clearly, something more than perspective is involved here; values also enter

into these various ways of defining and understanding alcoholism. Definitions are partly decisions; they are prescriptive as well as descriptive.

The view that alcoholism is a disease goes back at least as far as Benjamin Rush (1785/1994), surgeon general of the Revolutionary army, but it was the pioneer alcohologist Emil Jellinek who made the disease concept scientifically respectable. Jellinek's notable predecessors include the early 19th-century British naval physician, Thomas Trotter (Jellinek, 1994), who held that alcoholism was caused by heredity and premature weaning, and William Silkworth, a physician who treated Bill Wilson (who went on to found Alcoholics Anonymous) and taught him that "alcoholism was an allergy of the body and an obsession of the mind." Wilson incorporated Silkworth's conceptualization into the AA literature.

Suppose we accept the viewpoint of most contemporary writers and agree that alcoholism is a disease. Does that solve the problem? No, not at all. As Jellinek (1960) demonstrated, the disease concept of alcoholism is far from clear or unitary. If alcoholism is a disease, is it a physical disease? An emotional disease? A mental disease? All three? At the advanced stage in which the patient may have a history of DTs, cirrhosis, or brain damage, there is no question but that the patient has a disease, indeed diseases, that are physical—diseases of the body. But are these physical diseases the alcoholism? It seems more reasonable to say that they are the physical

consequences of the excessive drinking and secondary to it, rather than the alcoholism itself, although they may contribute to further excessive drinking by impairing the biological equipment necessary for the inhibition of impulsive behavior. In what sense then, if at all, is this excessive drinking per se a disease? Is it a genetic or metabolic disorder? An emotional disorder? If there is an emotional disorder, is it a result of the excessive drinking rather than its cause? Or as this question is sometimes put, is there a "prealcoholic" personality?

There is a vast and vexed literature devoted to answering these questions. It is inconclusive. Similarly, there is an extensive literature on the distinction between *problem* drinking and alcoholism. When does the drinker cross what AA calls the invisible line? Again, there is confusion and uncertainty. The issue of definition is seemingly inexorably linked with the question of etiology. Yet there is no reason why this should be so. We define many things the causes of which we do not understand or know with certainty. There is no reason not to do so with alcoholism. Therefore, let us attempt to cut this Gordian knot. For practical purposes, and in a rough and ready way, alcoholism can be defined as *drinking more than is good for one over an extended period of time*. There are three essential elements in this definition: (1) the drinking does serious harm of various sorts to the drinker; (2) the drinking continues despite its harmful consequences (that is, it is compulsive), and (3) the harmful drinking continues over an extended period

of time.

For me, the essential characteristic of alcoholic drinking is its compulsiveness. The drinker continues to drink regardless of the consequences to his or her health, relationships, emotional stability, or financial wellbeing. The problem drinker also harms himself or herself by drinking, but the damage is usually not so severe and the behavior is not so chronic. The distinction is hard to make, but it is vital both clinically and for research purposes. Problem drinkers sometimes become social drinkers; alcoholics do not. Of course, this is tautological: If you can drink without doing serious harm to yourself or your environment, then you are not alcoholic, although you might have had problems connected with your drinking in the past; conversely, if you cannot drink without harming yourself, then you are alcoholic. The key issue is the ability to drink safely (that is, without returning to compulsive drinking). Unfortunately, there is no way of knowing which problem drinkers will become social drinkers and which will become alcoholics, although it is known that problem drinkers with a family history of alcoholism are themselves at risk for developing alcoholism.

The question of definition is of great importance in the epidemiology of alcoholism. Epidemiological researchers' findings as to the prevalence and distribution of alcoholism in the population vary with and are dependent on their definitions of alcoholism. However, this is a research question and not

our primary concern here. The question of definition is also of clinical importance, but in a different way. You cannot diagnose what you cannot define. In cutting the Gordian knot of the problem of the proper definition of alcoholism, several *decisions* are necessary. Since definitions are prescriptive as well as descriptive, they are, in their very nature, decisions. First, the question of etiology will be held in abeyance, and our definition will be purely phenomenological. Regardless of the cause or causes, certain behaviors will be defined as alcoholic and others as not. Second, I will assume that any behavior that is as dysfunctional and selfdestructive as alcoholism is a disease. For an organism to destroy itself is pathological, regardless of the source of the pathology. In these prescriptive acts I am accepting the stances of the World Health Organization (WHO), the American Medical Association (AMA), and the American Psychiatric Association (APA), all of which define alcoholism as a disease (or behavioral disorder) and all of which remain agnostic as to the etiology of the disease, confining their definitions to the descriptive.

The purpose of a working clinical definition is to diagnose—to spot the critter if it is there. An understanding of etiology is more important in treatment than in diagnosis. Undoubtedly, there is more than one type of alcoholism (in fact, some authors speak of alcoholisms), and each comprises a different mix of biological, cultural, and psychological factors. However, since the primary treatment of any of these alcoholisms is to help the patient stop

drinking, the first step must be diagnosis of the problem. To this end, descriptive definitions are most helpful. Therefore, let us look at the WHO and APA definitions.

WORLD HEALTH ORGANIZATION DEFINITION

The WHO adopted Mark Keller's (1958) definition of alcoholism, which states that alcoholism is "a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to the extent that it interferes with the drinker's health or his social or economic functioning. . . . Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning, or who show the prodromal signs of such developments."[3] This is a clear and useful definition that stresses both cultural deviance and damage to the drinker. It can be used as a rough index for diagnostic purposes.

AMERICAN PSYCHIATRIC ASSOCIATION DIAGNOSTIC CRITERIA

The APA publishes a series of *Diagnostic and Statistical Manuals of Mental Disorders* (DSM-I, DSM-II, DSM-III, DSM-III-R, and DSM-IV). The DSM-

III was published in 1980. It was followed by the DSM-III-R (1987), a revision of the DSM-III, and by the recently published DSM-IV (1994). I continue to find the DSM-III most clinically useful. It contains a category of *substance use disorders*, which are classified according to severity as either substance abuse or substance dependence. The pathological use of alcohol is treated this way in the DSM-III. Since the DSM-III definitions of alcohol abuse and alcohol dependence provide very clear guidelines for the diagnosis of alcoholism, they will be quoted at length here.

Diagnostic criteria for Alcohol Abuse. The essential feature of Alcohol Abuse is a pattern of pathological use of at least a month that causes impairment in social or occupational functioning.

A. Pattern of pathological alcohol use: need for daily use of alcohol for adequate functioning; inability to cut down or stop drinking; repeated efforts to control or reduce excess drinking by "going on the wagon" (periods of temporary abstinence). ... or restricting drinking to certain times of the day; binges (remaining intoxicated throughout the day for at least two days); occasional consumption of a fifth of spirits (or its equivalent); amnesic periods for events occurring while intoxicated; continuation of drinking despite a serious physical disorder that the individual knows is exacerbated by alcohol use; drinking of nonbeverage alcohol.

B. Impairment in social or occupational functioning due to alcohol use: e.g., violence while intoxicated, absence from work, loss

of job, legal difficulties (e.g., arrest for intoxicated behavior, traffic accidents while intoxicated), arguments or difficulties with family or friends because of excessive alcohol use.

C. Duration of disturbance of at least one month. The essential features of *Alcohol Dependence* are either a pattern of pathological alcohol use or impairment in social or occupational functioning due to alcohol, and either tolerance or withdrawal. Alcohol Dependence has also been called *Alcoholism*.[4]

These definitions are very useful to alcoholism counselors. They are simple and clear; and they provide behavioral criteria upon which to base a diagnosis. According to the DSM-III definition, alcoholism entails physiological involvement. This is similar to Jellinek's category of gamma alcoholism, discussed later.

The DSM-III-R has "shopping lists" for both psychoactive substance dependence and psychoactive substance abuse. Alcohol is, of course, a psychoactive substance. Here are the lists. (It should be noted that the DSM-III-R avoids the term alcoholism, speaking only of abuse and dependence, thus sidestepping the "Is alcoholism a disease?" debate, although the inclusion of abuse and dependence in the manual makes them psychiatric disorders. Is a disorder a disease? If so, this is a distinction without a difference.)

DSM-III-R Diagnostic Criteria for Psychoactive Substance Dependence

A. At least three of the following:

1. substance often taken in larger amounts or over a longer period than the person intended

2. persistent desire or one or more unsuccessful efforts to cut down or control substance use a great deal of time spent in activities necessary to get the substance, taking the substance, or recovering from its effects

3. frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home or when substance use is physically hazardous (e.g., drives when intoxicated)

4. important social, occupational, or recreational activities given up or reduced because of substance use

5. continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., having an ulcer made worse by drinking)

6. marked tolerance; need for markedly increased amounts of the substance in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount

7. characteristic withdrawal symptoms

8. substance often taken to relive or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

Diagnostic Criteria for Psychoactive Substance Abuse

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:

1. continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance

2. recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated)

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time

C. Never met the criteria for Psychoactive Substance Dependence for this substance.[5]

The DSM-IV

The long-awaited DSM-IV was published in June 1994. Although heralded as a major revision, it does not in fact substantially differ from the DSM-III-R in most regards; however, the section on substance-related disorders does depart from the DSM-III and III-R in some important ways. Although adhering to the substance-dependence/substance-abuse distinction of previous editions, the new criteria for substance dependence no longer require physiological dependency. Rather, tolerance and withdrawal are two of seven symptoms, three of which must be present for the diagnosis to be made. Physiological dependence or lack of it is now specified as a qualification of the diagnosis, as is the degree and conditions of remission, if the disorder is indeed in remission. As in previous editions, substance abuse is defined as a less severe condition than substance dependency. Substance abuse is diagnosed if the patient meets at least one of four criteria and has never met the substance dependence criteria. Alcohol abuse and dependence are defined as a subset of the substance abuse and dependence criteria and do not differ from it. As the editions have progressed, the shopping lists for diagnoses have grown more complex, and in that growing complexity, they have become in some ways less useful, although the specification of physiological dependence is a gain in diagnostic clarity. For this reason and because the DSM-IV is a widely available standard reference, it will not be quoted in detail here. However, in most treatment settings the clinician will be expected to use the DSM- IV criteria to diagnose and, accordingly, should

consult it.

The DSM-IV has a new and useful category of *substance-induced disorders* including substance intoxication, substance withdrawal, and "substance-induced delirium, persisting dementia, persisting amnestic disorder, psychotic disorder, mood disorder, anxiety disorder, sexual dysfunction, and sleep disorder" (p. 191). This recognition that mental disorders may be caused by substance abuse and persist long into abstinence is important, although the differential between what is consequent and what is antecedent to substance abuse is often hard to establish.

In addition to tolerance and withdrawal, criteria for dependence include increasing use, failure to cut down or control, substantial time devoted to gaining supplies or recovering from use, neglect of other activities, and continued use despite knowledge that use is seriously hurting the user. Criteria for substance abuse emphasize recurrence. What must recur are impairment in a major life area such as work, dangerous risk taking, legal problems, and social or interpersonal problems. Although less severe than dependence, abuse is a serious disorder.

The WHO and APA definitions of alcoholism are useful clinically, but sometimes the counselor needs a more global evaluation instrument. A highly structured intake form called the *Comprehensive Drinker Profile* (CDP) is

available from Psychological Assessment Resources, in Odessa, Florida. I prefer a more informal approach that gathers the same information without inducing as much defensive reaction, but many beginning counselors feel more secure with a structure to follow.

Some philosophers of science maintain that the meaning of a concept is uniquely determined by how it is measured. Once the *operations* (steps) necessary to measure it have been specified, all that can be meaningfully said about it has been said. According to this school of thought, a concept whose meaning cannot be *operationalized* is meaningless and cannot be a subject of scientific discourse. So a definition is simply a statement of the measurements that specify the concept. Implicit in the *operationalists'* understanding of the nature of scientific definition is the notion of *quantification*—some sort of number derived from the measurement must be assignable to particular measurements of the concept. By this standard, the above definitions of alcoholism are semi-operationalized.

Several appendixes at the end of this chapter contain a number of "instruments" that have been devised to measure (and thereby operationalize) alcoholism. Each is a self-report device that defines alcoholism by a score and is intended to facilitate self-diagnosis. The first two, the *Johns Hopkins University Drinking Scale* and the *Michigan Alcoholism Screening Test* (MAST), are "scientific" instruments developed by researchers;

the third is a more "folksy" instrument developed by AA, which is no less an operationalization of the concept of alcoholism. Since the three instruments differ, they provide three different operational definitions; however, a person who "scores" alcoholic on one will in all probability score alcoholic on the others. These instruments have great clinical utility.

The above definitions assume that alcoholism is a unitary phenomenon. There are, however, many ways of classifying alcoholic behavior and alcoholics. They delineate alcoholisms and types of alcoholics. Some authorities believe that there is more than one type of alcoholism. They draw dividing lines around clusters of personality traits, presumed dynamics, heritability, or drinking behaviors. Some students of alcoholism regard these classificatory schemes as misguided and diversionary, as distinctions without a difference. In a sense they are right. Alcohol is alcohol, and if you drink enough of it, you will get hooked, regardless of your age, gender, psychiatric diagnosis or lack of one, personality, or cultural background. However, this hard-nosed traditional alcoholism counseling orientation is unpleasantly "know-nothing" and hardly scientific. For all of their limitations, the various attempts at classification have been important historically, and they do shed light on our all too obscure topic. In addition to the vexed but important distinction between problem drinking and alcoholism, illuminating typologies have been constructed by Jellinek (1960); Knight (1937); Blane (1968); Winokur, Rimmer, and Reich (1971); and Cloninger (1983, 1987b). Jellinek

distinguishes among drinking patterns, Knight among personality types, Blane among dynamics, Winokur, Rimmer, and Reich among psychiatric diagnoses or their absence, and Cloninger among patterns of heritability.

JELLINEK AND THE DISEASE CONCEPT OF ALCOHOLISM

Jellinek's *The Disease Concept of Alcoholism* (1960) was a groundbreaking book. In it Jellinek made the disease concept of alcoholism scientifically respectable. He did this by taking a very careful and painstaking look at each of the possible ways of understanding alcoholism as a disease. In doing so, he evaluated available empirical evidence and the conceptual strength of each approach. Two major findings emerged. One was the concept of alcoholism as a *progressive disease* culminating in *loss of control* (that is, the inability to stop drinking after having begun). Jellinek derived this view largely from responses to a questionnaire on drinking histories that he submitted to a sample of AA members. Few pieces of survey research have had such influence. Every alcohol rehabilitation program has a chart of Jellinek's stages of progression, which it uses to teach the disease concept of alcoholism to patients. According to this scheme (Jellinek, 1952), alcoholism progresses from "occasional relief drinking" to "obsessive drinking continuing in vicious cycles," having passed through such stages as "onset of blackouts," "grandiose and aggressive behavior," "family and friends avoided," and "indefinable fears." The order of progression is seen as invariant. This concept

of alcoholism as a progressive, fatal disease is canonical in AA. Later research (Park, 1973; Vaillant, 1983) has shown that neither progression per se nor Jellinek's order of progression is inevitable or invariant. However, Jellinek's basic finding holds. For most problem drinkers, things do not get better; if they continue to drink, they get worse, and their problems get worse in pretty much the way the respondents to Jellinek's questionnaire said they do.

It is this progression that is the essence of Jellinek's and later versions of the disease concept. Alcoholism thus seen has a "course" just like other medical illnesses.

CRITICISMS OF THE DISEASE CONCEPT

Although Jellinek's conceptualization of at least one form of alcoholism as a disease is based on a nuanced, subtle analysis that recognizes that not all problem drinking is best understood as a disease (see below), his ideas have come under increasing attack from a host of critics. Their arguments point to the fact that the progression is not inevitable nor invariant, and to experiments that show that alcoholics do not always drink themselves to oblivion when they have the opportunity. The critics maintain that the medicalization of addiction, including alcohol addiction, is essentially a political decision, which has had the at least partly intended effect of increasing compassion for alcoholics and rendering the treatment of

alcoholism reimbursable by insurance companies and government, and has, in general, made it easier to obtain financial support for alcoholism rehabilitation. This may be true, but it does not in itself constitute an argument against the disease concept. Even if its advocates' motivation is bleeding heartism or a desire to line their pockets, the disease concept must be evaluated on its own merits as scientific explanation.

To demonstrate that Jellinek's notion of progression is untenable, Herbert Fingarette (1988), one of the most thoughtful (and passionate) of the critics, cites both survey research by the Social Research Group at the University of California (Clark & Cahalan, 1976) and the Rand Corporation (Polich, Armor, and Brailler, 1981) that purport to show that symptoms of problem drinking come and go but do not progress, and Vaillant's (1983) longitudinal study showing that youthful problem drinking is a poor predictor of middle age alcoholism and that the rate of "spontaneous recovery" from alcoholism is substantial. He attacks the notion of loss of control by citing Mello and Mendelson's (1972) study that showed that hospitalized alcoholics who had open access to alcohol did not drink themselves into oblivion and that they drank less when they had to "work" for their drinks. He also cites evidence from more naturalistic settings of alcoholics being able to "control" their drinking. Fingarette also attacks the disease concept from a clinical standard point, maintaining that teaching alcoholics that they have an uncontrollable disease becomes a self-fulfilling prophecy. Marlett and Gordon

(1985) speak of the *abstinence violation effect* (AVE) in which an alcoholic who believes that if he or she takes one drink, he or she will be unable to stop, will in fact not be able to stop, not because of a "disease" but because of a cognitive expectancy. In fact, the expectancy literature showing that the effects of ethanol, behavioral and subjective, on the drinker are mediated by "mental set," or learned anticipations, is cited by Fingarette to bolster his argument.

Other critics of the disease concept offer essentially the same critique: the course of problem drinking is variable and unpredictable, loss of control is refuted by the scientific evidence, responsibility is denied and undermined by those holding the disease concept (which is morally reprehensible), and, clinically, the disease concept is anti-therapeutic. Sometimes the dubious wisdom of telling teenage problem drinkers (and drug users) that they have an incurable lifelong disease is stressed. Critics like Wendy Kaminer (1993) emphasize their judgment that the medicalization of human problems, including chemical dependency, has unintended, catastrophic moral and political effects and results in a culture of victimization and political apathy. Kaminer's is more a critique of the codependency movement and other spinoffs of AA than a direct attack on the disease concept of alcoholism, yet her argument echoes Fingarette's.

What can be said in reply to Jellinek's critics? Jellinek was well aware

that not all problem drinking is progressive and he distinguishes that which is not (behavioral disorders) from that which is (the disease). Researchers seem to have difficulty validating progression; clinicians do not. Their experience tells them that for a certain type of drinker, things do indeed get worse if drinking continues. Vaillant in analyzing his own and other data concludes that progression does occur, but that the time span needed to demonstrate it is long (15 to 20 years), and that neither the evidence of spontaneous remission nor the variable patterns of alcohol abuse undermine either the scientific credibility or utility of the disease concept. I find his argument convincing.

As for the loss-of-control issue, Jellinek's original formulation of it is clearly untenable. What loss of control does mean is that the "alcoholic" cannot predict what will happen when he or she picks up a drink. The social drinker may decide to get drunk, say as a way of dealing with frustration. That may be foolish or immature from somebody's standpoint, but that is not evidence of loss of control. The alcoholic, on the other hand, decides to have one beer and does, but if he or she continues to experiment, he or she finds that sooner or later the desire to have one drink does not prevent him or her from winding up completely smashed. The key issue here is *unpredictability*. Critics of the unpredictability notion of loss of control maintain that the alcoholic has simply decided to get drunk. This contradicts alcoholics' subjective experience, "I found myself drinking in spite of not wanting to,"

and just about everybody's clinical experience. If the critics mean to say that the "decision" to get drunk is unconscious, that seems indistinguishable from saying that the drinking is compulsive and, if indeed compulsive, reasonably regarded as a disease.

The argument that the disease concept has undesirable social and political implications in its undermining of the experience of personal efficacy and responsibility is simply saying that critics would make a different decision about what constitutes a disease. Having argued above that definitions are prescriptive as well as descriptive, I agree that deciding that alcoholism is a disease is, in part, a political decision—but it is also a clinical and scientific one. Although there is some validity in a position like Kaminer's, hers is a value judgment to be weighed against the positive value of the disease concept.

As for the clinical critique, I have not found that alcoholics who subscribe to the disease concept continue to drink; on the contrary. The disease concept makes sense of a bewildering experience, reduces anxiety and guilt, and facilitates taking responsibility for one's recovery. Although there are occasional alcoholics who say, in effect, "What do you want from me? I have a disease, so of course I drink," I know of no clinicians who report this response other than rarely.

The critics are on more solid ground in suggesting that teaching the disease concept is basically antitherapeutic with young people. Besides, there is no way of knowing which adolescent rebellion drinkers will become alcoholic, although we have good reason to believe that a family history of alcoholism is a potent risk factor. As for the AVE, the way to deal with that is to tell alcoholic patients not that if they have a drink they will be unable to stop, but rather that if they drink, they cannot predict what the result will be, and that continuing to drink will almost certainly lead to serious problems.

Conceptually, to say that alcoholism is a disease can have several meanings: to the strict determinist it is a tautology, simply meaning that alcoholism like everything else has a cause or causes; to the geneticist it means that there is an innate predisposing factor that makes the development of alcoholism probable; to the personality theorist it means that there is a certain constellation of personality traits, acquired or innate, that predisposes to alcoholism; to the physician alcoholism means that it has a predictable course; and to the neurochemist it means that drinking itself changes the brain chemistry in such a way that the reaction to alcohol is altered so that control becomes difficult or impossible. A reasonable conclusion seems to be that for some alcoholics there are predisposing factors of various sorts (the evidence for this appears in chapter 6), which make for various degrees of inevitability; that for some a predictable course will follow; and that it is possible that there are consequent factors resulting from the drinking itself

that make drinking safely impossible for some.

Although the disease concept may be based on a decision and be a metaphor, I regard it as helpful and useful. Therefore, although the reader is cautioned that this conceptualization has its critics and that their arguments have merit, I will continue to refer to the disease and the disease process in this text. Vaillant (1983,) after exhaustively reviewing the evidence, concluded that alcoholism is best compared to a chronic metabolic disease like diabetes, which can be significantly controlled by proper self care. I agree.

TAXONOMIC SYSTEMS

Jellinek's Types of Alcoholics

Jellinek's second major contribution is his taxonomic (classification) system. It too has its limitations, and drinkers sometimes move from one category to another. One might say that it has cross-sectional validity but that its longitudinal validity is questionable. That is, at any given time all alcoholics will fall into one of the categories, but any given alcoholic may move across categories with the passage of time. Jellinek's categories are as follows: alpha, beta, gamma, delta, and epsilon.

Alpha alcoholism is characterized by the presence of such symptoms as hangovers or blackouts and by psychological, not physical, dependence. The

alpha alcoholic is the person who needs alcohol on a regular basis and who becomes anxious if it is not available. However, he or she will not experience withdrawal symptoms upon cessation of drinking. The person who "requires" alcohol in order to do a particular thing, such as make love, can also be considered an alpha since this is a psychological dependency on alcohol. Alpha alcoholism is not necessarily progressive. In fact, in Jellinek's formulation it is not, and indeed some drinkers remain psychologically dependent on alcohol for life without deteriorating physically or mentally; nor do they become physically dependent. It is known, however, that some alpha alcoholics do deteriorate and end up in other categories, usually gamma. Jellinek did not consider alpha alcoholism to be a true disease.

Beta alcoholism is characterized by physical symptoms such as ulcers or liver disease but not by physical dependence. The typical beta alcoholic is a heavy drinker, usually of beer, who continues to function socially and economically in a fairly adequate way as he or she continues to inflict somatic injury on him or herself. The beta alcoholic's drinking pattern remains stable in terms of quantity consumed and the relative absence of psychological and social symptomatology. Although beta alcoholism is not a progressive disease, it too is a form of pathological drinking. There is something manifestly crazy about continuing to inflict bodily damage on oneself in this way. Again, Jellinek did not consider beta alcoholism to be a true disease, and he thought that betas remained betas. However, it is known that some betas move into

other forms of alcoholism, chiefly gamma. Beta alcoholism is strongly associated with male, blue collar, culturally syntonic (that is, socially approved) heavy drinking.

According to Jellinek, *gamma alcoholism* is the most prevalent form of alcoholism in the United States. Almost all members of AA are thought to be gamma alcoholics. Gamma alcoholics are both symptomatic and physically dependent (at least in the late stages). That is, they suffer emotional and psychological impairment, their social and economic functioning is compromised, and they develop a tolerance to alcohol and experience withdrawal symptoms if they stop drinking. Clearly, they are sick people, and Jellinek did consider gamma alcoholism to be a true disease. Gamma alcoholics include but are not limited to the chronic alcoholics seen in alcoholism clinics and detoxification facilities. It was from his study on the drinking history of members of AA that Jellinek developed and described the category of gamma alcoholism as a chronic progressive disease. He thought that gamma alcoholism was characterized by *loss of control*. That is, once the gamma alcoholic takes a drink, there is no way of knowing when or how the drinking will stop. Loss of control means unpredictability; it does not necessarily mean that the gamma alcoholic will always get in trouble if he or she takes a drink. Nevertheless, this unpredictability means that the gamma alcoholic cannot drink safely. This is important clinically. The alcoholism counselor must often point out to the client that he or she does not know

what will happen if he or she drinks again and the fact that nothing bad happened last time does not change this. As AA puts it, "It's the first drink that gets you drunk." This is true for the gamma alcoholic, as is the AA slogan, "One drink is too many, but a thousand isn't enough." The issue of loss of control and the disease concept are scientifically controversial (see earlier discussion). In my experience, however, for all practical purposes both are true enough for those who are deeply into "booze." They are true alcohol addicts. Therefore, it is my position that abstinence, not controlled drinking, is the preferred, indeed the only rational, treatment for gamma alcoholism. The trick is to distinguish the gammas from the problem drinkers who may settle down into less dysfunctional drinking patterns. In general, the more symptomatic and the worse the history, the more likely it is that the patient is a gamma. A history of repeated withdrawal crises confirms the diagnosis. In terms of the APA's DSM-III, the gamma alcoholic is suffering from alcohol dependence; in terms of the DSM-III-R, from psychoactive substance dependence; and in terms of the DSM-IV, from substance dependence with or without physiological dependence, as the case may be.

Delta alcoholism is characterized by physical dependence but few or no symptoms. Jellinek believes that alcoholism in heavy wine drinking countries such as France is largely delta alcoholism. The delta drinker does not lose control; he or she does not get drunk, violent, or pass out, but he or she cannot stop drinking without experiencing withdrawal symptoms. High rates

of liver disease are associated with delta alcoholism.

Jellinek's final category is *epsilon alcoholism*. Epsilon alcoholism is binge drinking, which the old psychiatric literature called *dipsomania*. The epsilon drinker goes on binges, often for no apparent reason, of undetermined length that usually lasting until he or she collapses. The epsilon drinker then does not drink at all until the next binge. The interval between binges may be weeks, months, or years. It may remain constant, vary widely, or systematically decrease. In the latter case the epsilon drinker eventually becomes a gamma. The epsilon alcoholic is also known as a *periodic*.

There is an interesting empirical study that attempts to find cultural confirmation of Jellinek's taxonomy. Babor and his associates (1992) reasoned that if Jellinek was right, then diagnosed American alcoholics (presumed gammas) would show greater severity of psychiatric symptoms and give more psychological reasons for drinking than diagnosed French alcoholics (presumed deltas), with diagnosed French Canadian alcoholics being in between. Their data supported their hypothesis for male but not for female alcoholics, a not surprising finding considering that Jellinek's original analysis was based on male drinking patterns.

Jellinek's categories are useful. However, many alpha, beta, and epsilon drinkers become gamma alcoholics. Of course, not all do. In each case, alpha,

beta, gamma, delta, or epsilon, the alcohol is doing serious harm to the mind and body. Therefore, at least temporary abstinence must be the treatment goal. For the gamma alcoholic, permanent abstinence is the treatment goal.

Knight's Essential Versus Reactive Alcoholism

Jellinek was a biostatistician and epidemiologist who became an alcohologist. It was not surprising that he devised a typology based on drinking behavior. Robert Knight was a psychoanalyst who spent much of his career as a hospital psychiatrist, first at the Menninger Clinic and later at the Austin Riggs Center in Stockbridge, Massachusetts. His interest was clinical rather than epidemiological. Knight's research interests were in the areas of borderline personality structure, which he was one of the first to describe, and alcoholism. Not surprisingly, his classificatory system, although somewhat dependent on drinking behavior, is essentially developmental. That is, he classifies alcoholism according to the developmental level of the alcoholic. Knight's schema is dichotomous. It is based on his work with institutionalized alcoholics at the Menninger Clinic. By definition, the cases he saw were severe. Within this severity, Knight distinguished between essential alcoholics and reactive alcoholics.

The *essential alcoholics* were the patients who never really established themselves in life. They had trouble from adolescence onward. They were

often financially and emotionally dependent on their families; they had spotty educational and work histories with very little evidence of accomplishment or achievement. Their *object relations*, the psychoanalytic term for interpersonal relations, were at the need-gratifying level. They failed to complete the normal developmental task of separation-individuation, and they were fixated at that developmental stage. Using traditional psychoanalytic language, Knight described these patients as oral characters who had not reached the "mastery of the object" characteristic of the anal stage of psychosexual development. Oral character disorder is characterized by angry dependency, impulsivity, and lack of frustration tolerance. These essential alcoholics were in trouble with alcohol from the beginning. They had never drunk normally. The essential alcoholics were those who had a borderline character structure. Fixation at and intense conflict around separation-individuation is characteristic of *borderline personalities*—called so because their level of psychopathology is between neurosis and psychosis. They are severely ill but not overtly psychotic. Borderline personality disorder overlaps with oral character disorder and is characterized by intense rage; wildly fluctuating levels of self esteem; stormy, unstable interpersonal relations; and difficulties at school and work. Knight thought that such borderline, essential drinkers could never drink safely. Therefore, the treatment goal with them was permanent abstinence from alcohol. It is now known that many borderline patients are or become alcoholic, although the

vast majority of alcoholics are not borderline.

The *reactive alcoholics*, on the contrary, were those who had managed some life successes. They had achieved economic independence and vocational attainments. They had generally succeeded in marrying and establishing families. The quality of their object relations had once been fairly adequate, even if now they were gravely impaired by their drinking. Most had had a period of social drinking before crossing the "invisible line" into alcoholism. Knight saw their addiction as a reaction to life stresses or losses. From his description of his reactives, they seem to be a mix of "normals" with drinking problems and *narcissistic personality disorders* (N.P.D.). Narcissistic personality disorder is characterized by low self esteem, feelings of entitlement, manipulative interpersonal relations, and psychological deficits in such areas as the ability to modulate anxiety. (This disorder is further discussed in chapter 10.) Knight thought that some of these people could return to normal or controlled drinking once their psychological conflicts had been resolved or ameliorated. This is doubtful.

Knight pioneered the psychoanalytic treatment of alcoholism. It is important to note that he did so within a controlled environment in which patients could not drink. Knight's distinction, however, is a useful one. Essential alcoholics suffer from such massive developmental arrests that they are extremely difficult to treat. They make up the population of many chronic

alcoholic wards. The reactive alcoholics are much more functional, although they too may suffer from grave psychopathology, albeit of a different type, much of which is caused by their drinking. Their prognosis is far more hopeful.

Blane's Dependency Types

Howard Blane is another clinician who developed a system of classifying alcoholics based on clinical experience. His system uses a different differential than Knight's. He is a subscriber to the *dependency conflict* theory of the dynamics of male alcoholism (discussed below) and he divides the male alcoholic population according to the ways in which males handle their dependency needs. In Blane's view, no alcoholic meets his dependency needs in a healthy way. In his book *The Personality of the Alcoholic: Guises of Dependency* (1968), Blane divides alcoholics into dependent, counterdependent, and dependent-counterdependent types.

The *dependent alcoholics* are openly dependent on others for financial and other forms of support. Theirs is not a healthy adult interdependence. Blane's dependent alcoholics are very similar to Knight's essential alcoholics. Blane believed that their prognosis is poor.

The *counterdependents* handle their dependency needs by denial and *reaction formation*, the psychoanalytic term for turning things into their

opposite for defensive reasons as in turning hate into love and becoming hoveringly overprotective of the "loved" one. They are the "two-fisted drinkers" who "don't need anybody." They are the people prone to break up the bar and give similar evidence of their "independence." Some are overtly sociopathic. Blane believed that their prognosis also was poor. With respect to the more sociopathic of this group, I would agree. However, some counterdependents can be successfully treated psychotherapeutically by a tactful and empathetic understanding of the fear underlying their defiant defense. The trick is to find a face-saving way of keeping them in treatment.

The third group, the *dependent-counterdependent*, are those alcoholics for whom the conflict around dependency is active and intense. They are in the most pain and therefore are the most amenable to treatment. Although the dependency conflict theory of the etiology of alcoholism is out of fashion, there is no question that dependency conflicts get played out in alcoholic behavior, and Blane's typography is of considerable clinical utility. The alcoholism counselor sees dependent, counterdependent, and dependent-counterdependent alcoholics, and it is sometimes useful to think of them in these terms.

Winokur, Rimmer, and Reich's Primary Versus Secondary Alcoholism

Winokur, Rimmer, and Reich (1971) drew a distinction between

primary alcoholism and secondary alcoholism. Actually, Winokur et al.'s typology is trichotomous: primary alcoholism, depressive alcoholism, and sociopathic alcoholism. However, both depressive alcoholism and sociopathic alcoholism are secondary to something else, namely, depression and sociopathy, respectively. Therefore, Winokur et al.'s scheme can be viewed as dichotomous, distinguishing between primary and secondary alcoholisms.

Primary alcoholics are those whose alcoholism is not preceded by a major psychiatric illness. *Secondary alcoholics* are those whose alcoholism follows a major psychiatric illness. By major psychiatric illness, Winokur primarily meant a major affective disorder. Most often this is a unipolar depression, that is, one that does not alternate with mania. Clinically, Winokur's distinction is of great importance. Both primary and secondary alcoholics may be seriously depressed. However, the depression associated with primary alcoholism will remit with treatment consisting of abstinence and appropriate psychotherapeutic intervention, while that associated with secondary alcoholism will not. Participation in AA also helps alleviate depression associated with primary alcoholism. This is not the case with patients suffering from secondary alcoholism. Their affective disorders are not a consequence of their alcoholism, which is an attempt at self-medication of that depression, and treatment of the alcoholism will not cure it. On the contrary, the major affective disorder must be treated psycho-pharmacologically (with therapeutic drugs) as well as psychotherapeutically.

Secondary alcoholism is more common in women. Winokur also drew attention to another important differential—that between primary alcoholism and alcoholism that is secondary to sociopathy. Primary alcoholics, while they are active drinkers, may display some sociopathic behavior, but they are not sociopaths; sociopaths, however, are often heavy drinkers without necessarily being alcoholic. Winokur's alcoholism as secondary to sociopathy overlaps with Blane's counterdependent alcoholism. Both are generally found in men and both are extremely difficult to treat. Today Winokur's secondary alcoholics would be called *dual diagnosis patients*.

The terms primary alcoholism and secondary alcoholism are confusing because their usage has not been consistent. They have been used in Winokur's sense, where primary means just that, that the alcoholism is primary and other conditions such as personality disorder or depression are secondary to or independent of the alcoholism, and secondary alcoholism means that the alcoholism is secondary to something else such as a personality disorder or depression. However, other researchers use primary to mean early-onset severe alcoholism, the kind that is generally believed to be largely heritable, and secondary to mean the kind of alcoholism that develops over 20 to 30 years and is more subtle at least in its early manifestations. In this book primary alcoholism means Winokurian primary.

Cloninger's Male-Limited and Milieu-Limited Alcoholisms

Robert Cloninger investigated the heritability of alcoholism. The alcoholics in his 1983 study who manifested early-onset severe alcoholism, characterized by inability to abstain, fighting, arrests, and little or no guilt about their drinking, had a type of alcoholism that is heavily influenced by heredity and limited to men. He called this *male-limited* or *type 2* alcoholism. The other group of alcoholics in his study showed late onset, progression, psychological dependence, and guilt about that dependence. This type of alcoholism occurs in men and women, and, although Cloninger believes that genetic factors are involved here too, they do not manifest themselves without environmental provocation. He called this *milieu-limited* or *type 1* alcoholism.

In Cloninger's view male-limited alcoholism will develop independent of the environment, while milieu-limited alcoholism will develop in those who are genetically susceptible and who live in heavy drinking subcultures. Cloninger's male-limited alcoholics are much like Blane's counterdependents and Winokur's sociopathic secondaries. His milieu-limited alcoholics do not quite overlap with any of the other categories, but they do seem to have something in common with Jellinek's gammas. Cloninger's differential has had a strong influence on the theoretical understanding of alcoholism during the past 10 years. It is further discussed in the next chapter.

CONCLUSION

Alcoholism in itself is not a personality disorder nor is it a manifestation of another psychiatric condition. Rather, it is a primary disorder that consists of drinking to the point where the drinker and his or her environment are seriously damaged. It is a disease insofar as it is compulsive and not under the control of the drinker. There are many ways of classifying alcoholism and the ones reviewed earlier have great clinical utility; however, alcohol abuse characterizes each and all of these categories. Personality disorders are certainly associated with alcoholism, but they are not the alcoholism, however much the alcoholism may be a futile attempt to treat the personality disturbance, and the alcoholism, the drinking itself, must be addressed before the patient can improve.

APPENDIX 5A

Johns Hopkins University Drinking Scale

Ask yourself the following questions and answer them as honestly as you can:

1.	Do you lose time from work due to drinking?	Yes —	No —
2.	Is drinking making your home life unhappy?	Yes —	No —
3.	Do you drink because you are shy with other people?	Yes —	No —
4.	Is drinking affecting your reputation?	Yes —	No —
5.	Have you ever felt remorse after drinking?	Yes —	No —
6.	Have you gotten into financial difficulties as a result of drinking?	Yes —	No —
7.	Do you turn to lower companions and an inferior environment when drinking?	Yes —	No —
8.	Does your drinking make you careless of your family's welfare?	Yes —	No —
9.	Has your ambition decreased since drinking?	Yes —	No —
10.	Do you crave a drink at a definite time daily?	Yes —	No —
11.	Do you want a drink the next morning?	Yes —	No —
		Yes	No

12.	Does your drinking cause you to have difficulties in sleeping?	___	___
13.	Has your efficiency decreased since drinking?	Yes ___	No ___
14.	Is your drinking jeopardizing your job or business?	Yes ___	No ___
15.	Do you drink to escape from worries or troubles?	Yes ___	No ___
16.	Do you drink alone?	Yes ___	No ___
17.	Have you ever had a complete loss of memory?	Yes ___	No ___
18.	Has your physician ever treated you for drinking?	Yes ___	No ___
19.	Do you drink to build your self-confidence?	Yes ___	No ___
20.	Have you ever been in a hospital or institution on account of drinking?	Yes ___	No ___

Three YES answers indicates a probable problem drinker. From 4-7 indicates definite early alcoholism. From 7-10 indicates an intermediate phase of alcoholism. Above 10 indicates advanced alcoholism.

APPENDIX 5B

Michigan Alcoholism Screening Test (MAST)

Points				
	0	Do you enjoy a drink now and then?	Yes ___	No ___
(2)	1.	Do you feel you are a normal drinker? (By normal we mean you drink less than or more as much as most people)	Yes ___	No ___
(2)	2.	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes ___	No ___
(1)	3.	Does your wife, husband, a parent or other relative ever worry or complain about your drinking?	Yes ___	No ___
(2)	4.	Can you stop drinking without a struggle after one or two drinks?*	Yes ___	No ___
(1)	5.	Do you feel guilty about your drinking?	Yes ___	No ___
(2)	6.	Do friends or relatives think you are a normal drinker?	Yes ___	No ___
(2)	7.	Are you able to stop drinking when you want to?	Yes ___	No ___
(5)	8.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes ___	No ___
(1)	9.	Have you gotten into physical fights when drinking?	Yes ___	No ___
(2)	10.	Has drinking ever created problems between you and your wife, husband, a parent, or other relative?	Yes ___	No ___
(2)	11.	Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	Yes ___	No ___

(2)	12.	Have you ever lost friends because of your drinking?	Yes __	No __
(2)	13.	Have you ever gotten into trouble at work because of drinking?	Yes __	No __
(2)	14.	Have you ever lost a job because of drinking?	Yes __	No __
(2)	15.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	Yes __	No __
(1)	16.	Do you drink before noon fairly often?	Yes __	No __
(2)	17.	Have you ever been told you have liver trouble? Cirrhosis?	Yes __	No __
(2)	18.	After heavy drinking, have you ever had Delirium Tremens (DTs) or severe shaking, or heard voices, or seen things that really weren't there?**?	Yes __	No __
(5)	19.	Have you ever gone to anyone for help about your drinking?	Yes __	No __
(5)	20.	Have you ever been in a hospital because of drinking?	Yes __	No __
(2)	21.	Have you ever been a patient in a psychiatric hospital or a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes __	No __
(2)	22.	Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?	Yes __	No __
(2)	23.	Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverage?	Yes __	No __
(2)	24.	Have you ever been arrested, or taken into custody, even for a few hours because of other drunk behavior?***	Yes __	No __
		If YES, how many times?	__	

* Alcoholic response is negative

** 5 points for the DTs

*** 2 points for EACH arrest

SCORING

5 points or more: Alcoholism

4 points: Suggestive of Alcoholism

3 points or less: Subject is not Alcoholic

APPENDIX 5C

Twelve Questions of Alcoholics Anonymous

1.	Have you ever decided to stop drinking for a week or so, but only lasted for a couple of days?	Yes ___	No ___
2.	Do you wish people would mind their own business about your drinking – stop telling you what to do?	Yes ___	No ___
3.	Have you ever switched from one kind of drink to another in the hope that this would keep you from getting drunk?	Yes ___	No ___
4.	Have you every had an eye-opener upon awakening during the past year?	Yes ___	No ___
5.	Do you envy people who can drink without getting into trouble?	Yes ___	No ___
6.	Have you had problems connected with your drinking during the past year?	Yes ___	No ___
7.	Has your drinking caused trouble at home?	Yes ___	No ___
8.	Do you ever try to get "extra" drinks at a party because you do not get enough?	Yes ___	No ___
9.	Do you tell yourself you can stop drinking at any time you want to, even though you keep getting drunk when you don't mean to?	Yes ___	No ___
10.	Have you missed days of work or school because of drinking?	Yes ___	No ___
11.	Do you have "blackouts"?	Yes ___	No ___
12.	Have you ever felt that your life would be better if you did not drink?	Yes ___	No ___

If you answered YES to four or more questions, you are probably in

trouble with alcohol.

About the Author

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References

Abraham, K. (1979). The psychological relations between sexuality and alcoholism. In *Selected papers on psychoanalysis* (pp. 80-90). New York: Brunner/Mazel. (Original work published 1908)

Alcoholics Anonymous World Services. (1952). *Twelve steps and twelve traditions*. New York: Author.

Alcoholics Anonymous World Services. (1976). *Alcoholics anonymous* (3rd ed.). New York: Author.

Alexopoulos, G. S., Lieberman, K. W., & Frances, R. J. (1983). Platelet MOA activity in alcoholic patients and their first-degree relatives. *American Journal of Psychiatry, 140*(11), 1501-1503.

Amark, C. (1951). A study in alcoholism: Clinical, social, psychiatric, and genetic investigations. *Acta Psychiatrica Neurologica Scandinavica, 70*, 1-283.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Babor, T. F., Wolfson, A., Boivan, D., Padouco-Thomas, S., & Clark, W. (1992). Alcoholism, culture, and psychopathology: A comparative study of French, French- Canadian, and American alcoholics. In J. E. Helzer & G. J. Canino (Eds.), *Alcoholism in North America, Europe, and Asia* (pp. 182-195). New York: Oxford University Press.

Bales, R. F. (1959). Cultural differences in rates of alcoholism. In G. McCarthy (Ed.), *Drinking and*

intoxication. Glencoe, IL: Free Press.

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

Bandura, A., & Walters, R. H. (1963). *Social learning and personality development.* New York: Holt, Rinehart & Winston.

Barnes, G. E. (1979). The alcoholic personality: A reanalysis of the literature. *Journal of Studies on Alcohol, 40*, 571-634.

Barnes, G. E. (1983). Clinical and prealcoholic personality characteristics, In B. Kissin & H. Begleiter (Eds.), *The biology of alcoholism, Vol. 6. The pathogenesis of alcoholism: Psychosocial factors* (pp. 113-196). New York: Plenum.

Bateson, G. (1971). The cybernetics of "self': A theory of alcoholism. *Psychiatry, 34*, 1-18.

Bateson, G., & Ruesch, J. (1951). *Communication: The social matrix of psychiatry*. New York: W. W. Norton.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Begleiter, H., Porjesz, B., Bihari, B., & Kissen, B. (1984). Event-related brain potentials in boys at risk for alcoholism. *Science, 225*, 1493-1495.

Bentham, J. (1939). An introduction to the principles of morals and legislation. In E. A. Burtt (Ed.), *The English Philosophers from Bacon to Mill* (pp. 791-852). New York: The Modem Library. (Original work published 1789)

Berglas, S. (1985). Self-handicapping and self-handicappers: A cognitive/attributional model of interpersonal self-protective behavior. In R. Hogan and W. H. Jones (Eds.), *Perspectives in personality theory: Theory, measurement and interpersonal dynamics*. Greenwich, CT: JAI Press.

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

Bleuler, M. (1955). Familial and personal background of chronic alcoholics. In O. Drethelm (Ed.), *Etiology of chronic alcoholism* (pp. 110-166). Springfield, IL: Charles C. Thomas.

Bohman, M. (1978). Some genetic aspects of alcoholism and criminality: A population of adoptees. *Archives of General Psychiatry, 35*, 269-276.

Bradshaw, J. (1988). *Healing the shame that binds you*. Deerfield Beach, FL: Health Communications.

Bunzel, A. (1940). The role of alcoholism in two Central American cultures. *Psychiatry, 3*, 361-387.

Butzel, R. (1982). Intoxication and withdrawal. In N.J. Estes & M. E. Heinemann (Eds.), *Alcoholism: Developments, consequences, and interventions* (2nd ed., pp. 102-108). St. Louis: Mosby.

Cadoret, R. J., O'Gorman, T. W., Troughton, E., & Heywood, L. (1984). Alcoholism and antisocial personality: Interrelationshps, genetic and environmental factors. *Archives of General Psychiatry, 42*, 161-167.

Cahalan, D., Cisin, H., & Crossley, H. (1969). *American drinking practices: A national survey of behavior and attitudes* (Monograph 6). New Brunswick, NJ: Rutgers Center for Alcohol Studies.

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

Child, I, Bacon, M., & Barry, H. (1965). A cross-cultural study of drinking. *Quarterly Journal of Studies on Alcohol* (Suppl. 3), 5-96.

Clark, W. B. & Cahalan, D. (1976). Changes in problem drinking over a four-year span. *Addictive Behaviors, 1*, 251-259.

Clark, W. B., & Midanik, L. (1982). Alcohol use and alcohol problems among U.S. adults. Results of the 1979 national survey. In *Alcohol consumption and related problems* (Alcohol and Health Monograph No. 1, DHHS Publication No. ADM 82-1190). Washington,

DC: U.S. Government Printing Office.

Cloninger, C. R. (1983). Genetic and environmental factors in the development of alcoholism. *Journal of Psychiatric Treatment and Evaluation, 5*, 487—496.

Cloninger, C. R. (1987a). A systematic method for clinical description and classification of personality variants: A proposal. *Archives of General Psychiatry, 44*, 573-588.

Cloninger, C. R. (1987b). Neurogenetic adaptive mechanisms in alcoholism. *Science, 236*, 410-416.

Cloninger, C. R., Bohman, M., & Sigvardsson, S. (1981). Cross-fostering analysis of adopted men. *Archives of General Psychiatry, 36*, 861-868.

Cloninger, C. R., Sigvardsson, S., & Bohman, M. (1988). Childhood personality predicts alcohol abuse in young adults. *Alcoholism: Clinical and Experimental Research, 12*, 494-505.

Conger, J. J. (1956). Reinforcement and the dynamics of alcoholism, *Quarterly Journal of Studies on Alcohol, 13*, 296-305.

Conner, R. (1962). The self-concepts of alcoholics. In D. Pittman & C. Snyder (Eds.), *Society, culture and drinking patterns* (pp. 455-467). Carbondale: Southern Illinois University Press.

Cox, W. M. (1985). Personality correlatives of substance abuse. In M. Galizio & S. A. Mausto (Eds.), *Determinants of substance abuse: Biological, psychological, and environmental factors* (pp. 209-246). New York: Plenum.

Cox, W. M. (1987). Personality theory and research. In H. Blane and K. Leonard (Eds.), *Psychological theories of drinking and alcoholism* (pp. 55-89). New York: Guilford Press.

Cruz-Coke, R., & Varela, A. (1966). Inheritance of alcoholism: Its association with colour-blindness. *Lancet, ii,* 1282-1284.

DeLuca, J., & Wallace, J. (1981). *The fourth special report to the U.S. Congress on alcohol and health* [DHHS Publication No. (ADM)81-1291], Washington, DC: U.S. Government Printing

Office.

Deutsch, H. (1965). Some forms of emotional disturbance and their relationship to schizophrenia. In *Neuroses and character types* (pp. 262-281). New York: International Universities Press.

Durkheim, E. (1987). *Suicide.* Glencoe, IL: Free Press.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Seacaucus, NJ: Citadel.

Ellis, A. (1988). *Rational-emotive therapy with alcoholics and substance abusers*. Oxford: Pergamon Press.

Fenichel, O. (1945). *The psychoanalytic theory of the neurosis.* New York: W. W. Norton.

Field, P. (1962). A new cross-cultural study of drunkenness. In D. Pittman & C. Snyder (Eds.), *Society, culture, and drinking patterns* (pp. 48-74). Carbondale: Southern Illinois University Press.

Fingarette, H. (1988). *Heavy drinking: The myth of alcoholism as a disease*. Berkeley, CA: University of California Press.

Freud, S. (1953). Interpretation of dreams. In J. Strachey (Ed. and Trans.), Standard edition of the complete psychological works of Sigmund Freud (Vols. 4 & 5, pp. 1- 628). London: Hogarth Press (original work published 1900).

Freud, S. (1955). Beyond the pleasure principle. In J. Strachey (Ed. and Trans.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp.1-64). London: Hogarth Press (original work published 1920).

Freud, S. (1956). The ego and the id. In J. Strachey (Ed. and Trans.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 1-66). London: Hogarth Press (original work published 1923).

Freud, S. (1957). On narcissism: an introduction. In J. Strachey (Ed. and Trans.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 67-104). London:

Hogarth Press (original work published 1914).

Freud, S. (1961). Dostoevsky and parricide. In J. Strachey (Ed. and Trans.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 173-194). London: Hogarth Press (original work published 1928).

Freud, S. (1974). *Cocaine papers* (B. Byck, Ed.). New York: New American Library.

Freud, S. (1985). *The complete letters of Sigmund Freud to Wilhelm Fleiss* (J. M. Mason, Ed. and Trans.) Cambridge, MA: Harvard University Press. (Originally written 1897).

Fromm, E. (1941). *Escape from freedom.* New York: Rinehart.

Fromm, E. (1964). *The heart of man.* New York: Harper & Row.

Galanter, M. (1993). *Network therapy for alcohol and drug abuse: A new approach in practice.* New York: Basic Books.

Gay, P. (1988). *Freud: A life for our time.* New York: W. W. Norton.

Gilman, A. G., Goodman, L. S., & Gilman, A. (Eds.). (1985). *Goodman and Gilman's The pharmacological bases of therapeutics* (7th ed.). New York: Macmillan.

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

Goldstein, G. (1976). Perceptual and cognitive deficit in alcoholics. In G. Goldstein & C. Neuringer (Eds.), *Empirical studies of alcoholism* (pp. 115-152). Cambridge, MA: Bollinger.

Goodwin, D. W. (1988). *Is alcoholism hereditary?* New York: Ballantine Books.

Goodwin, D.W., Schulsinger, F., Hermansen, L., Guze, S. B., & Winokur, G. (1973). Alcohol problems in adoptees raised apart from alcoholic biological parents. *Archives of General Psychiatry, 28,* 283-343.

Hall, T. (1989, March 15). A new temperance is taking root in America. *The New York Times*, pp.

Al, A6.

Harris, L., and Associates, Inc. (1971). *American attitudes toward alcohol and alcoholism* (Study no. 2188). A survey of public opinion prepared for the National Insti¬tute on Alcohol Abuse and Alcoholism. New York: Louis Harris.

Hartocollis, P., & Hartocollis, P. (1980). Alcoholism, borderline and narcissistic disorders: A psychoanalytic overview. In W. Fann, I. Karacon, A. Pokomy, & R. Williams (Eds.), *Phenomenology and treatment of alcoholism* (pp. 93-110). New York: Spectrum.

Hartocollis, P. (1968). A dynamic view of alcoholism: drinking in the service of denial. *Dynamic Psychiatry*, 2, 173-182.

Heath, D. B. (1958). Drinking patterns of the Bolivian Camba. *Quarterly Journal of Studies on Alcohol, 19*, 491-508.

Heath, D.B. (1991). Continuity and change in drinking patterns of the Bolivian Camba. In D. Pittman & H. A. White (Eds.), *Society, culture, and drinking patterns reexamined* (pp. 78-86). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Hewitt, C. C. (1943). A personality study of alcohol addiction. *Quarterly Journal of Studies on Alcohol, 4,* 368-386.

Horton, D. (1943). The functions of alcohol in primitive societies: A cross-cultural study. *Quarterly Journal of Studies on Alcohol, 4,* 199-320.

Hull, J. G. (1981). A self-awareness model of the causes and effects of alcohol consumption. *Journal of Abnormal Psychology, 90,* 586-600.

Huxley, A. (1954). *The doors of perception.* New York: Harper & Row.

Irgens-Jensen, O. (1971). *Problem drinking and personality: A study based on the Draw- a-Person Test.* New Brunswick, NJ: Rutgers Center for Alcohol Studies.

Jacobson, E. (1938). *Progressive relaxation.* Chicago: University of Chicago Press.

James, W. (1902). *Varieties of religious experience.* New York: Longmans.

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

Jellinek, E. M. (1960). *The disease concept of alcoholism.* New Haven, CT: College and University Press.

Jellinek, E. M. (1962). Cultural differences in the meaning of alcoholism. In D. J. Pittman and C. R. Snyder (Eds.), *Society, culture, and drinking patterns* (pp. 382-388). Carbondale: Southern Illinois University Press.

Jellinek, G. (1994). Heredity and premature weaning: A discussion of the work of Thomas Trotter, British Naval Physician. In J. Levin & R. Weiss (Eds.), *The dynamics and treatment of alcoholism: Essential papers* (pp. 28-34). Northvale, NJ: Jason Aronson. (Trotter's original work published 1804, Jellinek's article, 1943)

Jessor, R. (1987). Problem-behavior theory, psychosocial development, and adolescent problem drinking. *British Journal of Addictions, 82*, 331-342.

Jessor, R., Graves, T. D., Hanson, R. C. & Jessor, S. L. (1968). *Society, personality, behavior: A study of a tri-ethnic community.* New York: Hold, Rinehart & Winston.

Jones, K. L., Smith, D. W., Ulleland, C. N., & Streissguth, A. P. (1973). Pattern of malformation in offspring in chronic alcoholic women. *Lancet, i*, 1267-1271.

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

Jones, M. C. (1971). Personality antecedents and correlates of drinking patterns in women, *Journal of Consulting and Clinical Psychology, 36,* 61-69.

Julien, R. M. (1991). *A primer of drug action* (6th ed.). San Francisco: W. H. Freeman.

Jung, C. G. (1973). In G. Adler (Ed.), *C.G. Jung: Letters, Vol. 11, 1951-1961* (pp. 623- 625). Princeton, NJ: Princeton University Press. (Originally written 1961)

Kaij, L. (1960). *Alcoholism in twins: Studies on the etiology and sequels of abuse of alcohol.* Stockholm: Almquist & Wiksell.

Kaminer, W. (1993). *I'm dysfunctional, you're dysfunctional: The recovery movement and other self-help fashions.* New York: Vintage.

Kandel, D. B. (1975). Stages in adolescent involvement in drug use. *Science, 190,* 912- 914.

Kandel, D. B., Yamaguchi, K., & Chen, K. (1992). Stages of progression in drug involvement from adolescence to adulthood: Further evidence for the gateway theory. *Journal of Studies on Alcohol, 53,* 447-457.

Kant, I. (1929). *The critique of pure reason* (2nd Ed., M. K. Smith, trans.). London: MacMillan. (Original work published 1787)

Kazin, A. (1976, March). 'The giant killer': Drink and the american writer. *Commentary, 61(3),* 44-50.

Keller, M. (1958). Alcoholism: Nature and extent of the problem. *Annals of the American Academy of Political and Social Science, 315,* 1-11.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Jason Aronson.

Khantzian, E.J. (1981). Some treatment implications of ego and self-disturbances in alcoholism. In M. H. Bean & N. E. Zinberg (Eds.), *Dynamic approaches to the understanding and treatment of alcoholism* (pp. 163-188). New York: Free Press.

Kierkegaard, S. (1944). *The concept of dread* (W. Lowrie, Trans.). Princeton, NJ: Princeton University Press. (Original work published 1849)

Kirkpatrick, J. (1977). *Turnabout: Help for a new life.* New York: Doubleday.

Klausner, S. (1964). Sacred and profane meanings of blood and alcohol. *The Journal of Social Psychology, 64,* 27-43.

Knight, R. P. (1937). The dynamics and treatment of chronic alcohol addiction. *Bulletin of the*

Menninger Clinic, 1, 233-250.

Knight, R.P. (1938). The psychoanalytic treatment in a sanatarium of chronic addiction to alcohol. *Journal of the American Medical Association, 111,* 1443-1448.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders.* New York: International Universities Press.

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

Kohut, H. (1977b). *Psychodynamics of drug dependence* (National Institute on Drug Abuse Monograph 12, pp. vii-ix). Washington, DC: U.S. Government Printing Office.

Krystal, H., & Raskin, H. (1970). *Drug dependence: Aspects of ego function.* Detroit: Wayne State University Press.

Levin, J.D. (1981). A study of social role conflict in chronic alcoholic men afflicted with Alcoholics Anonymous (Doctoral dissertation, New York University, 1981). *Dissertation Abstracts International, 42-12B* 4970. (University Microfilms No. 8210924)

Levin, J.D. (1987). *Treatment of alcoholism and other addictions: A self-psychology approach.* Northvale, NJ: Jason Aronson.

Levin, J.D. (1991). *Recovery from alcoholism: Beyond your wildest dreams.* Northvale, NJ: Jason Aronson.

Levin, J.D. (1993). *Slings and arrows: narcissistic injury and its treatment.* Northvale, NJ: Jason Aronson.

Levin, J.D. & Weiss, R. H. (Eds.) (1994). *The dynamics and treatment of alcoholism: Essential papers.* Northvale, NJ: Jason Aronson.

Lex, B. (1985). Alcohol problems in special populations. In J.H. Mendelson & N. K. Mello (Eds.), *The diagnosis and treatment of alcoholism* (2nd ed., pp. 89-188). New York: McGraw-Hill.

Lipscomb, T. R., Carpenter, J. A., & Nathan, P. E. (1980). Static ataxia: A predictor of alcoholism? *British Journal of Addictions, 74,* 289-294.

London, W. P. (1990). Left-handedness and alcoholism. In S. Coren (Ed.), *Left-handed-ness: Behavioral implications and anomalies,* pp. 457-484. New York: Elsevier Science.

Loper, R. G., Kammeier, M. L., & Hoffman, H. (1973). MMPI characteristics of college freshmen males who later became alcoholics. *Journal of Abnormal Psychology, 82,* 159-162.

MacAndrew, C. (1965). The differentiation of male alcoholic outpatients from nonalcoholic psychiatric outpatients by means of the MMPI. *Quarterly Journal of Studies on Alcohol, 26,* 238-246.

MacAndrew, C. & Edgerton, R. B. (1969). *Drunken comportment.* Chicago: Aldine.

MacAndrew, C., & Geertsma, R.H. (1963). Analysis of responses of alcoholics to Scale 4 of the MMPI. *Quarterly Journal of Studies on Alcohol, 26,* 23-38.

Maccoby, M. (1977). Alcoholism in a Mexican village. In McClelland, D., Davis, W. N., Kalin, R., & Wanner, E. (Eds.). *The drinking man,* pp. 232-260. New York: Free Press.

Mahler, M., Pine F., & Bergman, A. (1975). *>The psychological birth of the human infant: Symbiosis and individuation.* New York: Basic Books.

Marlatt, G. A. & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford Press.

Masserman, J., & Yum, K. (1946). An analysis of the influence of alcohol in experimental neurosis in cats. *Psychosomatic Medicine, 8,* 36-52.

Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy.* Boston: Little, Brown.

McClelland, D. C., Davis, W., Kalin, R., & Wanner, E. (1972). *The drinking man: Alcohol and human motivation.* New York: Free Press.

McCord, W., & McCord, J., with Gudeman, J. (1960). *Origins of Alcoholism.* Stanford, CA: Stanford

University Press.

McCord, W., & McCord, J. (1962). A longitudinal study of the personality of alcoholics. In D. J. Pittman and C. R. Synder (Eds.), *Society, culture and drinking patterns* (pp. 413-430). Carbondale, Ill.: Southern Illinois University Press.

Mello, N.K., & Mendelson, J.H. (1970). Experimentally induced intoxication in alcoholics: A comparison between programmed and spontaneous drinking. *Journal of Pharmacology and Experimental Therapeutics, 173,* 101-116.

Mello, N. K. & Mendelson, J. H. (1972). Drinking patterns during work-contingent and noncontingent alcohol acquisition. *Psychosomatic Medicine, 34,* 139-164.

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

Meyerson, A. (1940). Alcohol: A study of social ambivalence. *Quarterly Journal of Studies on Alcohol, I,* 13-20.

Murray, H. A. (1938). *Explorations in personality.* New York: Oxford University Press.

National Institute on Alcohol Abuse and Alcoholism (1983). *Fifth special report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services* (DHHS Publication No. 84-1291).Rockville, MD: Author.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) (1988). *Sixth special report to the U.S. Congress on alcohol and health from the Secretary of Health and Human Services* (DHHS Publication No. 85-0009).Rockville, MD: Author.

National Institute on Alcohol Abuse and Alcoholism. (1990). *Seventh Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services* (DHHS Publication No. 90-1656). Rockville, MD: Author.

National Institute of Alcohol Abuse and Alcoholism (1994). *Eighth special report to the U.S. Congress on alcohol and health from the Secretary of Health and Human Services* (NIH Publication No. 94-3699). Rockville, MD: Author.

Park, P. (1973). Developmental ordering of experiences in alcoholism. *Quarterly Journal of Studies on Alcohol, 34,* 473-488.

Pavlov, I. (1927). *Conditioned reflexes.* Oxford, England: Oxford University Press.

Peninston, E. G. & Kulkosky, P. J. (1989). Brainwave training and B-endorphin levels in alcoholics. *>Alcoholism: Clinical and Experimental Research, 13,* 271-279.

Peninston, E. G., & Kulkosky, P. J. (1990). Alcoholic personality and alpha-theta brainwave training. *Medical Psychotherapy, 3,* 37-55.

Petrie, A. (1978). *Individuality in pain and suffering* (2nd ed.). Chicago: University of Chicago Press.

Pitts, F. N., Jr., & Winokur, G. (1966). Affective disorder—VII: Alcoholism and affective disorder. *Journal of Psychiatric Research, 4,* 37-50.

Polich, J., Armor, D., & Brainer, H. (1981). *The course of alcoholism.* New York: Wiley.

Polich, J., & Bloom, F. E. (1987). P300 from normals and adult children of alcoholics. *Alcohol, 4,* 301-307.

Pollock, V. E., Volavka, J., Goodwin, D. W., Mednick, S. A., Gabrielli, W. F., Knop, J., & Schulsinger, F. (1983). The EEG after alcohol administration in men at risk of alcoholism. *Archives of General Psychiatry, 40,* 857-861.

Porjesz, B., & Begleiter, H. (Eds.). (1983). *The biology of alcoholism, vol. VII: The pathogenesis of alcoholism, biological factors* (pp. 415-483). New York: Plenum Press.

Prochaska, J., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy.* Homewood, IL: Dow-Jones/Irwin.

Prochaska, J. V., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47,* 1102-1114.

Propping, P., Kruger, J., & Mark, N. (1981). Genetic disposition to alcoholism: An EEG study in

alcoholics and their relatives. *Human Genetics, 35,* 51-59.

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

Richards, H. J. (1993). *Therapy of the substance abuse syndromes.* Northvale, NJ: Jason Aronson.

Robbins, L. N., Bates, W. N., & O'Neal, P. (1962). Adult drinking patterns of former problem children. In D. J. Pittman & C. R. Snyder (Eds.), *Society, culture and drinking patterns* (pp. 395-412). Carbondale: Southern Illinois University Press.

Robbins, L. R., & Smith, E. M. (1980). Longitudinal studies of alcohol and drug problems: sex differences. In O. J. Kalant (Ed.), *Alcohol and drug problems in women.* New York: Plenum Press.

Roe, A. (1945). The adult adjustment of children of alcoholic parents raised in foster homes. *Quarterly Journal of Studies on Alcohol, 5,* 378-393.

Rohsenow, D. J. (1983). Alcoholics' perceptions of control. In W. M. Cox (Ed.), *Identifying and measuring alcoholic personality characteristics* (pp. 37-48). San Francisco: Jossey-Bass.

Rooney, J. F. (1991). Patterns of alcohol use in Spanish society. In. D. Pittman & H. R. White (Eds.), *Society, culture, and drinking patterns reexamined* (pp. 78-86). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs, 80.*

Rush, B. (1994). An inquiry into the effects of ardent spirits upon the human body and mind. In J. Levin & R. Weiss (Eds.), *The dynamics and treatment of alcoholism: Essential papers* (pp. 11-27). Northvale, NJ: Jason Aronson. (Original work published 1785)

Sandor, S. (1968). The influence of ethyl alcohol on the development of the chick embryo.*Revue du-Embryologie et de-Cytologie, Serie Embryologie, 5,* 51-76.

Schuckit, M. A., & Gold, F. O. (1988). A simultaneous evaluation of multiple markers of

ethanol/placebo challenges in sons of alcoholics and controls. *Archives of General Psychiatry, 45,* 211-216.

Shaffer, H. J. (1992). The psychology of stage change: The transition from addiction to recovery. In J. H. Lowinson, P. Ruiz, & R. B. Millman (Eds.), *Comprehensive textbook of substance abuse* (2nd ed., pp. 100-105). Baltimore: Williams & Wilkins.

Shaffer, H. J. (1994). Denial, ambivalence, and countertransferential hate. In J. D. Levin & R. H. Weiss (Eds.), *The dynamics and treatment of alcoholism: Essential papers,* pp. 421-437. Northvale, NJ: Jason Aronson.

Sher, K. J. (1987). Stress response dampening. In H. T. Blane & K. E. Leonard (Eds.), *Psychological theories of drinking and alcoholism* (pp. 227-271). New York: Guilford Press.

Shipley, T. E., Jr. (1982). Alcohol withdrawal and its treatment: Some conjectures in the context of the opponent-process theory. *Journal of Studies on Alcohol, 43,* 548-569.

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

Skinner, B. F. (1938). *The behavior of organisms.* New York: Appleton-Century-Crofts.

Smith, M. O. (1989). *The Lincoln Hospital acupuncture drug treatment program.* Testimony presented to the Select Committee on Narcotics of the U.S. House of Representatives, July 25, 1989.

Sobell, M. B. & Sobell, L. C. (1978). *Behavioral treatment of alcohol problems: Individualized therapy and controlled drinking.* New York: Plenum Press.

Sobell, M. B., & Sobell, L. C. (1993). *Problem drinkers: Guided self-change treatment.* New York: Guilford Press.

Solomon, R. L. (1977). An opponent process theory of acquired motivation: The affective dynamics of addiction. In J. D. Maser & M.E.P. Seligman (Eds.), *Psychopathology: Experimental Models* (pp. 66-103). San Francisco: W. H. Freeman.

Spitz, H. I., & Rosecan, J. S. (1987). *Cocaine abuse.* New York: Brunner/Mazel.

Szasz, T. (1958). The role of the counterphobic mechanism in addiction. *Journal of the American Psychoanalytic Association, 6*, 309-325.

Tabakoff, B., Hoffman, P. L., Lee, J. M., Saito, T., Willard, B., & Deleon-Jones, F. (1988). Differences in platelet enzyme activity between alcoholics and nonalcoholics. *New England Journal of Medicine, 318,* 134-139.

Tarter, R. E. (1981). Minimal brain dysfunction as an etiological disposition to alcoholism. In R. E. Meyer (Eds.), *Evaluation of the alcoholic: Implications for research, theory, and treatment* (NIAAA Monograph Series). Washington, DC: National Institute on Alcohol Abuse and Alcoholism.

Tarter, R. E. & Alterman, A. I. (1989). Neurobehavioral theory of alcoholism etiology. In C. D. Choudron & D. A. Wilkinson (Eds.), *Theories of alcoholism.* Toronto: Addiction Research Foundation.

Tillich, P. (1952). *The courage to be.* New Haven, CT: Yale University Press.

Trimpey, J. (1989). *Rational recovery from alcoholism: The small book* (3rd ed.). Lotus, CA: Lotus Press.

Vaillant, G. E. (1983). *The natural history of alcoholism: Causes, patterns and paths to recovery.* Cambridge, MA: Harvard University Press.

Varela, A., Rivera, L., Mardones, J., & Cruz-Coke, R. (1969). Color vision defects in non-alcoholic relatives of alcoholic patients. *British Journal of the Addictions, 64,*67-71.

von Knorring, A. L., Bohman, M., von Knorring, L., & Oreland, L. (1985). Platelet MAO activity as a biological marker in subgroups of alcoholism. *>Acta Psychiatrica Scandinavica, 72,* 51-58.

Williams, G. D. & DeBakey, S. F. (1992). Changes in levels of alcohol consumption: United States 1983 to 1988. *British Journal of Addictions, 87 (4),* 643-648.

Wilsnack, S. C. (1973). Sex role identity in female alcoholism. *Journal of Abnormal Psychology, 82,* 253-261.

Wilsnack, S. C. (1984).Drinking, sexuality, and sexual dysfunction in women. In S. C. Wilsnack & L. J. Beckman (Eds.), *Alcohol problems in women: Antecedents, consequences, and interventions,* pp. 189-228. New York: Guilford Press.

Wilsnack, S. C. & Beckman, L. J. (Eds.) (1984). *Alcohol problems in women: Antecedents, consequences, and intervention.* >New York: Guilford Press.

Wilsnack, S.C. (1991). Sexuality and women's drinking: Findings from a U.S. national study. *Alcohol and Health Research World, 15(2),* 147-150.

Wilson, G., & Lawson, D. (1978). Expectancies, alcohol, and sexual arousal in women. *Abnormal Psychology, 85,* 358-367.

Winnicott, D. W. (1958). The capacity to be alone. In *The maturational processes and the facilitating environment* (pp. 29-36). New York: International Universities Press, 1965.

Winnicott, D. W. (1960). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment* (pp. 140-152). New York: International Universities Press, 1965.

Winokur, G. (1974). The division of depressive illness into depressive-spectrum disease and pure depressive disease. *International Pharmaco-psychiatry, 9,* 5-13.

Winokur, G., Rimmer, J., & Reich, T. (1971). Alcoholism IV: Is there more than one type of alcoholism? *British Journal of Psychiatry, 18,* 525-531.

Winson, J. (1985). *Brain and Psyche: The Biology of the Unconscious.* New York: Anchor Press, Doubleday.

Winson, J. (1990). The Meaning of Dreams. *Scientific American,* November 1990. 86-96.

Wise, R. A. (1987). Psychomotor stimulant properties of addictive drugs. *Pharmacological Therapy, 35,* 227-263.

Witkin, H. A., & Oltman, P. K. (1967). Cognitive style. *International Journal of Neurology, 6,* 119-

137.

Witkin, H. A., Karp, S. A., & Goodenough, D. R. (1959). Dependence in alcoholics. *Quarterly Journal of Studies on Alcohol, 20,* 493-504.

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

Zucker, R. A. & Gomberg, E. S. L. (1986). >Etiology of alcoholism reconsidered: The case for a biopsychosocial process. *American Psychologist, 41,* 783-793.

Zuckerman, M. (1979). *Sensation seeking: Beyond the optimal level of arousal.* New York: Wiley.

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