THE INDIVIDUAL PSYCHOLOGY OF THE ALCOHOLIC PATIENT [1]

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It is almost unanimously agreed that alcoholism, as well as many other neuroses, represents an escape from challenge and possible defeat. It is apparent that alcoholism and other neuroses have many points in common. There are some differences, however. I shall show briefly how this is illustrated, both by symptoms and by some specific aspects of psychotherapy.

Alcoholics usually express an extreme degree of unwillingness or feeling of inability to assume responsibility. They consider themselves to be victims of a more or less mysterious addiction and that, therefore, they cannot be expected to assume responsibilities. More than other neurotics they place their burdens on the shoulders of other people, usually their wives, husbands or parents. They are prone to blame other persons for their shortcomings and this apparently accounts for the prevalence of suicides and attempted suicides among alcoholics. It has been stressed for many years that suicide is in most cases the attempt of one person to make others responsible for his failure. Death takes care of the situation, just as alcohol or other narcotic drugs did by the dulling of consciousness. To a greater extent than other neuroses the symptom of alcoholism represents, therefore, an alternative to suicide.

The difference between the psychology of chronic alcoholics and dipsomaniacs who have normal intervals would seem to be only one of degree. Alcoholism is not the only psychopathologic symptom in either group. Like other neurotics, they fail in several important spheres, appearing interested exclusively in themselves. They too expect appreciation before a task is accomplished instead of afterward. Alcoholics usually profess to be deeply concerned about the welfare of their relatives and friends but their alcoholism, like other neurotic symptoms, unfortunately prevents them from performing their duties.

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[1] Adler, Alfred: *Problems of Neurosis*, New York, Cosmopolitan Book Corporation, 1930, p. 126-130.
Social Interest: A Challenge to Mankind, London, Faber and Faber Ltd., 1938, p. 140-142.

It has been said that impotence is frequent in alcoholics and that this causes much of their psychopathology. However, their sexuality varies a great deal. They frequently profess to possess abnormally strong sexual power. They start relationships with many girls and drop them quickly. They are apt to contend that they started the relationship while drunk and hence, that for moral reasons, it should be given up as soon as possible. Or they may get drunk in a girl's company and thus antagonize her. The outcome is that no satisfactory relationship with the opposite sex is likely to develop. This would mean too great a responsibility for them. Their abnormal sexuality is, as is the case in other neuroses, an evidence of faulty development of the whole personality. A great many alcoholics are associated with homosexual circles. As far as the time factor is concerned, homosexuality has usually developed first, whereas the drinking bouts came later in a homosexual setting. It is interesting to note that unreliability is considered one of the characteristics of male homosexuals as well as of alcoholics.

Dipsomaniacs frequently come from families that are on a higher cultural level than those of chronic alcoholics. In these patients the bouts of drunkenness seem to be particularly well chosen in order to upset the family most effectively. Therefore, we find such patients frequently in families in which temperance is stressed. For example, they may be wives of judges or policemen, or of psychotherapists, all of whom may have been too eager to impress their own ideas of morals on their family circle.

A jovial mood is typical of many chronic alcoholics. If we analyze this mood we find constant joking and a minimizing of the importance of any situations with which they are faced. This is in keeping with their whole personality pattern which tends to avoid and to minimize responsibilities or to shift them upon other people.

Alcoholic bouts are frequent in neuroses in which social contact is especially inadequate. For example, one finds alcoholism rather frequently associated with such neuroses as erythrophobia. In this neurosis, the patient, afraid of criticism and of defeat, usually shuns all social contacts. But in a drunken state he may do things that otherwise he would avoid doing. A twenty-three year old patient suffering from erythrophobia came to me for treatment. His only social contacts were made when he was drunk. This happened about every other month. Then he went into drugstores and restaurants and threw bottles all around the place and "felt great," as he said. When he lost his erythro-

phobia there were no more of these episodes or bouts of alcoholic intoxication.

One symptom, which is found also in other types of drug addiction, makes the treatment of alcoholics different from that of most other neurotics. While neurotics are usually not ashamed of their symptoms and are ready to talk rather freely about their difficulties, especially to their psychotherapist, this is not the case with alcoholics and other drug addicts. Laymen look upon alcoholism differently from the way in which they view other neurotic symptoms. They are more prone to blame alcoholics for not stopping their habit, but nowadays they rarely consider patients suffering from a compulsive neurosis or a phobia to be responsible for their symptoms. Laymen usually think that the alcoholic could "snap out of it" if he wanted to. This is one of the reasons why alcoholics, as well as other drug addicts, are likely to lie to relatives and to psychotherapists about their drinking. It is frequently their chief desire to keep on drinking without letting anyone know about it. It is self-evident that psychotherapy must fail when a patient feels himself to be able to dominate the therapist. And so, in contrast to the treatment of other neuroses, one person alone can seldom suffice in the treatment of an alcoholic. Co-operation with other people who are able to observe the patient's conduct and to report to the physician is essential in the treatment of this type of neurosis. The set-up may well consist of the patient, the physician and an employed companion. The patient should know that this companion is expected to watch over him and to report to the physician. In rare instances a wife or husband or other member of the family may take the role of companion and, at the same time, of scape-goat as well. For obvious reasons family members are not best fitted for this job since alcoholism is usually directed against the family. Relatives may, however, be successful in helping if they have sufficient understanding and training and if the patient is co-operative.

In general, the psychotherapy of chronic alcoholism does not differ from that employed in other neuroses. The symptoms may disappear after a year's treatment in one case and after a treatment of several weeks' duration in another. It may disappear in patients who are seen once or twice a week and in others who had to be seen four or five times a week. Patients who are able to evolve suggestions and new ideas by themselves can be seen at greater intervals than can those who are unable to make any headway when left to themselves, practically all the work having to be done during the psychotherapeutic hour. I feel that the prognosis of

the treatment of alcoholism is about the same as that of the other neuroses. We have, however, in alcoholism a definite and objective index as to whether or not the neurosis has been cured: this is the alcoholic habit. While a physician may feel, mistakenly, that his neurotic patient has improved and the patient may even say so himself, there is no chance for this error so long as one's patient still indulges excessively in alcohol. This may be one of the reasons why some claim the prognosis of treatment of alcoholism is worse than that of other neuroses.

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