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PROBLEMS IN ADDICTION:

ALCOHOL AND DRUG ADDICTION

Edited by

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These Proceedings are dedicated to the memory of

KENNETH W. CHAPMAN

Public Health Officer and specialist in drug addiction, who devoted a major portion of his professional life to problems in this field.

1911-1959

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Preface

In 1955 the Psychology Department at Fordham University inaugurated a series of Institutes in Pastoral Psychology with the following stated aims: (1) to help the clergy to a better understanding of emotional problems encountered in pastoral work; (2) to help them handle such problems more efficiently; (3) to formulate a better understanding of the relationship between the clergy and the professional psychotherapist; (4) to evaluate the different approaches to mental health. These Institutes were undertaken with the conviction that psychology had something to offer the clergymen in their attempts to deal with pastoral problems, and the response of the clergy to these Institutes has testified to the fundamental correctness of this conviction.

The Institutes, offered in alternate years since 1955, have followed the same overall pattern. Each has been conducted for five days, Monday through Friday, of a single week toward the end of June. The Institutes have been sponsored by the Psychology Department, while their planning and conduct have been in the hands of a Committee appointed for this purpose by the President of the University. There has been some change in Committee personnel for the various Institutes, depending somewhat on the subject matter being treated, but three Committee members have formed the core of the Committee for all four Institutes. These members are: Rev. Joseph G. Keegan, S.J., Dr. Alexander A. Schneiders, and the present writer. Dr. Schneiders, former Director of Psychological Services at the University, was the Committee chairman.

The 1955 and 1957 Institutes treated a variety of topics, all of them chosen because they were in areas in which it was believed that psychology had something to offer to the clergyman. The Proceedings of these first two Institutes were issued on a limited basis, but have been out of print for some time. The Fordham University Press has now undertaken the publication of the Proceedings of these Institutes as a series in Pastoral Psychology. The best papers from the first two Institutes will be gathered together and will ultimately form Volume I of the series. The present work, which contains the papers delivered at the 1959 Institute on the topic of Addiction, is the first to be published, although it is actually Volume II in the series. A third volume, containing the papers from the 1961 Institute on the Clergy and the Teenager, will be published shortly.

Having determined upon addiction as the topic for the 1959 Institute, and having decided to give consideration to this question in

its two forms, namely alcohol and drug addiction, the Committee set to work to secure the best people obtainable to present this material. I think it will be agreed that a truly distinguished faculty was assembled for the Institute.

Because of widespread misconceptions with respect to alcohol addiction and because of simple ignorance in the matter of drug addiction, prevalent even among the clergy, it was more than ordinarily necessary to start in this Institute with a solid foundation of facts, as far as they could in any sense be ascertained. Etiology and background factors were first presented in both the alcohol and drug sections of the Institute; the personal, familial, social, and economic consequences of addiction were considered; and finally control, treatment, and presentation were discussed. Because of the nature of the Institute and the audience for whom it was intended, special attention was directed to the role of the clergyman in all of these presentations. Since alcoholic addiction is unquestionably the more frequent pastoral problem, it was accorded the first two-thirds of the Institute time, while drug addiction was considered in the final portion.

An addict is one who habitually uses and has an uncontrollable craving for an addicting drug. The alcohol addict, consequently, is an individual with an uncontrollable craving for alcohol. Usually such addiction develops as the end product after a long period of excessive drinking. Chronic alcoholism and alcohol addiction are properly distinguished, but they are nevertheless usually found together for the reason that one almost inevitably leads to the other. They combine in practice to produce what is popularly and not inappropriately known as "the alcoholic," an individual in whose case drinking interferes with normal living, and who, at the same time, cannot stop drinking.

It is evident that the alcoholic as thus defined is a pastoral concern, but it is also clear that he is only the focal point in a much broader problem. He himself did not become an alcoholic overnight, and there is usually an antecedent period of excessive drinking, more or less protracted, with its inevitable pastoral problems. The family of the alcoholic is also involved, and is forced to live in a difficult and unpredictable situation, continuing month after month, sometimes year after year, with the result that other members of the family are often as much in need of counsel and advice as is the alcoholic. All of them are likely to turn, at some time or other, to the clergyman for help.

Apart from an understanding of alcoholism as a disease (Father

John Ford, S.J., in his paper calls it a triple sickness of body, mind and soul), and apart from its many-faceted effects, two focal points stand out in the discussions on alcoholism presented in the following pages. These are, respectively, prevention and treatment, and in both of them the clergyman has an important role to fulfill.

We need to give a great deal more attention than we have in the past to the development of proper attitudes toward alcohol, its use and abuse, particularly on the part of our young people. This is a pastoral concern of the first magnitude, and in this connection Father Ford pleads eloquently for the cultivation of the Christian virtue of sobriety. The second focal point is the treatment of the alcoholic. In the acute stages of alcoholism the treatment must first of all be medical, but this is only a first step. After he is dried out, the alcoholic must be helped to face up to a future *without alcohol.* There is no other single point on which our experts are in greater agreement than the fact that the genuine alcoholic cannot drink—ever. The pledge, that traditional resort of the Catholic clergy in dealing with the alcoholic, is presented as being largely ineffective, but a number of our contributors have warm and even enthusiastic praise for the approach offered by Alcoholics Anonymous.

While the average clergyman may be assumed to have some knowledge of alcoholism and some experience, perhaps, in dealing with alcoholics, he is likely to have little or no information about drug addiction, and he may say that, thank God, he has had no experience with drug addicts. However, we have in our country at the present time more drug addicts than in any other Western country, despite 40 years of prohibitory laws, and the extent of drug addiction among teenagers in certain of our larger cities is attaining proportions which are truly alarming. It seemed, therefore, to the Committee that drug addiction was a topic about which the clergy could not afford to remain uninformed, and it was consequently made the subject of consideration in the final portion of the Institute.

Narcotics, which are at once a blessing and a bane, invite a curious ambivalence on the part both of the individual and of society. Medical use of narcotics for the relief of pain is a practice which receives universal approbation, but addiction to narcotics on the part of the individual leads to personal tragedy and social ills of catastrophic proportions. This basic ambivalence is reflected in the inability of even well-informed public opinion to decide whether drug addiction is to be treated as a crime or a disease. It will be seen that the experts, whose viewpoints are presented in the following pages, are

divided on such a question as the control of narcotics and as to whether our prohibitory legislation may not be more harmful than beneficial.

The reader of the following pages will perhaps find that some of his antecedent impressions of drug addicts are erroneous. It will be seen, for instance, that drugs do not produce "sex maniacs," but that, on the contrary, narcotics so depress sexual impulses as to create a sharp inverse relationship between drug addiction and sexual drive. Neither are drug addicts given to crimes of violence and assault against people. They may indeed be driven into criminality to support their habit, but their crimes are characteristically those of theft and shoplifting, rather than assault and armed robbery. Finally, the teenage addict is seldom the victim of a shadowy dope peddler, but is characteristically introduced to drugs knowingly either out of curiosity or out of a desire to be like the rest of the gang. The majority of those who turn to drugs do so, at least initially, for the same reason that others turn to alcohol, namely, because of personality limitations and because without such help they feel unable to meet the demands of life.

As editor, I am happy to pay grateful tribute to my fellow Committee members already named and to two others, who served on the Committee for the Institute on Addiction, namely, Rev. John J. McCarthy, S.J., Psychiatric Case Worker at Catholic Charities Guidance Institute, New York, and Rev. Elbert J. Rushmore, S.J., Assistant Professor of Theology at Fordham University. Many Committee meetings were needed to plan for the Institute and grateful acknowledgment is paid to these men for their generous donation of time and for the thinking which they contributed to the planning and conduct of the Institute. I was aided in some of the earlier editorial work on the volume by Father Keegan and Doctor Schneiders.

Appreciation is also expressed to the Institute faculty, all of whom are busy people who found time for the Institute only at a personal sacrifice. Genuine gratitude is also expressed to the New York State Department of Mental Hygiene whose financial support helped defray the expenses of the Institute and contributed toward the publication of the present volume. It is a pleasure finally to acknowledge the contribution of the Fordham University Press which, through its Director, Rev. Edwin A. Quain, S.J., is making possible the publication of the Institute Proceedings as a series in Pastoral Psychology.

March, 1962 William C. Bier, S.J.

PART I

ALCOHOL ADDICTION

The Problem of Alcoholism and Excessive Drinking

YVELIN GARDNER

Yvelin Gardner is Deputy Executive Director of the National Council on Alcoholism. His A.B. degree is from Harvard University. He has been nationally active in the field of alcoholism since 1947, and has lectured on this subject at the Yale School of Alcohol Studies; Teachers College, Columbia University; and the Utah School of Alcohol Studies of the University of Utah. He has also served as consultant in the establishment of alcoholism programs in the Health Departments of Maryland, New York, and Pennsylvania, among others, and continues to activate similar state-wide programs. He is a member of the American Public Health Association and the National Conference of Social Work. Among his nationally circulated articles are: "What the general practitioner can do about alcoholism," "Modern advances in the field of alcoholism," and "How to plan a clergy conference on alcoholism." Mr. Gardner is an ordained minister in the Episcopal Church.

There is an extended statement by Dr. Ruth Fox, which so graphically describes the insidious influence of alcoholism that I have chosen to use it to indicate at the very beginning of this important Institute, the nature and magnitude of alcoholism. Certainly it warrants the time we are planning to give it, and certainly is it logically to be

included in any institute devoted to a study of addiction. The quotation from Dr. Fox runs as follows:

> If some new and terrible disease were suddenly to strike us here in America—a disease of unknown cause, possibly due to a noxious gas or poison in our soil, air, or water—it would be treated as a national emergency, with our whole citizenry uniting as a man to fight it.
>
> Let us suppose the disease to have so harmful an effect on the nervous system that five million persons in our country would go insane for periods lasting from a few hours to weeks or months and recurring repetitively over periods ranging from fifteen to thirty years.
>
> Let us further suppose that during these spells of insanity, acts of so destructive a nature would be committed that the material and spiritual lives of whole families would be in jeopardy, with a resultant twenty-five million persons cruelly affected. Work in business, industry, professions, and factories would be crippled, sabotaged, or left undone. And each year more than one and one-quarter billion dollars would need to be spent merely to patch up in some small way the effects of the disease on families whose breadwinners had been stricken.
>
> Finally, let us imagine this poison or disease to have the peculiar property of so altering a person's judgment, so brainwashing him that he would be unable to see that he had become ill at all; actually, so perverting and so distorting his view of life, that he would wish with all his might to go on being ill.
>
> Such an emergency would unquestionably be classed as a country-wide disaster, and billions of dollars and thousands of scientists would be put to work to find the cause of the disease, to treat its victims, and to prevent its spread.
>
> The dread disease envisioned above is actually here. It is alcoholism (Fox, 1959, pp. 1-2).

Another well known doctor who has indicated the tremendous costliness and magnitude of the problem of alcoholism is Dr. William C. Menninger who has stated: "If alcoholism were a communicable disease, a national emergency would be declared" (Menninger, 1957, p. 10).

Although today it does seem quite natural for the subject of alcoholism to be given a clinical and scientific exploration on a formal professional institute program for the better part of a week, nevertheless, only a very short time ago it would have been impossible to have obtained the sponsorship of a great university, the personnel for conducting the Institute, and an interested audience eager to register and participate. It is for this reason that those of us who are devoting our lives to full time work in the field of alcoholism experience more than ordinary feelings of satisfaction to observe such a program as this and to share in it.

As the initial speaker at the week's conference, I think it is my charge briefly "to paint a broad backdrop" for the more specific discussions which will follow—and at the same time indicate some of the developments from which today's state of knowledge and information stems.

EARLY ATTEMPTS AT CONTROL OF ALCOHOLISM

We know that alcoholism is not a new problem. We know, too, that ever since man discovered that the fermented juice of the grape produced certain pleasurable sensations, the custom of using alcoholic beverages has become entwined in the fabric of social custom among many races and nations. As this custom has developed over the centuries there has always been a small percentage of individuals who have reacted differently to the intake of beverage alcohol sufficiently to be a concern of communities and families. This group seems to have averaged about six percent of those who have used alcohol. And all this while concerned persons have sought a remedy for dealing with the problems which these abnormal drinkers have presented.

As action developed, the problem came to be placed in the hands of the church and the law. It was natural for a problem which affected man's spiritual well-being as well as his physical health, to be brought to the clergy for solution. And, families, as well as alcoholics, in their desperation, naturally turned to a loving priest or pastor in hopes of finding effective help in dealing with this problem. Unfortunately, with no basic knowledge as to the true nature of this problem, all that could be done would be perhaps to deal with the matter on the basis of morals, and to moralize with the victim. For it was natural, without today's knowledge of the condition, to feel strongly that it was a moral problem. Without an understanding of the complicated emotional factors and deeply rooted tensions, anxieties, and insecurities which we now know to lie behind the chronic excessive drinker's reaction to alcohol, the futility of expecting abstinence from alcohol without help and therapy was not realized by counselors in those early years. Rather, in the days of no information, no research findings, and no investigations, it was but logical to assume that, if a person would but "mend his ways," abstain from alcohol, and grow in strength of character, he would find no more trouble with drink.

If, as was more often than not the case, the ministrations of the

church and clergy failed and the condition progressed, the victim was turned over to the law. The victim by now had become a culprit. As the condition worsened, it inevitably reflected itself in a growing pattern of antisocial behavior. And since a person whose deviant behavior indicated failure to stay within the bounds of accepted conduct, it was natural that he should be punished. And so, many of these persons who developed an addiction to alcohol came into the province of the courts, jails, and institutions. I wish it could be said that this approach was of historical interest only and that modern day treatment no longer reflects this practice. But, alas, it must be said that it still exists in many areas.

In the middle of the nineteenth century, the per capita use of rum and whiskey, the heavily-proofed distilled spirits, was greater than it is today. While it is true that today we have more beer drinking, and while there are more people who drink alcoholic beverages, the per capita use of heavy spirits in that century was greater than it is now. Keller tells us "in 1850 almost 90 percent of the absolute alcohol consumed in this country was in the form of distilled spirits and hardly 7 percent in the form of beer, but by 1950 only 38 percent was in spirits and 51 percent in beer" (Keller, 1958, p. 3). This condition gave rise to the temperance movements, whose first purposes were not to do away with alcoholic beverages, but to guide in the temperate or moderate use of alcoholic beverages. This was indeed a natural approach at the time, for little, if any, was known about the body tolerance to alcohol, varying individual reactions to drugs and depressants (as we know alcohol to be), and certainly no studies were available in those times as to psychic reactions and releases resulting from alcohol intake, nor the psychological factors often motivating the intake of alcoholic beverages.

Here again action was predicated exclusively on the basis that one's reactions to the intake of alcohol were entirely controlled by character and will power. These efforts were the only avenues for dealing with this particular problem, in view of the status of knowledge of the condition in those times. Therefore, we cannot be too critical of these approaches, merely because in the mid-twentieth century we have become accustomed to evaluating behavior and conduct in the light of environment, heredity, early family influences, and sociological as well as psychological factors. I think we shall all agree that our modern knowledge and such advances as we have made in the particular field of alcoholism could only have come

about as part of the general knowledge developed in the fields of medicine, psychiatry, and the social sciences. Such knowledge in this modern day leads us to deal with individuals as "whole persons" in what has come to be called the "holistic" approach to medicine. Even with these tools, our advances are only beginnings, and there is still much to be learned in this field.

With the growth of the temperance movement, total abstinence became the ultimate goal, and total abstinence by *all* would be necessary to eliminate alcohol, at this point considered to be the sole cause, the sole agent, of destruction of the individual, his personality, his health, and his soul. These efforts culminated in the legal sanctions imposed by the Prohibition Act in 1918 which was ultimately ended by repeal in 1933.

Today, looking back, it is easy to see why the approach of "abstinence for all" did not succeed. We can observe the fact that the use of spirituous beverages had become so closely entwined and ingrained in the customs and mores of peoples and races, that it could not be eliminated merely by imposing sanctions, legislative or otherwise. It was a custom deeply involved in the emotions of people. It was involved in ceremony and custom, in religious rites, in traditional usage. The signing of contracts was often attested to with wine; in the days of the gladiators, the intake of wine symbolized replenishment of blood; in marriage, on birthdays, and even in the Jewish rite of circumcision, wine drinking had developed a ceremonial use which was deeply traditional. Thus, when some 94 percent of a population which utilized this social custom, with its emotional implications, was asked to reject and relinquish it because of the depredations of six percent of the population, they refused. And thus the efforts at prohibition for all, of necessity were doomed to failure. Still the problem was growing in magnitude. As the population increased, and more persons gradually reached adulthood, the number of persons who chose to follow the social custom of drinking alcoholic beverages increased proportionately. What could be done?

MORE RECENT APPROACHES

The beginnings of modern findings and new knowledge of present day action and approaches can be said to have begun in the year 1935 when two significant events took place. First, in the

Laboratory of Applied Physiology at Yale University, two doctors determined to do exhaustive research on the effects of alcohol on the human body. This decision was the beginning of the broad "Yale Plan on Alcoholism," which quickly added two out-patient clinics for clinical treatment and research, a summer school of alcohol studies, the largest bibliography on alcohol studies and alcoholism material yet assembled, and the publication of the *Yale Quarterly Journal of Studies on Alcohol,* in which nearly all known activities and investigations in this field were recorded. Articles were sought from scientists and professional people doing work in various areas of basic research, psychological studies and investigations, and in the area of social science. The Yale activities gradually inspired some other medical centers to undertake investigations as well.

While the scientific studies were beginning to produce findings, two men in Akron, Ohio, in the same year, started the movement known as Alcoholics Anonymous. These two men, alcoholics who had been through the progressive process of alcoholism, felt that alcoholics who were shunned in everyday society could form a society of their own in which they could find understanding, and perhaps aid one another to attain sobriety and useful lives again.

The interesting fact in these parallel developments is that the basic findings of the scientific students of this subject were producing the same type of evidence that the living recoveries in the groups of Alcoholics Anonymous were bringing to light. Certain basic facts as to the nature of this problem, reflected in the "before" and "after" of the problem drinker's career, were becoming evident. And so, by the fourth decade of this century, we began, for the first time, to have evidence that certain basic factors are involved in the condition which typifies the person who, in the old days was known as the "chronic inebriate" and today is called the person with alcoholism —a person with an addiction to alcohol.

We must acknowledge that one of our great problems in this field is that of definition. Semantics have sometimes caused us more confusion than would ordinarily be involved with investigations leading to the control and prevention of a major health problem. Efforts are underway to clarify the nomenclature in this field, but there is basic agreement that the condition, which we are studying as part of our week's deliberations on problems in addiction, can be described clearly enough to give us a satisfactory working basis for more specific discussions.

CURRENT UNDERSTANDING OF ALCOHOLISM

The generally accepted definition has been given by the World Health Organization: "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 (World Health Organization, 1952, p. 16). We can now see that the traditional concept of the "inebriate" or "drunkard," as a weak-willed creature who desires to drink for the pleasurable sensations derived therefrom, as one with little potential for constructive living, is disappearing. For, as this condition received the study and attention of more and more members of the professional disciplines, evidence developed that there were components in its nature, which had been completely overlooked prior to the last few decades.

While the etiology of this condition is not finally and clearly defined as yet, investigations, and the evidence of over 200,000 living recoveries, have given us a pretty clear picture of this particular condition, and there are certain areas of agreement among specialists from the various disciplines, in describing its complex nature. It is generally agreed that alcoholism is a disease with physiological, psychological, and spiritual components. We do not have any evidence to indicate that certain persons are "alcoholism-prone," physiologically, and thus we cannot say whether or not certain individuals gradually lose their capacity to absorb alcohol in the system and "use" it as they once might have done and as the person known as the "normal" or "social drinker" continues to do. But there does come a time when the intake of one drink of a substance containing alcohol will set up a reaction which calls for a continuing intake far beyond the original intent of the user. This indicates the development of a physical dysfunction. Although the area of this dysfunction has not yet been located organically, there seems to be little doubt that the habituation process, typical of addiction, sets in. Jellinek (1959) suggests that a "tissue adaptation" of the sort noted in the development of the addiction to morphine and other strong narcotics takes place.

Another area of general agreement is the fact that deep emo-

tional factors are involved, when a person gradually and progressively becomes dependent upon alcohol to the point of addiction. It is generally agreed that the person with alcoholism drinks to relieve pain. This may be "social pain" involving awkwardness, shyness, and difficulty in relating to others in the group; it may be chronic physical pain; but most of all, dependency on alcohol seems to come through the motivation of using alcohol to relieve "psychic pain." Usually, the emotional maladjustments involved, which call for release through the use of alcohol, stem from early experiences in childhood, insecurities and anxieties during adolescence, which more often than not involve a broken or disturbed home situation. Thus, we have underlying causative factors which existed, prior to the intake of the first drink of alcohol.

With a new and progressive condition developing, the problems of alcohol are superimposed on this personality structure. We find a new condition, known as the syndrome of alcoholism, developing with its own characteristics and identifiable symptoms. Thus we have the alcoholic concerned with the immediate problems developing through his drinking episodes—possible loss of home, shaky job situation, new aches and pains from chronic overindulgence in alcohol and lack of nutrition, financial worries and debts, etc. He must first receive aid and surcease from these anxieties and pains. When, with abstinence and proper initial guidance, he is able to face these problems stemming from drinking, he must then, through long-term treatment, adjust the basic emotional immaturities, the latent neuroses, fears, anxieties, etc., which are the primary factors in his addiction.

Finally, and this, of course, relates us to the province of the clergyman, the inroads of alcohol over a period of years, superimposed on this insecure personality structure, have made the person with alcoholism very sick in another and most vital area of his being—the spiritual area. If he is physically in need of help, if he is psychologically maladjusted, and distraught, now indeed is he spiritually depleted and bereft. The fears and hopeless feelings of the person enmeshed in the disease of alcoholism are frightful to behold. And, making it more difficult for the therapist or pastoral counselor is that this disease seems to provoke a blindness in the patient which makes him unable to admit at least, unable even to recognize, the erosive progress of the condition.

TEAM AND COMMUNITY APPROACH

Thus it is possible now (as we recognize the tripartite nature of alcoholism), to see why treatment, directed to only one of the three equally important areas in need of healing, would be unsuccessful. A physician would naturally direct his attention to the immediate physical and medical needs of the patient and he could indeed put him in a condition of physical well-being. It is not his province, however, to deal with the underlying tensions, drives, and frustrations which lead to the mounting stress within the patient and ultimately to his resumption of drinking. The psychiatrist, in the tradition of psychiatry, concerns himself with the underlying factors and looks upon the drinking behavior and the alcoholic syndrome as a mere symptom. It is the psychiatrist's belief that, if the emotional maladjustments could be thoroughly removed, the symptom of excessive drinking should also disappear. Finally, as the mediator of God's love, the concerned priest directs his ministrations to the sick soul of the victim—and while it is true that spiritual conversion has restored numerous victims of this ailment, how much more successful have our clergy been since they have allied their efforts with other professional skills.

And so, today's most effective efforts are undertaken basically on the structure of a "total push." Not only does this disease affect and invade all areas of the human personality, but it invades all areas of the community. It is involved with the courts and law enforcement groups, with the family service agencies, with the doctor's office, with the pastor's study, with the hospital wards, with the mental health clinics and child guidance services. By virtue of its many social implications and the fact that community resources are involved with the problem, much more so than with most health problems, a team approach is vital for long-term success in bringing about ultimate prevention and control of this vast problem.

The National Council on Alcoholism has for fifteen years endeavored to bring communities a blueprint for action for the development of this team approach within the community. Happily we can say that over sixty major community areas in the country now have committees or councils on alcoholism which ally members of the various professional groups, together with others, in a program of education, prevention, and rehabilitation. Resulting from these volun-

tary activities, tax-supported efforts have been extended to the point where some 38 states now have appropriated funds for state programs on alcoholism which deal with study and surveys, large scale rehabilitation and treatment, and some research.

Universities are now putting on summer schools and institutes for graduate and professional people. The Universities of Utah, Colorado, Texas, Wisconsin, Indiana, Mississippi, and South Carolina, among others, have all followed Yale University's lead in providing a summer school of alcohol studies. Certain divinity schools and seminaries have installed alcoholism courses in the curriculum during the summer months. Other special institutes, such as the one here at Fordham, are being conducted for special vocational groups.

New information and techniques are being given to our teachers included in the manuals of our public schools, so that our key area of prevention, which lies among our young people, can be strengthened and made more effective. This year the Women's Auxiliary of the American Medical Association, the United States Junior Chamber of Commerce, and the General Federation of Women's Clubs have all made alcoholism their health project for the year. The American Medical Association not only has an effective committee on alcoholism, but is now providing a proposed curriculum for the teaching of alcoholism in medical colleges. The American Public Health Association recently announced the formation of its own committee on alcoholism.

To me perhaps the most outstanding and stimulating statement of principle which has come out in recent years has been the pronouncement adopted by the General Board of the National Council of Churches of Christ in the U.S.A., and issued February 26, 1958, which read as follows:

> Alcoholics are persons in need of diagnosis, understanding, guidance and treatment. They are especially in need of pastoral care and the divine love which the church can bring them. There need be no condoning of their behavior, but neither should a church permit its antagonism to alcohol to prevent its offering an effective ministry to alcoholics and their families. Ministers and churches should not be content merely to direct alcoholics to treatment centers.

The above statement propounded by denominations, many of which have strong total abstinence doctrines and tenets, indicates that, without any compromise on their basic beliefs concerning drinking, they have come to recognize that the person with alcoholism suffers

from an addiction to alcohol and should be regarded and treated as a *sick person.* In the aggregate these gains on all fronts in the treatment of alcoholism as a major health problem are very heartening, but much still remains to be done.

The clergy has invariably been the most concerned group, and the group most interested in utilizing new tools and benefiting from new findings in this field. Whenever we establish new community voluntary programs, we can rely on the clergy to be among the first to come forward and serve as active workers in getting the program underway. Certainly the clergy, who are in a unique position in ministering to the needs of the alcoholic as effective pastoral counselors, should know how and when to refer a case to the proper resource. And at last, today, the church and its clergy have many willing and skilled allies with whom to team up and through whom their own efforts can be made much more effective. They will not have to do the job alone any longer, and not only have their own techniques and skills been improved, but they are allied with a growing number of resources. As the days go by this week, you will discuss techniques for counseling, effective measures for prevention, the nature of various resources available to you in meeting this problem as well as ways and means of working in a community or team approach.

I can only say, in closing, that this is indeed a matter which challenges the skills and powers of members of the clergy. We are indeed making progress, as can be attested by the fact that the average age level of those seeking help, in the groups of Alcoholics Anonymous and the many out-patient clinics, is well below that of ten years ago. While dealing with this problem calls for much patience and perseverance, nevertheless there are perhaps no greater satisfactions than seeing the person who has once been able to hold his head high in the community, and who has drifted downward through the erosive effects of alcohol, rise again from defeat and resume his place in the community. More often than not, we find he is a more effective person than he would have been without the crisis through which he has passed and which has resulted in a transforming process of personality change. I am sure that by the end of the week this conference will have sharpened your interest and concern as mediators of God's love, and will make you more effective pastors and community members.

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The Forms of Drinking

RAYMOND J. H. KENNEDY, S.J.

Father Raymond J. H. Kennedy, S.J. is Director of Adult Education and of Alumni Relations at Le Moyne College, Syracuse, N. Y. He holds an A.B. and an M.A. degree from Boston College, and a doctorate from the Gregorian University in Rome. Fr. Kennedy has studied at the Yale Center of Alcohol Studies and has interested himself in the problem of alcoholism for a considerable period of time. He is a member of the Board of Directors of the National Clergy Conference on Alcoholism, a member of the Board of Directors of the Onondaga (Syracuse) Committee on Alcoholism, and a member of the Committee on the Homeless Alcoholic of the National Council on Alcoholism.

As part of the Second Institute for the Clergy on Problems in Pastoral Psychology held here at Fordham just two years ago, Father John L. Thomas, of St. Louis University, participated in a panel which bore the general title: "Alcoholism and Other Factors." Father Thomas selected four categories of factors, which he called: Drink, Adultery, Irresponsibility, and Clash of Temperaments. To me it is very interesting that he used the term "Drink." He did not use the term "Alcoholism." It is also most interesting that the editors of the Proceedings of that Institute used as the title which tops every page of Father Thomas' presentation: "Marital Discord: Alcoholism."

Permit me to begin by quoting two paragraphs from Father Thomas:

> Drinking as such never appears alone in marriage breakdown. The excessive use of alcohol bears in its train serious consequences for the family. To be specific, alcohol in any form costs money, and its excessive use tends to hinder occupational advancement. It is not surprising, therefore, to find that drinking and non-support are frequently found together. Further, drinking often leads to abuse and physical cruelty. A good percentage of cases in this category allege drink and abuse as the main factor in the disintegration of the family. Another result of drinking is the association with doubtful characters of the opposite sex leading to the presumption of adultery. One often finds drinking and adultery linked together. At the same time, the excessive drinker tends to be a poor companion for wife and children. Although friendly when sober, his unpredictable episodes of drinking destroy the basis for true companionship and render the wider social life of the family precarious if not impossible.
>
> I have found that a good percentage of these cases cannot be classified as alcoholics in the usual definition of that admittedly somewhat vague term. Rather, they are periodic drinkers or "weekenders" capable of holding fairly steady jobs. Many of them boast that they have never missed a day's work! However, some spend much of their after-work leisure in taverns with the "boys"; others act as if they had an inalienable right to a "drunk" whenever they felt so inclined. In some cases, home conditions are such that the husband remains away as long as possible and eventually falls into the habit of drinking with the gang (Thomas, 1958, p. 47).

Your attention is called to the fact that the word "Alcoholism" does not appear at all in those two paragraphs and that the word "alcoholic" appears only once, and then in the cautious sentence: "I have found that a good percentage of these cases cannot be classified as alcoholics"—and he adds "in the usual definition of that admittedly somewhat vague term."

The accuracy of Father Thomas and the nodding of the editors points up the reason for this paper, whose title is not exactly a happy one. I have not been asked to discuss for you Scotch, Rye, Bourbon, Gin, or Rum, nor a Wine List or Cocktail Menu but rather to endeavor to distinguish for you those forms of drinking which can be classified under the term Alcoholism and those which cannot. This distinction is by no means merely academic, but rather one of major importance in counseling.

> Alcohol problems are often lumped together in the public mind with considerable resultant confusion. People think of pathological drinking and of getting tight at the Senior Prom and of drinking at all, for that matter, under the one comprehensive heading of "alcoholism."

> But the problems of pathological drinking, of occasional excess, and the possible problems involved in drinking at all, are very different and require entirely different approaches. It is a mistake to consider them all together, merely because they have one element in common, the use of beverage alcohol (Ford, 1958, p. 1).

It is my understanding that those who are participating in this Institute, clergymen all and of different denominations, are here to increase their competence as counselors, advisers, spiritual directors, and confessors. And it is basic in the field of alcoholism that we have defined in our own minds, as sharply as is possible with the present knowledge available, just what alcoholism is, and what are other forms of drinking which may be causing the difficulty which brought the counselee, client, or penitent to us.

With an interdenominational group such as this happily is, I should start, I think, by calling attention to the fact that the various churches have basically differing attitudes toward beverage alcohol. It is not my assignment here to assess, evaluate, praise, or condemn any of them, nor to defend or explain the Catholic teaching on this highly controversial subject. Whether your church is found in the camp of the Drys or of the Wets, whether you personally are a total abstainer or an occasional drinker, in guiding souls you have the obligation to improve your competence as a counselor in this very important subject and your very presence here is witness to your desire to do so.

MEANING OF ALCOHOLISM

We begin then with the fact that approximately 75 million Americans, 15 years and over, indulge at least occasionally in beverage alcohol. It is estimated that of these, some 5,200,000 have developed alcoholism. But what is alcoholism and what are other forms of drinking? Oddly enough, the second part of this question is far easier to answer with accuracy than the first. But let us tackle the more difficult problem of endeavoring to come up with at least a working definition of alcoholism and in the light of that definition, endeavor to evaluate other forms of drinking.

It has been said, not with cynicism but with obvious exaggeration, that there are as many definitions of alcoholism and the alcoholic as there are speakers and writers on the subject. The truth behind the statement is that our knowledge of alcoholism, though greatly advanced today over what it was a quarter of a century ago, is still far

from the point where a truly accurate, scientifically established, and philosophically satisfactory definition is possible. Bear with me then while I propose to you some of the better and more widely accepted descriptive definitions which are used today.

Dr. Robert Straus, author of the study: Alcoholism:

> Alcoholism can be described as a complex progressive syndrome, characterized by the chronic uncontrolled use of alcoholic beverages and by various symptoms of psychological, physiological, and social maladjustment (Straus, 1951, p. 1).

Dr. Selden Bacon, Professor of Sociology at Yale and Director of the Yale Center of Alcohol Studies:

> What is an alcoholic? Alcoholics may be distinguished from other drinkers primarily by the purpose for which they drink. Some people drink to fulfill a religious ritual, others in order to be polite, still others for a good time, or to make friends, to experiment, show off, get warm, or cool, quench thirst, or because they like a particular alcoholic beverage as a condiment or because they want to go on a spree. None of these is the purpose of the alcoholic, although he might claim any or all to satisfy some questioner. The alcoholic drinks because he *has* to, if he is to go on living. He drinks compulsively; that is, a power greater than rational planning brings him to drink and to excessive drinking. Most alcoholics hate liquor, hate drinking, hate the taste, hate the results, hate themselves for succumbing, but they can't stop. Their drinking is as compulsive as the stealing of a kleptomaniac or the continual hand-washing of a person with a neurosis about cleanliness. . . . From this statement alone it can be seen that alcoholism and drunkenness are different phenomena. All alcoholics exhibit drunkenness but many who get drunk are not alcoholics. For example, a college boy on a spree or a member of a group which drinks regularly (and usually to excess) on specific occasions such as holidays, reunions, Saturday nights, may or may not get drunk, but they are not alcoholics unless their drinking is compulsively brought about by some inner need or an unresolved conflict (Bacon, 1951, p. 4).

In the *Manual on Alcoholism,* prepared by the Committee on Alcoholism, Council of Mental Health of the American Medical Association, Dr. Jackson A. Smith of the Nebraska Psychiatric Institute and the University of Nebraska College of Medicine, writes:

> Any individual who relies on alcohol to meet the ordinary demands of living and continues to drink excessively after alcohol has caused him marital or occupational difficulty is an alcoholic whether he drinks only in the evening, has never taken a drink when alone, or has not touched anything but beer for five years (Smith, 1957, p. 53).

The Subcommittee on Alcoholism of the World Health Organization defines the condition as covering

> those excessive drinkers whose dependence on 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 development (World Health Organization, 1952, p. 16).

Dr. Oskar Diethelm, Psychiatrist-in-Chief, the New York Hospital, and Professor of Psychiatry of the Cornell University Medical College, New York states:

> A patient suffers from chronic alcoholism if he uses alcohol to such an extent that it interferes with a successful life (including physical, personality, and social aspects), and he is either not able to recognize this effect, or is not able to control his alcohol consumption, although he knows its disastrous results (Diethelm, 1955, p. 568).

To these five definitions, I will add one more, not by a sociologist, psychiatrist or man of medicine, but rather by a moralist whose reputation and eminence in this special field are internationally recognized, Father Ford. He offers the following definition in the article on alcoholism in the Supplement to the *Catholic Encyclopedia*:

> Alcoholism can be described as the condition of those whose excessive drinking creates serious problems in the management of their lives, and yet who usually are unable to stop drinking, even if they want to, without outside help.

Summarizing these definitions and adding a thought from that masterpiece of successful therapy in this field, the book *Alcoholics Anonymous*, I would say then that the characteristic elements of alcoholism are: 1) a pattern of excessive drinking, usually over a long period of time; 2) a physiological reaction to the ingestion of beverage alcohol which sets up a strong, even at times overpowering craving for more alcohol; 3) an intellectual obsession, present even when the person has no alcohol in his system, that life without liquor is either impossible or totally undesirable; and 4) serious problems of living.

It is evident, I think, that the condition spoken of by these various authorities, representing many different disciplines, is a pathological one which lies frequently within the competence of the medical practitioner, sometimes within the area of the psychiatrist, but always within the province of the priest and minister.

Father Ford in his pamphlet, *Church goals in alcohol education,* has written:

> There are millions of heavy drinkers whose use of alcohol exceeds clearly the bounds of moderation but who have not become involved in a degree of difficulty or degree of dependence which would classify them as alcoholics. They are an extremely difficult group to reach, partly, perhaps, because so many of them still seem to be getting more pleasure than pain out of alcohol. What can be done to reach them? We have a responsibility not only to alcoholics but to these other millions. . . . One of our goals should be to work out a practical program for reaching these heavy drinkers and bringing them back to the practice of sobriety. . . . It must be remembered that just as the total abstainer never becomes an alcoholic as long as he remains a total abstainer, so it is equally true that no truly moderate drinker ever becomes an alcoholic as long as he remains a truly moderate drinker. Obviously he is in greater danger of excess and of subsequent alcoholism. But it is not quite true to say that all alcoholics started as moderate drinkers. Actually all alcoholics started as total abstainers and some drank excessively from their very first drink. . . . I am convinced that it is the excessive use of alcohol itself which is the principal cause of alcoholism in any given case. It is the repeated toxic dosage that eventually results in alcoholism. If this is true, then prevention of excess, the mere practice of the virtue of sobriety, will result in preventing a great deal of alcoholism. This may sound rather obvious but apparently it is not obvious to everyone (Ford, 1958, pp. 3-4).

OTHER FORMS OF DRINKING

Apart then from the pathological condition known as alcoholism, the counselor or spiritual director should have clear notions of other forms of drinking. We hear the terms Occasional Drinker, Social Drinker, Weekend Drinker, Spree Drinker. We also hear of the neurotic drinker, the psychotic drinker, and occasionally we hear the term "Plateau Drinker." A few comments on each is in order, for certainly the advice to be given to one who has alcoholism will be worlds apart from that to be given to the others.

The Occasional Drinker. This term can be taken in two senses, first, referring to the man who drinks only on special occasions, such as weddings, christenings or when a toast is offered, and secondly, to the man who drinks rarely or, as we say quite indefinitely, "on occasion." Such a person will seldom if ever seek the advice of the clergyman unless both are members of a Church which condemns

drinking entirely. It is obvious, I think, that such a person is not suffering from alcoholism.

The Social Drinker. This person has a drinking custom quite different from the rather abstemious drinker just mentioned. I would like to call attention here to the superb publication of the Joint Commission on Alcoholism of the Protestant Episcopal Church published within the past year under the title "Alcohol, alcoholism and social drinking." Under the caption "Social Drinking and Changing Customs," we read the following:

> With rare exception, drinking in America is a custom involving more than one person. Solitary drinking is outside the limits of the custom and does not come within the definition of social drinking. Customs of this sort, requiring interpersonal behavior, must, if they are to persist, carry mutual rewards to the participants. In other words, if drinking is to be social, then the drinking by Mr. Jones must be rewarding to Mr. Smith and the drinking by Mr. Smith must be rewarding to Mr. Jones. The fact that Mr. Jones finds relaxation or a feeling of happiness from his drinking is secondary and almost irrelevant to this social function. . . .
>
> This view may help one judge the degree of "socialness" in a drinking situation. If the drinking by one person in the two or ten drinking together does not reward but even renders anxious one or more of the others, then to that degree the social character of the drinking is reduced. The party or the group is then tending to become a number of non-integrated persons, each involved in individualistic drinking practices. Drinking that occurs in a group is not necessarily social drinking.
>
> It is also true with occasional exceptions that the drinking custom in America is connected with some other social activity which is primary to the interests of the drinking group. Ordinarily people who drink do so at a wedding, at a meal, when greeting a friend, at a party, after a meeting, or with some other leisure-time activity. In these instances the drinking is definitely secondary. In other words the function to be served, whether it is celebrating or eating or commiserating or playing, is the major function and it could be achieved, though perhaps not with such rewards for these persons, if no drinking occurred at all. . . . On the American scene drinking as the central purpose and the main function of a gathering may be viewed, with rare exception, as a deviation from custom. But customs change, and persons with a Christian concern for alcohol problems may well ask themselves if the customs of using alcoholic beverages in America are tending to change from a secondary position to a primary one. For example, is the cocktail offered prior to a business luncheon becoming the major item of that luncheon instead of an introduction? At an evening party

> at home for relaxation with friends, is the host becoming more and more of a bartender, continuously and anxiously filling all glasses during the party and urging one last libation at the time of departure so that he hardly completes a conversation and at the evening's end has found no relaxation at all? When friends gather together, is fishing, golfing, bowling, dancing, or listening to music the main purpose for the occasion, or is drinking being pushed forward to the point where it starts earlier, where it readily interrupts the previously major function, or where, if it were omitted, the joint activity would be considered a failure? When asking the question "what is social drinking?" it is useful to keep in mind the relative importance of alcoholic beverages to these and other similar social customs. It is not enough to state that offering cocktails to people coming to one's home for dinner is "social drinking." One must also state the degrees of purpose, of duration, of amounts, of timing, of emotional investment by participants, even of cost, and of many other aspects of the drinking in comparison to other concurrent activities of the gathering. If, as seems the case to many observant Americans, the custom of drinking is changing, then the opinion one might have held about social drinking twenty or one hundred years ago is hardly pertinent to the current situation (Protestant Episcopal Church, 1958, pp. 13-15).

Certainly, regardless of our ecclesiastical affiliation, all of us should feel gratitude to the Joint Commission of the Episcopal Church for this excellent statement. I would strongly urge all participants in this Institute to obtain a copy of this publication. All counselors, spiritual directors and confessors will profit by its attitudes and suggestions.

Father Ford has expressed deep concern about our American drinking customs:

> Education in true moderation would help to change some of the dangerous drinking customs which exist in this country. A degree of excess which is definitely contrary to the virtue of sobriety, and would be excluded even by social standards of good taste and civility in other parts of the world is still socially acceptable and rather taken for granted in many circles here. The immature search for excitement, thrills and the more violent effects of alcohol has, in the opinion of many, a causative relation to our high rate of alcoholism. Our social customs sanction or at least tolerate the habitual use of an easily available chemical in toxic quantities. The medical scientists tell us that such customs are incompatible with sound bodily and mental hygiene. The theologians tell us that such customs are incompatible with the practice of the Christian virtue of sobriety. There is remarkable agreement between the principles of hygiene and the principles of morality. Here we have an immense and fertile field for religious education (Ford, 1958, p. 5).

The Weekend Drinker. When we come to the Weekend Drinker and the Spree Drinker, we are beginning to approach once more the

area of alcoholism, if not actual, at least potential (or, to put it less technically, if not obvious, at least suspicious). Through the research done at the Yale Center and through the many excellent popular publications of the National Council on Alcoholism, it is a fact becoming more and more widely known that the vast majority of the alcoholics of America are still working and living with their families. Their alcoholism has not advanced sufficiently as yet to have cost them the loss of their jobs, their homes, their families. They comprise the many thousands of "Monday Absentees" who so plague our industries today and they have been referred to in many lectures and articles as "The Hidden Alcoholic" and "The Half-Man in Industry." On both the executive and the labor levels they are the men who start their drinking on Friday afternoon or evening, and maintain it, with varying rates, over Saturday and Sunday. As this pattern continues and progresses (as it inevitably does, if true alcoholism is developing), Monday absenteeism begins to appear, or if they report to the plant or office, their efficiency is so lowered and impaired that they might as well have been absent. The term Weekend Drinker almost always means excessive drinking and (particularly if there is some underlying personality problem present also), the Weekend Drinker can usually be properly suspected of being at least in the pre-alcoholic phase of alcoholism, if not already in its early stages.

The Spree Drinker. Oddly enough, the Spree Drinker may be in an entirely different situation. Obviously, the Weekend Drinker is a Spree Drinker, in a sense, but this latter term is usually applied to those whose pattern of drinking is quite different. They remain drunk for days at a time, and then, sobering up on their own, return to normal living. They usually are impulsive personalities, not infrequently moody, who show an immaturity of emotional development in that they cannot make a normal adjustment to unusual situations. They get drunk deliberately, and so, cannot be excused of guilt, and they rationalize their episodes with such fatuous statements as "Every man is entitled to a drunk once in a while." Though they offer a problem to themselves, their families, and their employers, it is usually merely a problem of patience with an otherwise hardworking man of normal habits. The danger of developing alcoholism is always there, particularly because of their personality maladjustments, and the spiritual advisors should warn them of it, in addition to calling attention to their sin of excess and the consequent injustice and suffering which they inflict on their fellow-work-

ers, on whatever level, as well as on their families and dependents.

The Neurotic and Psychotic Drinker. The Neurotic and Psychotic Drinkers pose special problems. The former in that the spiritual director or counselor should be adept enough to recognize a neurotic condition when he is confronted with it, and if he finds the neurosis such that it is beyond his competence, he should make the proper referral to a trustworthy psychiatrist. The psychotic, of course, is entirely beyond his competence and should receive medical and psychiatric care at once. In both cases, should there be a drinking problem, the advance toward true alcoholism is almost inevitable.

The Plateau Drinker. This is a relatively new term in the field of alcohol problems, but one which has a very real meaning which should be clearly understood by all counselors and spiritual directors. It is a known fact today that most of the habitués of the Skid Rows of our great cities are Plateau Drinkers and not alcoholics. These are those unfortunate individuals frequently referred to as "social misfits," insufficient personalities who have adopted Skid Row as a way of life. They cannot face the realities of life without the anaesthetic effect of alcohol and have developed a technique whereby they can bring themselves to a semi-intoxicated state and maintain that state throughout their waking hours. They rarely, if ever, have a bad hangover, and are, even less rarely, completely drunk. Theirs is a state of being constantly "high," frequently "tight," but seldom drunk. Theirs is a state for which the true alcoholic longs but can never attain. They have no family or employment problems for the obvious reason that they have no family or employment. Panhandling is their practice, Welfare their Utopia. How many real alcoholics learning of their proficiency have sighed "They have it made!" They are known to get deliberately drunk with the advent of the first frost so that they might get heat, board, and lodging for the winter months at city or county expense, and they usually end their relatively placid days in the city or county home, where, their need for mingling with the normal population being absent, they spend a pleasant old age in the understanding fellowship of their peers. From a counseling point of view, they offer no problem for they never come for spiritual direction or advice, or if they do, it is for a rather obvious ulterior motive at the Salvation Army or the Rescue Mission. Otherwise "the man in black" meets them only with hands outstretched. I merely commend these unfortunate yet placid souls to your kindly prayers. Should any of the participants in this Institute desire further

information on this point, a wealth of material can be obtained from the Homeless Man Committee of the National Council on Alcoholism and from the studies which are published occasionally in Yale's *Quarterly Journal of Studies on Alcohol.*

A rather interesting and somewhat unusual example of the Plateau Drinker is in the employ of a Catholic religious house of my acquaintance. The man in question works alone there in the laundry, and has charge of the washing and ironing of all the linens, domestic and personal, of the thirty priests who reside there. For the five years of his employment he has never been drunk, never sober. He puts in a rather easy day's work, due to modern washing and ironing equipment and throughout the day maintains his placid way by regular drafts of wine. He has come to the state that he feels he cannot work or live without this; he has his steady job, his furnished room, his blessed bachelorhood, and never reflects on the futility of his life. There has been no progression in his drinking habits; he is no problem to himself or others; he smiles his pleasant smile through his alcoholic haze and does satisfactorily the work for which he is employed. What a blessing that a kindly Providence did not give him an analytic mind to apply to his own condition or he might have taken his own life years ago! Dr. Jellinek of the World Health Organization has suggested that the Plateau Drinkers be classified as "habitual symptomatic excessive drinkers" and clearly distinguishes them from "addictive drinkers."

Returning now, full cycle, to the man who has alcoholism, it is obvious, I hope, that he is the only addictive drinker in the group. It follows as a corollary, then, that the technique of the counselor will differ entirely in his case from the approach to be used with all the others.

SUMMARY

Summarizing, I would say that Problem Drinkers fall into three general categories: the alcoholic, the plateau drinker, and the others. The techniques to be used with these others are known to all of us. Primarily the help to be offered them is spiritual and the proven use of the pledge is certainly in order, making, of course, the usual allowances and taking the usual precautions of prudence. For the Plateau Drinker little can be done, since he is perfectly satisfied with his state and will rarely seek any spiritual advice or rehabilitation. But with the man who has or is developing alcoholism, a very spe-

cialized type of approach is required. Exhortation, scolding, threats, and pointing out the great harm which the drinker is doing and has done to himself, his family and his job—all these are not only out of place but positively dangerous. They lead the person to further drinking. The pledge has no place here at all. The immediate goal in therapy here is recognition of the fact that he *has* alcoholism. Yet, oddly enough, no one can point out that fact, so obvious to all others, to the alcoholic himself. There must be a process of self-diagnosis. For this an extremely useful tool for the clergyman has been worked out by a priest of the Diocese of Rochester, which he calls "The Priest's Do-It-Yourself Kit for Alcoholic Counseling." The kit contains a transcript of a lecture on alcoholism written by a doctor who is a specialist in this field, together with a step-by-step procedure for the counselor to follow in his interview with the alcoholic. I most strongly urge all participants of this Institute to obtain a copy (Collins, 1957). The steps in this procedure are: first, self-diagnosis of alcoholism; second, frank admission of the condition; and third, a sincere desire to do something about it. With these three steps behind him, the alcoholic is usually well on his way to rehabilitation and a life of happy sobriety.

Permit me to conclude this presentation with one more quotation. In the beautiful surroundings of the White Mountains of New Hampshire there assembles every June a group of clergymen of all denominations for the North Conway Institute on Problems of Alcohol and Alcoholism. Each year the group issues a statement of their conclusions and convictions concerning the subject of that particular Institute. Two weeks ago the Institute discussed the topic: "Pastoral Care of Alcoholics and Their Families" and I am sure it will be of great interest, possibly a real inspiration, for the participants of our Institute to hear a paragraph or two from this year's statement which was subscribed to by 69 men and women, clergy and laymen representing Catholic, Jewish, and thirteen Protestant groups from all over the United States and Canada. The statement reads, in part, as follows:

> Whether alcoholism be called disease, sickness, addiction, social problem, or sin, it demands attention. Recognition of the reality of the situation and effective means of meeting it are imperative, far more important than terminology because alcoholics and their families are worthy of compassion and in desperate need of help. . . . We have discovered that whether we believe it right or wrong to drink, we are agreed that alcoholism presents a special problem and that the alcoholic suffers from a situation from which he cannot escape without help.

> We can, therefore, regardless of our ecclesiastical ties, work together in our communities to provide hope and help for the alcoholic and the members of his family. We have learned that our congregations and clergy can effectively provide much of what the alcoholic and his family need. . . .
>
> The ministry of the church and synagogue is not limited to counseling but includes the utilization of all their resources—worship, the sacraments or religious duties, preaching, exposition of the Scriptures, the fellowship of the congregation, and pastoral visitation—for the assistance of the alcoholic and his family. Responsibility for providing hope and help for the alcoholic and his family does not, however, rest solely on the church and synagogue. Alcoholism is a community problem, and part of the function of the clergyman is to stimulate community action where it is lacking and support its maintenance and extension where it exists. . . .
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> We recommend that clergymen assist in the formation of and work with local committees on alcoholism. Pastor and rabbi can work with Alcoholics Anonymous, the most effective of all the ways in which alcoholics are being helped, and with the Al-Anon Groups, which provide similar assistance for families of alcoholics, always respecting the anonymity of their members, and we urge that parish houses and church buildings be made available wherever desired for A.A. and Al-Anon group meetings. . . . (North Conway Foundation, 1959, pp. 1-2).

In the name of all who are active in this fascinating field whether in research, therapy, or education it is most encouraging to find such institutes as these for clergymen of all denominations multiplying in so many parts of our country. I conclude by quoting once again from this year's North Conway statement:

> As we respond to God's love for us by love for and service to all men, we of the church and synagogue must include in our concern the alcoholic and his family. Because a primary need of the alcoholic is awareness of God's love for him, we have a special responsibility to minister in God's name to him (North Conway Foundation, 1959, p. 1).

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Social Effects

TERRENCE J. BOYLE

Terrence J. Boyle, who has devoted many years of his life to the study of alcoholism, came into this field through the study of law and social work. He has a law degree from Syracuse University, a master's degree in social work from the New York School of Social Work, and has earned a certificate from the Yale School of Alcohol Studies. At the time of the Clergy Institute in 1959, Mr. Boyle was Executive Director of the New York City Alcoholism Information Center. He left that post, as well as the joint one of Director of the New York Alcoholism-Vocational Rehabilitation Project, in the spring of 1961 to assume the position of Director of the Alcoholism Unit of the Ohio State Department of Health. He was one of the founders and served two terms as Secretary of the New York State Association of Committees on Alcoholism. In his new post, Mr. Boyle is responsible for planning and executing a state-wide program of education, research and consultation in the field of alcoholism for the State of Ohio.

The custom of using alcoholic beverages is apparently as ancient as the earliest period of recorded human history. Many reasons have been advanced for the persistency of this custom in our culture. Such explanations generally concern three types of drinking: social, excessive, and addictive or pathological. The distinctions, however,

have not been clearly defined. Social drinking, for example, suggests to some a relatively incidental social activity and well within the range of mild intoxication. To others and in certain cultures, occasional, excessive alcohol intake, or drinking to a very obvious degree of intoxication, may also be interpreted as social drinking.

Some individuals, although very seldom drinking to excess at any one time, habitually consume a spaced, daily ration of an alcoholic beverage sufficient to maintain a fairly consistent degree of intoxication. Such individuals are hardly to be classified as social drinkers. It also seems patently obvious that all those arrested for drunken driving and all those excessive drinkers to be found on the Bowery are not justly to be characterized as alcoholics. The man who customarily indulges in excessive drinking on Friday nights or at the close of his week's labor, except when such activity interferes with the attention required by other interests or obligations, is not necessarily an addictive drinker. In fact, he may never arrive at the stage in which the first drink of an alcoholic beverage is followed by an irresistible desire for more alcohol, or in which he experiences an uncontrollable, compulsive appetite for that first drink.

Drinking to the point of excess, particularly in a conducive social environment or situation, is alone, therefore, insufficient evidence of addiction. A fairly consistent pattern of excessive or abnormal drinking, however, strongly suggests a so-called "drinking problem." Such a conclusion becomes more obvious if the drinking involves an apparent disregard for personal consequences or the welfare of others. Among the significant changes to be noted, in addition to the increased consumption, unusual hours and character of the drinking, is a deterioration in social relationships and the tendency to substitute drinking for heretofore customary interests and activities.

Acknowledging such illustrative and typically progressive changes as symptomatic in nature permits a more comprehensive interpretation of alcoholism rather than a definition relying entirely upon positive addiction. The inclusion of the "drinking problem" area in our understanding of the term *alcoholism* increases the scope of counseling and therapy obligations in the direction of earlier and more favorable treatment opportunities.

Nevertheless, while the social effects of the advanced stages of alcoholism and excessive drinking without addiction are probably similar in many respects, the moral and legal issues involved and the remedies to be applied may be only relative. In other words, the

non-compulsive, excessive drinker may justly be held to a higher degree of accountability for the consequences of his behavior than the excessive, addictive drinker.

This is to suggest, therefore, that an interpretation of alcoholism which incorporates initial, symptomatic indications does not also assume the burden of rationalizing all violations or omissions with respect to normal personal and social responsibilities without reservation. In this respect the alcoholism may be compared by analogy to other diseases in which the degree of physical and mental liability is to be judged according to the stage of deterioration at the time in question. An adequate study of a specific drinking history, including related personal, emotional, and social implications, will usually disclose whether the drinking pattern is reasonably indicative of potential addiction, or a more advanced stage in which loss of control and/or drinking of a dependent character is clearly evident. In fact, by the use of such guides as *13 Steps to Alcoholism* (pamphlet issued by the National Council on Alcoholism) the drinker is enabled to make his own tentative diagnosis.

SOCIAL EFFECTS OF ALCOHOLISM

If it has not already been made apparent, may I re-emphasize that alcoholism affects all areas and segments of our society. The common denominator is alcohol, whether obtained from champagne or cheap wine. The label also remains the same whether the immediate, acute aftermath stage is spent in a private sanatorium or in a lonely hotel room.

Yet, I can assure you that the idea persists in many quarters that alcoholism is exclusively a "skid-row" problem. Actually, as reported by the National Council on Alcoholism, while probably 30 percent of the skid-row habitués are alcoholics this percentage is only 3 percent of our total alcoholic population. I also recall a few years ago reviewing the records of 200 alcoholics whom I had counseled and found that less than 30 percent had ever been arraigned for public intoxication or any other offense.

Viewing the magnitude of the problem of alcoholism in this country, we should be shocked at the revelation that there are close to 5,000,000 alcoholics in various stages of this illness. The United States leads the world in the rate of alcoholism per 100,000 population, approximately 4,400 as compared to less than 3,000 for France.

Incidentally, California has the greatest number of alcoholics, New York ranking sixth.*

In our national economy: ". . . it seems reasonable to accept two million workers as an authoritative guess of the number of employed problem drinkers" (Trice, 1956, p. 10). The cost to industry in terms of absenteeism and other labor losses is roughly estimated at a billion dollars annually.

> The Uniform Crime Reports for the United States, issued recently by the Federal Bureau of Investigation for 1956, disclose that in 1551 cities of over 2500 . . . 40 percent or 842,415 (arrests) were for alleged drunkenness. This figure does not include arrests for disorderly conduct which totaled 241,167, a portion of which were undoubtedly for drunkenness (Kruse, 1957, p. 23).

Such statistical information is sufficient to attest to the magnitude and seriousness of the social effects of alcoholism in this country. There is also a considerable amount of similar data on social consequences that might be added. But, what is the meaning of alcoholism and the significance of such data in terms of the individual alcoholic, his family, and our community? How can we identify the social effects of this socio-health problem at the level of our more immediate relationships?

The answers to these questions might be adequately disclosed by further reference to investigations and research reports. But I would prefer to discuss the social implications of alcoholism in terms of the typical alcoholic and his environmental relationships, adding a sense of reality out of my own professional contacts. Experience and studies to date make it possible to offer a fictional reproduction of a typical case history, including related social and environmental reflections.

FICTIONAL CASE HISTORY

Joe Alcoho, as we shall call our composite alcoholic, is 43 years old, and therefore within the typical age range of 35 to 50 (Trice, 1956). He is married and lives with his wife and two children in the home they purchased about ten years ago. There is a mortgage on the house which has become more threatening these past few years.

* A more recent report issued by the Office of the Commissioner on Alcoholism for the state of Massachusetts, *Highlights for 1958* (739 Boylston Street, Boston 16) ranks New York fourth among the states and our nation second to France.

After short term jobs for two or three years, following the termination of formal schooling, Joe went to work for his present employer. Consistent with the fairly typical employment histories of a large percentage of alcoholics (Straus and Bacon, 1951), Joe's employment record appears surprisingly stable, nearly twenty years with the same company. He started working in the shop and was gradually advanced to a white collar job in the front office. In fact, some of his fellow workers claim that Joe would have been an officer in the company were it not for the "booze."

In any case Joe has not received a promotion nor a substantial wage increase in about five years. Instead he has been "called up on the carpet" several times, since his immediate superior was no longer able to "cover up" for him (Trice, 1959). Joe has received several warnings about his frequent absences, prolonged lunch hours, "shakiness," and irritability when reporting for work some mornings, increasing evidence of unreliability on the job, etc. Only the fact that he has been with this locally owned company for so many years, and is remembered for the number of improvements he contributed to the manufacturing of their product, has delayed the final separation notice.

Joe had his first drink, in a place other than his home and in the company of persons outside the family (Trice and Pittman, 1958), near the end of his junior year in high school. The following year the group of boys with whom Joe associated became accustomed to having a few beers, especially during the weekend or in connection with a party. His contact with these friends was temporarily interrupted following graduation and during the year he spent at college. Joe soon lost interest in the life of a student, however, regarding the lack of money and other sacrifices required as being too great a price.

Back in circulation again and now a wage earner, Joe soon reestablished contact with the "old gang," adding new members from among his associates at work. Drinking now became a part of their recreation, but the emphasis was on a sociability basis; they rarely became seriously intoxicated. After marriage Joe continued social relations with his old friends. He occasionally stopped with fellow employees for a few drinks after work and, of course, beer in connection with their weekly poker games. Joe's wife did not question the custom of serving drinks to their guests.

Around his thirtieth year, or about thirteen years ago, it was becoming apparent that Joe's pattern of drinking differed from that of his circle of about fifteen or sixteen close friends. He began to drink

a larger quantity and insisted on drinking longer and often to the point of "passing out." The contrast in drinking patterns became so marked that his wife no longer asked friends to their home. Mrs. Alcoho was also spared invitations which would inevitably lead to embarrassing incidents. Joe gradually became more comfortable with a new, so-called hard drinking crowd, or better still a bottle to drink alone.

In this process Joe was changing from a quiet, good natured, generous, able, and well-liked individual into a suspicious, often quarrelsome, visibly unstable, lonely man. Yet, during periods of sobriety and particularly at home he seemed overly grateful for the least kindness shown to him, as though trying to compensate for his offensive behavior during drinking episodes. Inwardly, however, Joe was becoming increasingly frightened; he was constantly aware of a sense of shame (which he covered up by a defensive attitude). His alibis were no longer worth the effort, and the increasing intensity of his remorse seemed to accentuate his reliance on alcohol for relief.

Joe managed to make his Easter duty but had otherwise gradually ceased to practice his religion. He would tell you that he didn't feel comfortable in church now. Joe might also reveal that he has prayed many times for his freedom from alcohol. Drinking served to relieve his anxiety about his spiritual welfare.

Obviously, Joe is about ready for the chronic stage, in which he will be less concerned about his responsibilities, feelings and appearances—whether we classify him as an alcoholic, excessive, or a willful, selfish, social drinker. The use of alcoholic beverages has become no longer a matter of choice when he feels the need, particularly after that first drink, regardless of the sacrifices involved.

Joe is of Irish descent and the youngest of five children. His father, to whom Joe was particularly attached, was a heavy drinker. His mother, who rarely drank an alcoholic beverage and then only sparingly, consequently carried the principal burdens of parental authority. For years his parental family existed on a marginal budget until Joe's sisters, the eldest children, were able to go to work.

Following Joe's birth his mother was ill for several months, and never seemed to gain her normal strength thereafter. Soon after the onset of her illness Joe's two brothers, then five and seven years of age, respectively, went to live with his mother's sister and her

husband, a childless couple. Unlike his mother, who believed that drinking was all right if not abused, Joe's aunt would not tolerate any alcoholic beverages in their home. Her attitude did not create any conflict, however, since Joe's uncle did not appear to be the least concerned.

Apparently the lack of exposure to daily contact with an alcoholic parent (Roe, 1945) had a marked effect on Joe's brothers, who continued to live primarily with the aunt and uncle to adulthood. Neither of the brothers has exhibited more than a casual interest in alcoholic beverages, whereas Joe's unmarried sister is now also suspected of becoming an alcoholic.

Joe's wife was well aware of his drinking habits before their marriage. In fact, her father was obviously an alcoholic and died while in a state of intoxication. Mrs. Alcoho has also, therefore, wondered how she could have married Joe under the circumstances. She once declared, with feigned amusement, that she guessed she had hoped to reform him. Joe sometimes reminded her of her father.

The home situation was not too seriously disturbed in the early period of his excessive drinking. From the beginning he had allowed his wife to assume the major responsibility for their domestic affairs, because she seemed so capable and it was to their mutual satisfaction. But, when Joe's excessive drinking began to extend through the weekend and eventually through Monday or beyond, the relationships and atmosphere in that home began to change dramatically. As Bacon so aptly declared:

> Excessive drinking will not only wreck the economic and prestige structure of the family, it will also deteriorate the normal social roles of husband and wife as they exist in our society. For the close, continuing, all purpose, intimate association which is the family, it (excessive drinking) is catastrophic (Bacon, 1945, p. 232).

His wife and children sometimes wondered if the contents of the bottle—containing whiskey or wine if necessary—had not become more important to Joe than his family. They did not realize that Joe had become relatively less dependent on his family. His drinking became entirely unpredictable and the intervals of sobriety shorter. His sensitive thirteen-year-old son, for example, lived in fear of the next episode, of encountering his father drunk while in the company of his schoolmates, of his father's senseless complaints about him when Joe was drinking. At times the boy felt ashamed of his feelings about his father, and the father became embarrassed

in his son's presence. The seven-year-old daughter was apparently not as keenly aware of the abnormal home situation; in fact, she had not known it as being very different.

Mrs. Alcoho now only halfheartedly resorts to appeals, destroying discovered bottles, scolding, and threats. She is thankful for the children's sake that Joe has never "gotten mixed up" with other women and has become almost impervious to insinuations that she is interested in other men. She is very familiar with his charges that his superior or superiors are discriminating against him and suggestions that they are actually jealous of his abilities. She has grown accustomed to his pledges of "never again," his talk of getting another job, or moving to another city, and grandiose ideas regarding the future. She has a conflicting sense of fear of receiving his separation notice, but is no longer able to telephone to report him sick. The economic situation is frequently a desperate one. In short, "the family is constantly in a state of flux, in a state of indecision, over the alcoholic member." Mrs. Alcoho is seriously on the verge of determining ". . . to reorganize her family without the alcoholic husband" (Kruse, 1957, pp. 20-21).

Finally, what about the social effects of this composite man's drinking in terms of the community and its institutions? It has been said that the "use of alcoholic beverages (after the industrial revolution) became more and more related to destitution, delinquency, disease and pestilence. The consequence was a progressive build-up of moral indignation" (Lipscomb, 1959, p. 328). To this might be added the apparent widespread tendency to pretend that this public health problem does not exist.

Assuming that, as the result of prolonged drinking, Joe's alcoholism becomes complicated by other body disturbances, where will the family turn for help? Don't be surprised if they have a difficult time finding a doctor who will respond (despite the A.M.A. and the New York State Medical Society's classification of alcoholism as a disease). If the doctor comes will he be able to get Joe admitted to the general hospital for alcoholism? It will not be easy in many communities, including New York City (although general hospitals willing to accept alcoholics increased from 93 to 3,000 in this country over a ten-year period).

Joe will be more certain of admission if a serious case of pneumonia, an accident, or some other condition is also clearly apparent. If, as a result of the abuse of his general health, Joe contracts tuberculosis, he will have less trouble in becoming included

among the variously estimated 25-30 percent male patients in our tuberculosis sanatoriums. If his excessive, abnormal drinking induces a temporary psychosis, he may be admitted to a state mental hospital. Twenty percent of the admissions to the California State Mental hospitals were alcoholics, following a 1937 revision of their mental health laws (Philip, 1959).

Assume that Joe's wife and children abandon him and he subsequently loses his job. Now he is tragically vulnerable, having lost his two major protections against exposure to public disposition. While such a catastrophe is not typical of the great majority even in the advanced stages of alcoholism, many thousands of alcoholics eventually become dependent upon the mercy of the community. Their addiction to alcohol in an active phase takes precedence over food, lodging, and other basic necessaries of normal living. For their own protection and the welfare of others, when found in the street in a helpless state of alcohol poisoning, such individuals may be taken into custody by the police. Brought before the police court for disposition on behalf of society, we find that the community's principal solution is jail. Other than perhaps the immediate relatives and exceptionally loyal friends, however, a very few members of the community are concerned. Such unfortunates are soon forgotten as individuals and become socially amalgamated with a heterogeneous group more often referred to as "drunks" or "bums."

Again, however, our typical alcoholic, Joe Alcoho, was not abandoned by his family nor employer. They merely substituted toleration as the basis for their loyalty. This substitution occurred during the latter phase of his evolution from a social drinker to alcohol addiction. The transition in drinking classifications was as subtle as the normal process of aging. When did Joe become an alcoholic? We cannot be certain, although reviewing the expanse of years it is apparent that the early phase began to emerge shortly after his thirtieth year, or about ten to thirteen years ago. Neither do we know why he became an alcoholic. Most of those intimate friends of his early adulthood also drank socially during that period and on occasions excessively. But, consistent with the general ratio, they did not become alcoholics. Either their pattern of drinking remained the same or became relatively negligible following the assumption of marital and family responsibilities.

Joe Alcoho's story illustrates the disintegrating influences of alcoholism. As his loss of control and dependency became more positive, changes in his personality and ego structure became increasingly

evident. This debilitative process was characteristically accompanied by maladjusted marital, family, and social relations, in a generally indifferent, unsympathetic social environment.

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Moral Aspects

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Sometimes when I talk about alcohol problems, especially in colleges, I put four categories on the blackboard. The first is No Drinking, the second is Moderate Drinking, the third is Excessive Drinking, and the fourth is Alcoholic Drinking. Then I say something about the problems involved in each of these. You might think that there is no problem connected with No Drinking, but that is the question of total abstinence, and that is quite a problem, both for people who drink too much, and for young people who can't decide whether to drink or not. And even with regard to moderate drinking there is a

certain problem, because the boys, and the girls, too, for that matter, don't know how to decide what is moderate drinking. Some people have very generous ideas of what is meant by moderate drinking. One of the most frequent questions that you get in addressing young audiences is: "How can I tell my capacity?" And of course they aren't asking what is their capacity within the bounds of the Christian virtue of sobriety. They want to know how much they can drink without passing out or without getting drunk, or without getting too tight.

I do not intend to talk about all those categories this afternoon, but I do think it is well, as every speaker has done today, to emphasize the complexity of the problems of alcohol. It isn't all alcoholism. There are other questions. There are questions about moderate drinking, there are questions about excessive drinking, as well as the question of alcoholic drinking.

EXCESSIVE DRINKING AND ALCOHOLISM

I am glad that on our program, we are treating excessive drinking as well as alcoholism, because I think the excessive drinker who is not yet an alcoholic has been somewhat neglected. Nevertheless, he is a real pastoral concern for the clergy. And since excess, in my opinion, leads to alcoholism, if we could prevent some of the excess we could prevent some of the alcoholism. Besides, think of the enormous extent of the problem of excess! We haven't the same kind of statistics on excess short of alcoholism as we have on alcoholism itself, understood according to that very broad, inclusive definition of the World Health Organization. But Dr. Jellinek, who was largely responsible for that definition, calculated some years ago that, in addition to the four million alcoholics then estimated in the United States (now it has gone up to five million), there were at least three million heavily excessive drinkers whose problems were not yet serious enough to classify them as alcoholics.

But here is a point I would like to make in view of this constant reference to excessive drinkers and alcoholics. In our pastoral work I think we can presume generally that, when somebody comes to us for help or is sent to us for help, it is much more likely that he is an alcoholic than that he is just an excessive drinker, because the excessive drinkers do not generally come for help. They are not in enough trouble yet to be forced to come for help, and a great many of them are still having more pleasure than pain from their drinking. That

is why they are so hard to reach and that is why they constitute such a problem. In general, I think you are safe in making that presumption. At any rate, when a person comes to me with a drinking problem, my feeling is that he is probably an alcoholic. I do not know yet, but the chances are that he is. But of course I do not tell him so. I would not think of waving the red flag of that word "alcoholic" in front of him.

Enough has already been said here to enable you to distinguish between the merely excessive drinker and the alcoholic. I would only add that I have found it helpful to use the following three traits to decide whether I shall classify a person in my own mind as an alcoholic: first, excessive drinking over a period of years (and this trait he may have in common with the merely excessive drinker); second, serious life problems that result from his drinking; third, an element of compulsion or addiction, so that he cannot stop drinking for good, even when he seriously tries to do so, without outside help. If a person has these three traits together there is little doubt that you are justified in considering him and dealing with him as an alcoholic.

It is important to know the difference between merely excessive drinkers and alcoholics because, as you are well aware, the moral implications are different where alcoholics are concerned. Where there is compulsion or addiction the moral responsibility is diminished according to the strength of the compulsion or addiction.

Fundamental to this whole question of the moral aspects of alcoholism is the idea that alcoholism is a sickness. Very often the question is put in this form: "Is alcoholism a sickness or is it a moral problem?"—as if it had to be one or the other. But obviously alcoholism can include both sickness and sin. I am convinced that it is both a sickness and a moral problem. I hope that you will have some questions with regard to alcoholism as a sickness. That concept is not universally adopted yet and even among those who accept it, I think there is a good deal of confusion as to what it means, and perhaps a certain amount of exaggeration in the way it is explained.

It seems to me that my function is that of outlining the headings for our discussion, rather than to develop the topics raised. I shall begin by outlining the main moral questions concerning the abuse of alcohol, will then make some remarks about our responsibilities and certain popular attitudes in this matter, and end by indicating what I believe should be our professional goals as clergymen in an educational program for the prevention of excess.

MORAL PROBLEMS

With regard to the moral problems, there is first the sin of deliberate intoxication. I went into the morality of drunkenness at some length in *Man takes a drink* (Ford, 1955a). That is the sin that is treated in our moral manuals in the seminary, and is usually treated fairly well, although I think there is a certain amount of schematic rigidity in the way it is treated, with entirely too much emphasis on that odious and misleading expression, "theological drunkenness." I shall return to that point.

Second, there is the question of one's responsibility for sinful acts committed while drinking. This question applies both to ordinary intoxication and to pathological drinking. We attempt to answer it according to our general norms for the imputability of indirectly voluntary acts.

Third, the question arises as to the responsibility of an alcoholic for becoming an alcoholic. Personally, I don't think that many alcoholics are formally and subjectively guilty of the mortal sin of becoming an alcoholic. Nobody says to himself: "Well, this kind of drinking is going to make an alcoholic out of me, but I don't care; I'm going to go right on drinking the same way." When people warn the potential alcoholic or the dangerous drinker that he is becoming an alcoholic, if he believes them at all, he says: "Why, I've got to do something about that. From now on, I'll stick to beer." But he doesn't give up drinking, which, at this point, is probably the only thing that will keep him from becoming an alcoholic. He says: "I'll stick to beer" or "I'll never take a drink until 12 o'clock noon" (and he drinks at exactly 12 o'clock noon), or "I'll drink only wine now." That is a socially acceptable thing to do, drink a little wine. But of course he always chooses 20 percent wine. Chianti is no good for him. So I do not think that people are often seriously guilty of the sin of becoming alcoholic. They just don't believe it will happen, or else they do "something" about it and think that something is sufficient when it is not.

Fourth, there is the question of the responsibility of the alcoholic for his excessive drinking after he has become an alcoholic. I believe that everybody is agreed that in the case of the alcoholic there is a definitely diminished responsibility. I went into that question in some detail in a monograph, *Depth psychology, morality, and alcoholism* (Ford, 1951); and also in the book, *Contemporary moral the-*

ology (Ford & Kelly, 1959) that Father Gerald Kelly, S.J. and I wrote together.

Finally, there is the question of the alcoholic's responsibility for doing something about his drinking after he has discovered that he is an alcoholic. It is so much easier nowadays for him to do something about it because there are many kinds of help available.

I would like to insist, though, that those who say that alcoholism is a sickness (and that is the vast majority of all the experts in the field) are not trying to say that the alcoholic has no responsibility for what he is doing or what he is going to do about his problem. The treatment that is suggested by all schools of thought always involves an appeal to the responsibility of the alcoholic. If you didn't appeal to that, you would have nothing to appeal to. And very often when people say carelessly that alcoholism is not a moral problem, or that you can't handle it morally, what they mean is: "Please don't be *moralistic* when dealing with the alcoholic." Moralistic is an exaggeration of the moral point of view, just as legalistic is an exaggeration of the legal or juridical point of view. Besides, there is a question of tactics in approaching the alcoholic. Do not misunderstand, then, a recurring insistence here on the idea that alcoholism is a sickness. When I talk to clergymen I insist on the idea of the sickness of the alcoholic. When I talk to psychiatrists or sociologists, I insist on the idea that there are moral problems involved. I really do believe that alcoholism is a triple sickness of body, mind, and soul, and that all of these elements have to be taken into consideration.

ATTITUDES OF THE CLERGY

While we are pointing out all the moral problems in the behavior of excessive drinkers and alcoholics, it might be a good idea for us clergymen to think over our own professional responsibilities and certain popular attitudes in the matter of alcohol problems. I encounter a great deal of apathy in these matters. This is surprising, in view of the size of the problem and the frequency with which the average clergyman runs into it in his pastoral ministry; in view also of the enormous number of family problems, sex problems, other problems in which alcoholic excess plays a part. Obviously this criticism does not apply to the present audience. Your presence here is the best proof of your pastoral concern.

Perhaps we have to overcome certain false attitudes on the part of both clergy and laity before we can hope to succeed with a pre-

ventive program. Many of our people have false attitudes, and jejune ideas with regard to the use of alcohol and the problems of alcohol. For instance, if you show a special interest in these problems, you must be a prohibitionist. If you suggest that drinking to get high is not in accordance with the true moderation of Christian virtue, you encounter a defensive reaction: "What's wrong with getting high? What is drinking for, if you don't get a jolt out of it?" There is no doubt that many Americans think of alcoholic beverages in terms of excitement, partying, and experiencing the more violent effects. Some observers believe that this attitude is one of the factors that leads to a very high rate of alcoholism in the United States.

It is part of our task as clergymen to answer the question: "What is drinking for?" And if we believe, as most of us do, that truly moderate drinking can have a legitimate place in the life of a Christian, we ought to exert our influence to make known what that place is, to explain what true moderation means, and to disabuse people of the immature notion that "drinking is for kicks."

In that clergy kit which was generously provided for the members of this Institute by the National Council on Alcoholism (NCA), there is included a reprint of an article of mine called "Clerical attitudes on alcohol" (Ford, 1955b). More or less with tongue in cheek, I described these attitudes as the uninformed, the unformed, the misinformed, the deformed (that is the man who is beginning to have a personal problem, and is on the defensive about it), and finally, the reformed attitude. Those are some of the clerical attitudes I have run into. I have also encountered often, but not often enough, the truly well-balanced attitude, based on scientific information and on Christian principles of theology and asceticism.

Sometimes I have been amused to hear some amateur theologian, when criticized for getting high, react by saying, "Well, *usque ad hilaritatem,* you know. All the moralists teach you can drink to hilarity." Being a moralist I resent this. The Latin word *hilaritas* does not mean hilarity. It means cheerfulness. Furthermore the moralists I have read add a qualifying phrase: *ob rationem proportionatam.* They say nothing about drinking to hilarity, while those who speak of drinking to the point of cheerfulness permit it only for a proportionate cause. This is an example of what I mean by a misinformed (and perhaps deformed) attitude. An opinion of some moralists, formulated to draw the line at sin when drinking verges towards excess, is twisted to a meaning it never had in the first place, and then

elevated to the dignity of a principle of action—almost as if it were an ascetical norm for Christian living.

I have already used the phrase "theologically drunk" (*theologice ebrius*)—reluctantly. By theological drunkenness is meant a state of drunkenness which is so advanced, so complete, that even the most lenient, most casuistical of moralists would have to say that, if anyone got that drunk on purpose, he would be certainly guilty of mortal sin.

This concept has little or no practical value in judging sins of excess. It is speculatively of interest to know where drunkenness becomes objectively grave in itself and always, namely when reasonable control over one's activities is completely gone, when a human act is no longer possible. But the average excessive drinker does not commit the subjective mortal sin of setting out deliberately to get that drunk; and considerably short of "theological drunkenness" his thinking can be so impaired that he is hardly capable of subjective mortal sin in continuing to drink to that point. Furthermore, a person may be far from theological drunkenness and yet be a grave menace driving a car, a grave menace to the welfare and happiness of his family, a grave menace to the spiritual welfare of his own soul. This emphasis on theological drunkenness is to my mind useless and misleading because it distracts attention from all the other realities involved in a true moral appraisal of excess.

As for alcoholism, the phrase is not only misleading but totally irrelevant. It is not going to be of any real, practical help in judging the alcoholic's state of soul. And what difference does it make, as far as helping him to solve his problem is concerned, whether he drinks to the point of complete loss of reason, or just short of it, or, as many alcoholics do, far short of it. There are some alcoholics who have never become theologically drunk in their lives. A great many alcoholics, in my opinion, become theologically drunk rather infrequently. They rarely drink to that extreme point where they are completely without the use of reason while still standing on their feet. But they are true alcoholics if they have those three traits: excess, plus problems, plus compulsion or addiction.

Yet it is a very common misconception that one whose drinking stops short of theological drunkenness cannot be an alcoholic. Perhaps you have seen the case of a man called on the carpet for excess, whose immediate defense is: "But I wasn't *theologically* drunk,"—as if that were the norm of Christian virtue. The same man, two years

later, will probably be saying: "No one ever *saw* me theologically drunk." And two years after that: "My boss can't *prove* that I was theologically drunk."

We could save a lot of misunderstanding about excess and alcoholism by eliminating from our current usage the two expressions *usque ad hilaritatem* and *theologice ebrius*. The use of such expressions is symptomatic of certain attitudes which exist both among clergy and laity, and which will have to be replaced by more mature, better-informed attitudes if we hope to institute a well-balanced program for the prevention of alcoholism and excess.

PREVENTION OF ALCOHOLISM

Perhaps you will allow me to share with you now, some thoughts I have as to what our goals should be in a preventive educational program under the auspices of the Church. Such a program ought to be based on an understanding of the scientific facts that are involved. Not that I think that the Church is the one to be teaching science, but when it is neglected someone must do it. Father Kennedy spoke about the situation in our schools. I think it is true, quite universally, that there is no sufficient scientific foundation of information about alcohol and its effects on the human person provided in our ordinary primary and secondary education. That neglect has to be supplied. Scientific facts are often essential to the formulation of moral conclusions. You cannot form and apply moral principles about the values involved in drinking unless you know the scientific facts about drinking.

It would appear that a religious prevention program should not be aimed explicitly at the prevention of alcoholism—or of excess—but rather at the positive practice of the Christian virtue of sobriety. My reasons are the following: First, the practice of the Christian virtue of sobriety is a positive religious goal which is obviously within the competence of the religious educator; second, from the standpoint of motivation, alcoholism seems very, very far away to most young people, and its prevention often does not have a personal meaning for them. They cannot bring themselves to believe that this could ever happen to them, or at least they cannot believe that they should abstain from this drink or these few extra drinks here and now lest alcoholism catch up with them ten years from now. Besides, fear of future personal harm, or future addiction, is not the highest of motives; it does not appeal to the generosity and enthusi-

asm of youth. Third, I'm convinced (and this has been brought out already, I think) that the excessive use of alcohol itself is one of the principal causes of alcoholism. That may sound pretty obvious, but I don't think it is obvious to everybody.

For these reasons, I think a prevention program under Church auspices should have the positive, immediate, and explicit aim of the practice of the virtue of sobriety. It can be practiced in two ways: by total abstinence from alcoholic beverages for supernatural motives, and by true moderation in the use of alcoholic beverages, also for supernatural motives.

I believe also that a program for the promotion of voluntary total abstinence as a Christian practice of self-denial and reparation should play an important part in a general preventive program. I am not sure how ready the public is for such a movement at present, but I think that it should be part of the program.

We must be realistic. Let us face the fact that there are multitudes of people drinking at present who would simply turn away in disgust from a plea for total abstinence. These people are going to continue to drink, a great many of them in an entirely harmless way. I do not believe in trying to take their drinks away from them. But I think the least we can do is to correct false ideas as to what drinking is for, and inculcate true ideals of virtuous moderation.

MORALITY OF PLEASURE-GIVING SUBSTANCES

I will close with some remarks on the larger aspects of the morality of pleasure-giving substances. We live in an age which can be properly called a pleasure-loving age. What age is not? But the increasing secularization of our culture, plus the increasingly ingenious means at our disposal for satisfying our native appetite for pleasure, present a special challenge to the Christian doctrine of the Cross. There should be an essential contrast between the attitude of a follower of Christ toward pleasure and pain, and the attitude of the non-believing world. But Christianity, while inculcating self-denial, is not a religion which excludes human pleasures whether of the body or of the mind. And so there is a rather nice line to be drawn between a use of pleasure which is truly Christian and one which is hedonistic and excessive.

Whether human beings today are more tense, more lonely, more self-indulgent, or more pleasure-seeking than at other times, I do not know. But we are certainly exposed to a pressure campaign in favor

of ease, pleasure, and comfort. Pleasure values are given an unusually high place in our culture. But the thing that is most distinctive of our age and nation is the availability of multiplied means of satisfying our desire to escape from pain and discomfort, and to experience ease, comfort, pleasure, and even euphoria. We have not only the availability, but also the social acceptability, the facilitation that Dr. Schneiders spoke of this morning.

You can walk down the street and meet a friend and say: "I'm feeling down, let's go in and get a drink." But you could not walk down the street and meet a friend and say: "I'm feeling down, let's go in and get a fix of heroin." People can't do that. It isn't available. It isn't socially acceptable, either. There is a great difference in the problems of alcoholism and drug addiction just on that account. The fact that it is not socially acceptable and not physically possible to get the heroin is one reason why the rate of drug addiction is so very much lower than the rate of alcohol addiction. I hope we are going to keep it that way.

Among the means by which we are able to achieve pleasure and comfort there is a great variety of chemical substances, some of which were known, but most of which were unknown, to ancient man. I think it would be a very instructive thing to study at this stage of our history the relations between human tensions, chemical comfort, and Christian virtue. I'm not speaking merely of alcohol as a form of chemical comfort, which it certainly is—alcohol certainly does relieve tension. It certainly does relieve the pain of loneliness for some, and it does induce positively pleasurable states for large numbers of people when taken in appropriate quantities. They would not spend billions of dollars on it annually if it did not. We spend more than 10 billion dollars a year on alcoholic beverages in this country. I think a study of this topic would also include a whole list of substances which provide chemical comfort of a sort.

But since I do not believe that the moderate use of chemical comforts, whether to relieve pain or to induce pleasure, is of itself incompatible with the truly Christian view, I am not at all disposed to make total abstinence from any of these chemicals an essential part of the Christian way of life. Furthermore, I'm a little bit afraid of what the consequences would be if we suddenly took away from immense numbers of people the minor satisfactions they have been accustomed to achieve through chemicals, including alcohol. What would they do instead? It reminds me of the story told about the man who

first cut out smoking, then cut out drinking. Now he is cutting out paper dolls.

The fact is that social customs and long usage have habituated millions of people to a certain measure of satisfaction from chemicals, especially from beverage alcohol. This is a fact that has to be faced and reckoned with. It is simply too much to expect that people are going to deny themselves these satisfactions, and it would be unwise to try to make them do so, unless we are prepared to put in their place other satisfactions of a more acceptable kind, and, if possible, of a higher kind. They are going to be satisfied somehow or other, that is sure.

Have we not now arrived at the point where we should lead our people to inquire whether chemical comfort is the best answer, or the wisest answer, or the most Christian answer to these needs, and should not this question be posed more explicitly in the case of those chemicals which have proved themselves to be addicting? And should not the inquiry be directed most especially to the use of alcohol in our society simply because it is readily available, socially acceptable, easily abused, and when abused, dangerously addicting for some millions of people? I feel sure that experts in bodily and mental hygiene would agree that, while alcohol in small quantities does relieve tension, or temporarily eases the pain of loneliness, or produces a degree of comfort and pleasure, it is not the best method, from the viewpoint of these sciences, of achieving these effects. Most of all I am sure that medical science would agree that repeated doses of alcohol in toxic quantities is a bad method of achieving these effects. And, of course, you arrive at toxic quantities long before theological drunkenness!

I am also convinced that sound principles of bodily and mental hygiene do not go counter in any respect to sound Christian principles as to the use of pleasure, the use of pain, and the acceptance of suffering. What Catholic theology teaches about the sin of intoxication agrees thoroughly not only with common sense, but with scientific hygiene. There is a place, therefore, for the truly moderate use of alcohol, both from the viewpoint of hygiene and of virtue. I don't say it is a very high place, but taking human beings as they are, it is a legitimate place. This remains true even when one is acutely conscious of the widespread abuses and serious dangers which the use of alcohol involves.

The realities of the situation demand an educational program

which is not aloof from these practical considerations. Not everyone is called to heroic self-abnegation; men will continue to seek the comfort of chemical substances and will sometimes use them to excess. Almighty God must smile sometimes at the minor irrationalities of His rational animals. The virtue of Christian sobriety, properly understood, does not exclude a temperate resort to chemical comfort. Christianity has standards by which to evaluate this method of easing pain or inducing pleasure. Certainly, our ingenuity and know-how can help people to find better ways of doing it. But the final and highest answer of Christianity to these problems is not the discovery of new and higher pleasures; it is to be found only in the doctrine of the Cross, which is not a doctrine of self-indulgence but of self-renunciation, a doctrine which entails the acceptance of pain and suffering in union with the pain and suffering of Christ.

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Legal Implications

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It is difficult to think of a social problem that has a more evident impact on police enforcement and the administration of criminal justice than alcoholism and excessive drinking. On May 2, 1959, Police Chief William H. Parker, in arguing against a proposed reduction in the annual budget of the Los Angeles police department, suggested wryly that perhaps the department should abandon its policy

of harassing drunks in favor of "the New York system, where drunks are left to lie in the gutter."

PUBLIC INTOXICATION ARRESTS

Chief Parker had reference to the fact that public intoxication arrests total nearly 100,000 annually in Los Angeles, compared to between 10,000 and 15,000 in New York City. And his implication that the policy of not harassing drunks is largely peculiar to New York is not without basis. Virtually every other city in the United States and the District of Columbia has a program of mass arrests of drunks. Of some two million arrests made annually in the principal cities of the United States for all crimes from murder down to disorderly conduct, 40 percent are arrests made under a public intoxication statute, and an additional 10 percent are the same type of arrests designated as disorderly conduct arrests. In short, almost half the criminal arrests in urban areas throughout the country, or approximately one million annually, are so-called public intoxication arrests. More than half of those confined at any time in county jails throughout the United States are persons committed for public intoxication.

And indeed New York City for decades also pursued a policy of wholesale arrests for public intoxication. A review of the court dockets of New York City during the Civil War era gives the impression that the police department did little else but round up drunks. The early annual court reports, first published in 1874, reflect the fact that public intoxication arrests alone constituted over 50 percent of all criminal arrests—some 40,000 arrests out of a total arrest rate of approximately 80,000 annually. Not without significance is the fact that slightly over one third of these arrests were arrests of women, and on occasion children as young as eleven years of age were among those arrested.

Over the years, however, there has been a change in policy in New York City. Notwithstanding an ever increasing population and a corresponding increase in total criminal arrests, there was a gradual diminution of arrests for public intoxication up to the year 1935. On November 7 of that year Magistrate Frank Oliver, presiding in the Bronx Magistrates' Court, had a derelict by the name of Louis Schleicher arraigned before him. Judge Oliver dismissed the case as soon as the charge of being "intoxicated in public and lying on the sidewalk" was read. He ruled that a public intoxication complaint

that contained no allegation of a disturbance of the peace was insufficient. This decision, which was featured in the press, caused consternation in some quarters.

The Committee on Criminal Courts of the City of New York wrote in protest to the then Chief City Magistrate pointing out that the statute involved proscribed public intoxication and made no specific reference to a disturbance of the peace. Both their protest and the decision of Judge Oliver, however, went largely unnoticed for some five years until 1940 when a new Chief Magistrate, Henry H. Curran, was appointed. Judge Curran agreed with the position of Judge Oliver. On November 13, 1940 Judge Curran directed the clerks of court to forward to judicial headquarters all court forms of complaint and commitment dealing with the charge of public intoxication. He then directed that they be destroyed. He obviously sought thereby to preclude the police from thereafter invoking the statute against public intoxication before any magistrate, confining the police to charges of disorderly conduct and assault, and thus limiting them to arrests of inebriates whose conduct interfered with public peace and order. Since that date the public intoxication statute has never been used in New York City, and drunk arrests made under the disorderly conduct statute have constituted only approximately 3 percent of the total arrests—contrasted with a national average of almost 50 percent.

A policy of wholesale and repeated arrests of inebriates prevails also in England. On May 11, 1954, Mary Ellen McGregor, a tiny, silver-haired old lady of 74, appeared in court in Liverpool, England, for the 500th time on a drunk disorderly charge. The magistrate gasped when Mary Ellen's record was read by a court official, then commented, "We have no flags to put out here, but I am going to discharge you in commemoration of your notorious record."

When an inebriate's excessive drinking is reflected in aggressive behavior, he is frequently arrested on an assault charge rather than a charge of public intoxication or disorderly conduct. This is particularly true when the inebriate is arrested on the complaint of a spouse who can no longer tolerate his behavior. While the number of assault arrests in the principal cities throughout the United States annually exceeds 100,000, it is impossible to estimate the percentage of these that result from over-indulgence. Doubtless, however, it is substantial.

A more modern phase of the administration of criminal justice that involves the problem of excessive drinking has developed from

the advent of the automobile. The cover of an issue of *Leslie's Weekly* dated December 15, 1904, bore a cartoon depicting a police officer on horseback drawn up alongside a motor vehicle and beneath the cartoon a caption, "The Interrupted Ride—'Show Your License!' A Common Incident on the Streets of New York." This cartoon was an early recognition of the beginning of the motor age and of the use of criminal and quasi-criminal laws to promote moral or socially desirable conduct in the operation of the newly invented horseless carriage. It is doubtful, however, that G. W. Peters, the cartoonist, could have foreseen how very common this incident was to become in subsequent years, not only in New York but throughout the country, and it is particularly doubtful that he could have foreseen that arrests for drunk driving would now exceed 100,000 annually in the principal cities throughout the country.

LEGISLATION TO CURB DRUNKENNESS

On principle, it is difficult to assert that the state exceeds its authority when it attempts to curb drunkenness by penal law. Drunkenness is condemned by the moral law. Drinking that results in a complete loss of reason or the power to distinguish between right and wrong is a mortal sin. Drinking that results in a partial loss of reason is a venial sin. Moreover, the drunkard brings disgrace and disaster not alone to himself but also to his family. He is a nuisance to his friends and neighbors.

But conceding the moral justification for legislation designed to curb drunkenness, consideration must also be given to the wisdom and desirability of such legislation, and also to the wisdom and desirability of specific statutes. In determining the wisdom or desirability of a statute, consideration must be given to such matters as the effectiveness of the statute, the extent to which drunkenness affects the common good, and the evils that flow from the enactment and enforcement of the statute.

For the present discussion, it may be broadly stated that there are three types of drunkenness—the drunkenness of the average person, the drunkenness of the typical or social alcoholic, and the drunkenness of the undersocialized, whether alcoholic or merely chronic excessive drinker.

The occasional abuse of alcoholic beverages by the average person, although in violation of the moral law, does not seriously affect the individual, and normally does not seriously affect his family or

the community. Judge Oliver would seem to have been correct in interpreting a public intoxication statute as having been intended only to proscribe public drunkenness that tends to disturb the peace. The average person merely by over-indulging certainly does not therefore come within the prohibition of a public intoxication statute. When such a person, however, becomes disorderly, commits an assault, drives a motor vehicle, or engages in other aggressive antisocial conduct, we have a different situation. Society not only has a right to proscribe such conduct by penal legislation, but it is desirable for community well-being that the police be vigilant in curbing such conduct.

The drunkenness of the alcoholic presents special and difficult problems. The alcoholic is a sick person. He has a pathological condition that has appropriately been described as a disease of the body, of the mind, and of the soul. One aspect of the disease is a pathological compulsion that makes it very difficult for the alcoholic to avoid drunkenness. Indeed the compulsion is so severe that in many cases the subjective, moral responsibility of the alcoholic is greatly reduced if not entirely eliminated. Human law, however, views conduct from the standpoint of objective and not subjective responsibility. Unless the offender is so lacking in reason as to be legally insane, the law does not concern itself with questions of objective or subjective responsibility or with degrees of responsibility. Such considerations should indeed affect the sentence to be imposed by the court, but they do not enter into the determination of guilt or innocence.

The drunkenness of the alcoholic is especially perplexing in relation to drunk driving. There are no reliable data as to the percentage of drunk driving offenders who are alcoholics. If it is true, as it may possibly be, that a very substantial percentage of drunk driving offenses are currently being committed by alcoholics, we may well ponder the question of the effectiveness of existing legislation and police programs. Will the knowledge that drunk driving is proscribed and an awareness of a strong likelihood or certainty of incarceration following conviction have a tendency to induce the alcoholic to abstain or to avoid the use of his automobile when he contemplates drinking? When the alcoholic comes under the influence of drink, is this knowledge and awareness apt to influence his conduct to any degree? While we are inclined to answer these questions negatively, there is too little known of the alcoholic pathology to give a categorical answer.

THE SKID ROW DERELICT

It is the third type of drunkenness, the drunkenness of the undersocialized, the inadequate husband and father, and the homeless skid row derelict, that is primarily responsible for the mass arrests that take place throughout the country. There can be little quarrel with the arrest and arraignment of a drunken spouse on an assault charge. Whatever the offender's subjective responsibility, immediate police intervention is often necessary to prevent serious injury to a wife and children. Moreover, the offender's continued course of conduct is detrimental to the welfare of his family, and of society.

Many problems of emotional instability and juvenile delinquency have their origin in the drinking problem of a parent. The drinking problem is, however, frequently merely symptomatic of basic social, cultural, and pathological problems. This is true whether it is a problem of alcoholism or pathological, excessive drinking of a noncompulsive nature. In either case the total problem presented will be better dealt with not by fine or imprisonment but rather by avoiding an adjudication and having the offender voluntarily participate in an appropriate therapeutic program. Indeed, because of deprivation and the traumatic experiences resulting from years of the offender's chronic drinking, it may be indicated that the other spouse and one or more of the children also receive therapeutic aid. The Home Term Court in New York City has been pioneering in developing such a judicial approach to the problem. This court not only provides social and psychiatric therapy but integrates into the judicial setting the various services of social agencies in the community.

Skid row derelicts have traditionally been regarded as alcoholics. Many of them doubtless are. Others are chronic drunkards who, although not compulsive drinkers, use alcohol to excess in order to escape the tragedy and degradation of their surroundings. They may be described as habitual, symptomatic, excessive drinkers. Dr. Robert Straus, who has written extensively on the subject of alcoholism (Straus, 1951; Straus & Bacon, 1951; Straus & Bacon, 1953) speaks of such drinkers as seeking a plateau and putting more emphasis on the duration of their drinking than on its intensity.

Whether alcoholic or not, skid row derelicts have a complex pathological condition that is only now beginning to attract the attention of the social and medical sciences. As any other group of human beings, derelicts are of all kinds and types. Some degree of generali-

zation is possible, however, at least as to those who are repeatedly arrested. They appear to be grossly inadequate individuals who are unequal to providing for themselves, unequal to meeting life's responsibilities and life's challenge. In the main, their early lives were deprived—lacking maternal and other affection and respect. Most of them left their parental home at an early age, often following the death of one or both parents. They are emotionally immature. Either they never marry or, if they do, the marriage is soon terminated. They are usually unattached to any family and live on a day-to-day basis, unable to establish a residence with any degree of permanency. Their education in most instances was terminated before graduation from grade school. The great majority are unskilled or casual laborers. More important, they never develop the work habit. They seem unable to apply themselves to continuous employment. Their physical condition, while not good, is usually such that they can do a day's work. Having a self-centeredness more characteristic of an infant, they have never learned to rely on their fellow man and on God. They thus have an insecurity that makes it difficult for them to cope with life. The culture of skid row is, on the one hand, their salvation and, on the other, their doom. They find in skid row some of the comfort and security they seek. And yet the environment is not conducive to their attaining a greater degree of emotional and social stability. No adequate therapies and techniques have yet been devised to solve the problems of skid row.

When we thus consider the pathological nature of alcoholism or the pathological nature of the problems of the skid row derelict, it would seem likely that any effort to contribute to the welfare of the skid row derelict through penal legislation of any kind will be largely futile. Penal sanctions will neither solve problems of this kind nor tend to reduce the drunkenness related to them.

Laws specifically proscribing public intoxication have been notoriously futile. Such legislation was originally designed to deal primarily with the drunkenness of the derelict and, in any event, it has been used by the police primarily to deal with this problem. Here as in England the grim, hopeless shuttle, skid row to jail and back again, has been the course of countless derelicts down over the years. Night after night, in one city after another, we find the police picking up men and women on the street—filthy, battered, sick, unutterably pathetic—and locking them up in the "drunk tank." In the morning they are released or sentenced to a short term in jail, only to be picked up again soon after their release. Virtually all of these

chronic drunks are recidivists. Some of them, like Mary Ellen McGregor, make the grim circuit hundreds of times before the final trip to the morgue. It is an endless "revolving door" process. Frequently, as in Los Angeles, from three to five hundred derelicts are arraigned before a judge in a single day. It is hard to imagine a drearier example of the futile use of penal sanctions. The procedure cannot be defended, but it goes on day after day, year after year. The enforcement of such laws has not only been ineffective but involves a degree of cruelty to the skid row derelict that cries for correction. The resultant court proceedings bring the entire judicial system into disrepute.

The magistrate in Liverpool referred to the record of Mary Ellen McGregor as being notorious. It is submitted that her record was not nearly so notorious as the record of British and, yes, American justice in dealing with such a tragic human problem. The ultimate answer to the problem of course lies in an improved society, a society composed of fewer families that are inadequate materially, socially, emotionally, and spiritually. In the meantime, has not society a moral obligation to provide more adequately for the poorest among us—to provide within the community for the immediate day-to-day needs of these unfortunates, and to provide some program of rehabilitation for such derelicts as might benefit therefrom? Such a program would further reduce any justification that may exist for the current practice of mass arrests.

Should we not adopt more of the spirit of Christ, Who found so much joy in saving one lost sheep, Who preached forgiveness of sin, Who welcomed home the prodigal son?

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The Etiology and Background

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In this country there are 70 million people who use alcohol, but 65 million of these do so in a way that is not harmful (Bowman, 1956). The remaining five million, who account for one of every 22 persons aged 20 and over (Willard and Straus, 1958), are alcoholics. Despite the fact that alcoholism ranks as the third most prevalent "disease," no one definition of it is generally accepted.

THE FORMS OF ALCOHOLISM

Most workers, however, have seen fit to distinguish between the essential, primary, chronic alcoholic and the habitual inebriate. The latter has been called the reactive (Knight, 1937), the escape (Alex-

ander, 1956), or the symptomatic (Jellinek, 1947) type, and Jellinek estimates that this type accounts for about 3,750,000 of the total. For people in industry, alcohol is a major problem in about two to six percent; and 80 percent of these are also of the symptomatic type (Franco, 1957; Bowman, 1959).

Symptomatic drinkers use alcohol frequently and in large quantities, and they may behave pathologically under its influence. But they are able to overcome the habit when they become aware of the necessity for it (Diethelm, 1955). It is generally believed that the symptomatic drinker uses alcohol as a means of escape from present-day traumatic or conflictual situations rather than primarily as a form of gratification. He effects his escape from conflict by means of the pharmacologic dampening of anxiety and elimination of the higher discriminatory functions. The result is an intemperate drinker whose behavior is adversely affected by frequent, recurrent intoxication. The overall effects, of course, extend far beyond the individual himself, and involve his family, his friends, his employer, and his fellow-workers. The alcoholic employee, for example, in a year averages about ten days more of absenteeism than his non-alcoholic counterpart (Bowman, 1959). And how much violence and crime, and how many automobile accidents, are directly traceable to alcoholism can only be guessed. It has been estimated that alcohol is responsible or implicated in one of every four highway fatalities.

The term essential alcoholism (Knight, 1937), also known as regressive (Alexander, 1956) or addictive alcoholism (Jellinek, 1947), refers to drinkers who from prolonged and excessive use of alcohol, usually for many years, finally develop definite physical and/or psychologic changes; their drinking interferes with successful living (physically, personality-wise, socially and occupationally); in addition they are unable to recognize the full effects of their drinking or, if they do recognize them, are unable to control their compulsive craving (Tiebout, 1950; Sherfey, 1955).

To be sure, the line of division between these two groups is inexact, and any number of indicators have been used to establish the diagnosis of malignant, addictive alcoholism (Bacon, 1958). Does the patient, for example, need a morning drink to face the coming day? In what way does he satisfy his craving? Does he drink furtively and secretively, or does he gulp his drinks so that he is always far ahead of his companions at the bar or in the cocktail lounge? Does he suffer periods of temporary amnesia? Is his behavior while

under the influence of alcohol excessively deviant? Does he become extraordinarily fearful or morose or resentful when he drinks? Once he takes his first drink, does he lose all ability to control subsequent consumption? Does he go on "benders"? Is he constantly seeking some new way of indulging his craving such as trying to drink only wine, or drinking only every other day, or drinking only with particular people? Has he ever gone into a full blown psychotic episode during or after a spree? In essence, however, any individual who relies on alcohol to meet the ordinary demands of living and continues to drink excessively even after alcohol has brought him marital or occupational difficulty is an alcoholic. It makes little difference if, in addition, he is an alcoholic who drinks only in the evening, or never drinks when alone, or has had nothing but beer for five years (Smith, 1958).

At this point, I should like to mention two special entities which are sometimes confused with malignant alcoholism. One is dipsomania, and while in lay parlance this may be almost synonymous with alcoholism, in psychiatry the term is used in a more limited sense. In general, dipsomania refers to those problem drinkers who succumb to paroxysmal drinking bouts, during which they drink steadily for days or weeks. They are often found unkempt and penniless in some hotel room, or wandering about aimlessly in an amnesic state. After several days they sober up and for weeks or months remain abstinent and highly remorseful over their last episode. A great many of these individuals are schizophrenics whose drinking bouts represent an acute episode of psychotic decompensation; others in this group are in the so-called psychopath class and in the intervals between sprees appear relatively stable and adjusted; still others are manic-depressives whose manic episode is expressed in part by alcoholic excesses; and a small number are latent epileptics whose first convulsive episodes are precipitated by drinking.

The second entity is pathological intoxication, or *mania a potu.* This is a rare condition, but important medicolegally, that is presumed to depend upon an inherent hypersensitivity to alcohol. It consists of extreme excitement with aggressive, dangerous, and even homicidal reactions, and often with definite persecutory ideas. This alcoholic fury, as it has aptly been called, ends with the patient falling into a deep sleep. Usually there is complete amnesia for the episode.

ETIOLOGY OF ALCOHOLISM

It must be admitted that we know very little about the etiology of alcoholism; we do know, however, that alcohol itself is not the cause, but only the vehicle of the disorder, for less than ten percent of those who drink become alcoholics (Bacon, 1958). Ignorance in any field commonly dons the cloak of staggering volubility on irrelevant issues, and trying to avoid this pitfall Gordon has advocated a definition of alcoholism along epidemiologic lines; ". . . the use of alcohol as a beverage, irrespective of amount, place, periodicity or practice" (1956, p. 18). This definition separates people into those who do and those who do not use alcohol, and those who do are subdivided on a biologic gradient. Gordon likens the problem to ineffective processes, such as diphtheria, with the abstainers corresponding to the immunes and susceptibles; the social drinker corresponding to the subclinical infection; the symptomatic drinker analogous to atypical diphtheria or modified disease, the addictive drinker to classical diphtheria and the exaggerated, deteriorated cases to malignant or black diphtheria. Such an approach allows for an understanding of alcoholism as a nonspecific syndrome with multiple etiology, ". . . a complex of many factors, variously related to the agent of the disease, the host affected, and the environment in which both exist" (Gordon, 1956, p. 29). The problem then becomes one of finding the factors resident in the host which allow for spread of the condition, and the environmental elements which allow or favor its expression.

The chronic, malignant alcoholic is usually described in terms of gradual deterioration in the moral and intellectual spheres. Although he may keep a job in the early stages, he never reaches a high level of energy or efficiency and he tends to slide along, a "half man," on past performance. A sociable, sympathetic, boisterous drinking companion to his friends, he is irritable, moody, suspicious, and jealous in his home and neglectful of his family. He bemoans the tricks fate plays on him and he is loath to accept responsibility for his errors or admit that he has made a mistake. He is untrustworthy, unreliable, and full of promises to reform. But he soon loses his sense of ethics and his ability to sublimate; despite his many guilt feelings and anxieties, he often gives direct expression to his sexual and aggressive drives. Psychologically he becomes less and less able to handle even run-of-the-mill frustrations; he uses immature, regressive defenses, shows impaired reality testing, and memory becomes faulty. Second-

ary physical signs become increasingly prominent, atrophic gastritis, vitamin deficiencies, kidney and liver involvement, coarse, bloated facies, tremors, impotence, and a host of others. His course is a steadily downhill one, and although it may proceed slowly the alcoholic finally hits skid row.

No doubt this grim picture aptly describes some alcoholics, but it is hardly a valid description of most. Contrary to popular opinion, most alcoholics do not show social or personality disorganization. Less than ten percent are on skid row, and about half are engaged in top-level jobs (Wellman, Maxwell, and O'Hallaren, 1957). The vast majority function in a fairly normal fashion for a very long time. In one study (Lemere, 1953) of the life history of untreated alcoholics, derelict status was reached in only five percent of the total group of 500 patients. In 28 percent drinking became worse, in 10 percent drinking was moderated, and in 29 percent it stayed the same as when the patients were first seen. The remaining 33 percent stopped drinking, 22 percent in their terminal illness and 11 percent on their own or as a result of religious associations or following nonspecific medical treatment. In eight percent, relapses occurred after three years or more.

Alcoholism, in other words, is a chronic, probably life-long process characterized by many complicating factors and innumerable side effects which are often mistakenly labelled causative. Because of this, we really have little idea of what the essential and crucial determinants of alcoholism might be. We are as yet unable to predict to any significant degree which one of every ten or eleven American adults who drink will become an alcoholic. The differentiation between reactive alcoholism and addictive alcoholism is not an easy one to make and is often not carefully drawn, so that even the few data which are available are often unsatisfactory in helping us to define the essence of the addictive alcoholic. The diagnosis of addictive alcoholism depends on chronicity and irreversibility, and these features have often favored the exclusion of alcoholics from adequate study of their makeup. Despite all this, however, we do know some things about the alcoholic, and with these reservations in mind let us review some of the relevant data.

THE TYPICAL ALCOHOLIC

The typical alcoholic is a northern European, Gentile male, married, and between the ages of 35 and 50 years. Malignant alcoholism

is high in the Irish but low in the Chinese, in the Mediterranean countries, and in the Jew (Gordon, 1956). I might digress for a moment to point out that, while most workers agree that alcoholism is a type of addiction (Bowman, 1956; Wikler *et al.,* 1956), the epidemiology of different addicting substances is not identical. Narcotics addiction is hardly rare in the Chinese, and in the Jew it occurs certainly as frequently as in the Gentile (Meyer, 1952). Malignant alcoholism is also rare in cases of hyperthyroidism or toxic goiter (Richter 1956). In the United States, male alcoholics exceed female alcoholics by a ratio of six to one (Keller and Efron, 1955), in the British Isles by two to one, and in Scandinavia by 23 to one (Gordon, 1956). And there are many indications that alcoholism, like smoking and lung cancer, is on the rise in the American woman (Zwerling and Clifford, 1957), making the so-far unexplained difference between the Anglo-American woman and her Scandinavian counterpart even more striking.

The fourth and fifth decades, i.e., the age range of 30 to 50 years, supply between 70 and 80 percent of addictive alcoholics, although the peak age for women is somewhat lower than for men (Zwerling and Clifford, 1957). Apparent alcoholism in younger patients, as already mentioned, tends to be a symptomatic expression of underlying schizophrenia or psychopathy, and in the older groups a type of involutional or senile reaction in rigid personalities who are unable to cope with the frustrations or accept the restrictions which advancing age brings in our culture. One wonders about these data, however. Is the 30 to 50 age range so prominent because it takes this long to make the diagnosis? Or, like cancer, is alcoholism a condition which more people will manifest if they live long enough to have the opportunity?

PERSONALITY TRAITS OF ALCOHOLICS

Attempts to identify more specific personality traits in the alcoholic have been more confusing than enlightening. Many alcoholics seem to fit into the classification of anxiety neurosis, but equal numbers could be diagnosed conversion or dissociative or phobic or obsessive compulsive psychoneurosis. We can agree with Bleuler (1955) that alcoholics in general stem from a poor psychologic environment, but we cannot designate any particular neurosis which is typical of malignant alcoholics. *In toto,* there is little to justify the conclusion that there is any specific type of personality that is related

to or prone to the development of chronic alcoholism (Wexberg, 1949; Sutherland, Schroeder and Tordella, 1950; Syme, 1957; Shagass and Jones, 1957; Bowman, 1956; Lemert, 1956). If all alcoholics are neurotic, why do not all neurotics become alcoholics? Both the Irish and the Jews have their share of neurosis, but compared to the former the Jewish peoples enjoy an enviable immunity to addictive alcoholism (Smith, 1958), but not to other addictions, as has been mentioned.

Only one conclusion seems justified from the various attempts to describe a specifically alcoholic personality: no matter what defense or group of defenses the individual alcoholic picks in his struggle with reality, he is unable to contain the anxiety against which the defenses were erected. He remains intolerant to tension and frustration, he resents responsibilities, he demands immediate gratification of his unrealistically high goals, any interference with his aims is perceived as an intolerable blow to his self-esteem, and his life is marked by frequent, recurrent periods of dejection. For these latter, only alcohol seems to afford relief (Conger, 1956).

In the main, the alcoholic's anxiety appears to stem from one or more of the following areas: (1) conflicts over dependency; (2) conflicts over aggressivity; and (3) conflicts over sexuality. The alcoholic quite often is passive and dependent in his interpersonal relationships; he leans on others for support and reassurance, and he tries to manipulate his environment into caring for him. He is highly sensitive to criticism and disapproval, and to the alcoholic a single word of scorn may constitute a major threat to his tenuous self-esteem. He denies his own aggression in all areas and dreads the appearance of overt hostility from any source in his environment. He is a pacifist and a compliant compromiser who avoids open competition and rivalry. A certain number of alcoholics express their hostility as overt psychopathic behavior, but this is relatively rare; the more usual mechanism is to turn it inward, upon the self, in the form of masochistic, self-destructive maneuvers, or suicide (which occurs in about 11 percent of untreated cases (Lemere, 1953)). The alcohol addict feels inadequate socially, and he is uncertain about his masculinity. Sexual problems are almost ubiquitous in the alcoholic (Wilkins, 1956), various inhibitions, numerous potency disturbances and, very often, latent or overt homosexuality. Again, however, we are tempted to ask how many of these characteristics are a result rather than a cause of alcoholism.

Perhaps, though, it is the accidental discovery—hardly a monu-

mental feat in the United States where we can boast of world leadership in alcoholism, having nosed out even France—of the sedative effects of alcohol by people with conflicts in those areas which produces malignant alcoholism. In support of this possibility is Bleuler's (1955) finding that propinquity to other alcoholics, especially before the age of 20, is a significant feature in many alcoholics' histories. Further, the family pattern is often such that alcohol and drinking have an aura of sin or forbidden fruit. Alcohol artificially removes anxiety and other consequences of frustration, it banishes care and guilt, it offers a relief from disappointments. And in the important conflict areas it affords a simple solution, even though temporary and unrealistic. Through its direct physiologic actions on the central nervous system it encourages a retreat into passivity and isolation; some would say it further reproduces the warm glow of the crib or the mother's arms, and this brings back the mother figure from whom the alcoholic is more or less constantly seeking support and nurture. Through its actions on the neuromuscular system, alcohol eliminates the mechanism whereby the dreaded aggression could be expressed, and all the while it renders the drinker inactive and helpless, his very drinking of itself is a subtle, antisocial maneuver. And in the sexual area, alcohol in the beginning at least reduces the fears that ordinarily inhibit sexuality and later, removes the very drive itself so that the alcoholic is content to regress to a passive, non-sexual stage.

Whatever it is that brings him to his first drink, the alcoholic soon discovers its effects and eventually comes to use it as a panacea for all his emotional upsets. For a time he hides his need from himself, perhaps for all his life he can hide his need from his family and friends, but the need is there, and he cannot face the demands of life without the false courage, bravado or indifference to reverses that, in his experience, only alcohol can bring.

While recognition of these factors of dependency, aggression and sexuality as being of great importance may help us to better understand the alcoholic as a person, we must be cautious in presuming that herein also lies the full explanation of alcoholism. For it is hard to think of any emotional situation which cannot be explained in terms of these three elements. And thus it behooves us to continue our search for more specific constellations.

PSYCHOANALYTIC VIEW

Psychoanalytic studies, particularly those of Knight (1937), Rado (1933), and Alexander (1956), emphasize the predominance of oral craving in malignant or essential alcoholics. In line with this is the finding that the incidence of peptic ulcer in alcoholics is more than twice as high as in the general population; usually the ulcer precedes the development of alcoholism, and this difference appears to be particularly significant when one considers that patients with peptic ulcers are almost routinely warned against drinking. Many workers have emphasized the importance of specific infantile experiences in determining this oral craving, usually overindulgence by a permissive mother, so that the child does not learn self-control but reacts with rage to every frustration, and perpetuation of this by an inconsistent father who at times forbids, and at other times gratifies, the child's dependency needs, thus fixating the child at an early, oral stage. In such individuals, alcoholism offers a means of returning to the blissful feeling of omnipotence which is unhampered by the need to deal with external reality and which is free from the self-criticism that would otherwise whittle down the illusion of infantile omnipotence. The alcoholic state engenders a return of such omnipotent feelings; the alcoholic thinks anything is possible. We know that the megalomania of the infant is nourished by the effortless, passive gratification he receives early in life; later, however, reality experiences and failure to achieve immediate gratification modify this omnipotence.

Self-esteem essentially is a measure of how successful the individual has been in coping with his environment. If he is unsuccessful, and particularly if his failures come early in life, he will give up trying to cope and will retreat to the earlier stage, longing once again for passive gratification by the mother, and longing particularly for gratification along the original oral route. In the alcoholic, we find that orality is relatively or absolutely increased, and that parental attitudes deny the gratification which such increased orality demands. This dearth of oral supplies leads to chronic disappointment and rage but since, quite literally, the helpless child can hardly bite the hand he hopes will feed him, this rage must be blocked from expression. It is turned inward, against the self, in the form of a tense depression (Rado, 1933) and gives rise to all-pervasive guilt and a tendency to masochistic maneuvers. Later in life, any frustration re-

activates this cycle, and alcohol is used both to reduce in a direct way the strength of the drive, stress, and aggression and also as a symbolic substitute for the desired gratification. Alcohol thus produces pleasure, elation and a retreat to the original infantile state. The rejecting mother is often relinquished as a potential provider and the father is turned to as a substitute, in a passive, longing, more or less homosexual way. Consumption of alcohol becomes an irreversible habit, and physiologically the alcoholic soon adapts himself to a condition of chronic drunkenness (Button, 1956).

Like our previous formulations, this one too is extremely interesting and gives us new insight into the alcoholic; but does it really explain anything? One need not be an addictive alcoholic to experience a tinge of omnipotence after a glass or two of champagne on New Year's Eve; and, again, indulgent mothers and inconsistent fathers with the unconscious tendency not to allow their children to mature are a much more common occurrence than is addictive alcoholism (Alexander, 1956). Smith (1958) points out that, while it is true that most men drink in the presence of other men, there are only two sexes to choose from; and while sucking on a bottle may indeed characterize oral eroticism, there are few other routes possible. One must still wonder why only some oral characters become addictive alcoholics, when others of the same orientation, even though most have been exposed to alcohol throughout their lives, are able somehow to avoid the destructive path of their less fortunate brothers. I am in full agreement with Bacon's (1958) opinion that a more specific etiology than the oft-sung psychodynamic one is indicated by this paradox, and I would suggest that the oral fixation is, in reality, a constitutional orality (or alcohol "proneness," to use Wilkins' [1956] term) determined by specific metabolic or physiologic abnormalities.

There are several findings in favor of such a view. All who have worked with alcoholics agree that the controlled alcoholic must be totally abstinent (Bowman, 1956). Results obtained with reconstructive types of psychotherapy have been disappointing and are inconsistent with the view that this is a wholly psychogenic disorder. And, on a more theoretical basis, the low tension tolerance and the excessive amounts of freefloating anxiety so characteristic of the alcoholic are also characteristic of epilepsy and other non-psychotic brain disorders.

But what is the specific abnormality? To this question, we have no satisfactory answer as yet. The earlier idea that malignant al-

coholism is on a hypersensitivity or allergic basis is no longer tenable (Himwich, 1956; Robinson and Voegtlin, 1952). Not long ago it was suggested that underactive adrenal glands were the basis of the disorder (Smith, 1950; Tintera, 1956), but it seems more likely that hypoadrenocorticism is a result of drinking. Still more recently Williams (1952) has posited a genetotrophic theory: a metabolic defect renders the subject incapable of utilizing certain essential foodstuffs; on this basis, a nutritional deficiency develops and alcohol is used in a vain attempt to fulfill his dietary needs. Although this is far from established in the human, the experiments on which this view is based clearly demonstrate that an increased oral need can be induced metabolically. In the human, some similar defect, coupled through repetition with alcohol intake, may determine the specific addiction to alcohol which is seen in the malignant alcoholic.

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Children in the Alcoholic Family

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A review of the literature on the effect of alcoholic parents on their children reveals surprisingly few direct and well-controlled studies. That there is an enormously damaging effect we know from the constant references to behavior disturbances among the children of those alcoholics who reach the courts, mental hospitals, alcoholism clinics, private doctors, social agencies, ministers, and marriage counsellors. Also, in analyzing emotionally disturbed non-alcoholic adults, one finds that alcoholism in one of the parents has not infrequently been one of the contributing factors in the development of the neurosis, psychosis, or psychopathic trends for which they seek treatment. I

have felt that the more severe the alcoholic pathology in the parent, the greater has been the damage to the developing child.

SCOPE OF THE PROBLEM

Alcoholism has been called *the family disease* for every member in such a family is affected by it—emotionally, spiritually and, in most cases, economically, socially, and often physically. The security, love and warmth necessary for adequate development of children are rarely present in such a home or, if present at times, have such an unpredictable quality that the child has difficulty developing the trust and confidence in himself and others which he will need for future successful living. The child of the alcoholic enters adult life with a definite handicap. How crippling this handicap will be, will depend on many variables, among which we might mention his inherited temperament and constitutional equipment; his physical health; his intelligence, education and training; economic security; the personality and maturity of his non-drinking parent and siblings; the degree of the drinking pathology of the parent; the way the alcoholism has been handled; and whether or not the drinking parent has brought his addiction under control.

Is there an inherited predisposition to alcoholism? I believe not. In spite of the fact that 52 percent of a large group of alcoholics studied had one or both parents who were also alcoholic, there is no definite evidence that alcoholism *per se* is inherited. Evidence is accumulating (Jellinek, 1945) which would incriminate rather the poor social environment of the child brought up in an alcoholic family plus such factors as imitation of a drinking parent, faulty identification, an emotionally-charged attitude toward alcohol drinking, and the example set for the child of excessive drinking as a way of life—a way of celebration, or dealing with problems, or carrying on social intercourse. On the other hand, some investigators believe they have evidence that there is some genetically determined enzyme abnormality (Williams, 1959) or some disturbance in the pituitary-adrenal axis (Smith, 1950; Tintera and Lovell, 1949) or an allergic constitution (Randolph, 1956) which predisposes to alcoholism. We shall have to wait for further studies of cellular metabolism before a definite answer is possible.

One study which would seem to refute the theory of an inheritance of alcoholism is that of Anne Roe (1945). She studied the adult adjustment of children who had been taken away from alcoholic

parents by court order at an average age of five and one half years and placed in non-alcoholic foster homes. When followed up 27 years later, at an average age of 32 years, not one of them had become alcoholic. Had these children continued in their own family setting, the expected incidence of alcoholism would be between 20 and 30 percent. Not only are these individuals not alcoholic, but most have also established adequate personal lives. Were there a genetic basis for alcoholism, we would expect a certain percentage to have become alcoholic. This study is reassuring, not only because it seems to refute a specific inherited pattern in alcoholism, but because it shows the remarkable recuperative ability psychologically and socially of these severely traumatized children when removed from their poor environment.

GENERAL PERSONALITY DEVELOPMENT

One cannot understand the damaging effect of an alcoholic parent on the development of his or her child without some basic understanding of the forces which shape personality in general. During the first year of life, the child lives in a symbiotic relationship with the mother in which his every need for food, warmth, support, protection, tenderness, love and care are supplied to him by the vigilant and loving mother without any effort on his part. Since he cannot yet differentiate self from non-self (mother), the immediate gratification of his wishes gives him the illusion that he himself is responsible for his feeling of well-being. This gives him a sense of power and self-confidence, borrowed as it were from the mother, out of which can grow his later sense of self-esteem and belief in his power to extract from his environment what he needs for body comfort and pleasure. In the normal and healthy sense of unity and empathy between the mother and child, the normal mother feels fulfilled and content and the infant feels invulnerable with an absolute trust in her and in himself. Any disruption of this bond between them will seem like a threat to the infant's life and will be reacted to by him with a feeling of utter helplessness and panic. His expansive and illusory sense of power and esteem will be shattered, leaving him apathetic, anxious, afraid, and utterly without resources for survival. Such feelings may persist into adult life if not repaired early in life and will be found in most, if not all, neurotics.

Toward the end of the first year of life, this illusion of omnipotence in the infant must be gradually given up in favor of the

reality that he and mother are *not* one and that his needs are fulfilled not by himself but by his mother. He can give up this illusion without serious damage to his self-esteem if he can continue to trust his mother to administer to him. In developing a sense of separateness from her, he finds a new kind of self-esteem as he learns, through walking and talking, to gain a partial mastery over his environment. He learns to accept some frustrations and to find substitute gratifications. If he feels secure enough, he will accept the restrictions of training and acculturation without undue pain, learning that mother's approval is, on the whole, more important to him than gratification of certain impulses. Many neurotics, however, have never really learned to face reality and still yearn for the feelings of omnipotence of the infant. Other neurotics have never learned that some frustrations are inevitable and react with rage to any restriction of personal liberty.

Another task for the young child is the acquisition of a conscience which will allow him to accept and live according to the rules of his parents and the culture in which they live. He must learn to accept their social standards as his own. The child's early dependence on the parents' ideas of right and wrong should give way by the age of 7 or 8 to an internalization of their standards so that he himself is able to guide his own behavior. Many immature persons have either never developed a reliable conscience at all or have developed too harsh and punitive a one, so that they feel chronically guilty without cause.

As the child reaches the third or fourth year, he notes the differences in the sex of his parents and himself and siblings. He begins to identify with the parent of his own sex and tries to imitate and be like him. He gradually evolves a different kind of loving for each of the parents. With two normal, mature parents, this identification takes place easily and smoothly but the number of adults who are still basically unsure of their sexual identification shows how often this phase in childhood is not passed through successfully; the basis for homosexuality or other sexual disturbances are laid down in these early years.

As the child reaches school age, his horizons, socially and emotionally, broaden beyond his immediate family. He learns to be part of the larger group and begins his education for his future participation as an independent person. Adolescence, with all its turbulence and sexual anxieties, is also a time of great ambitions and dreams. One is learning then to play various roles for future adult life. The vicissitudes of the school years are many and varied. However, if

the first 12-15 years have been successfully lived, the foundations are generally firm enough to withstand later adversities, provided they are not too overwhelming. How often the socializing process is beyond the individual's ability to cope is seen in our juvenile delinquency, our school failures, and the mental breakdowns of adolescence.

The development of the individual from infancy to adulthood does not occur in a vacuum. The growth of personality is as much dependent on the social milieu as it is on the biological development of the individual. During the early formative years, it is the family which constitutes the child's entire social environment. Whether the child will grow into a mature adult will depend largely on how well each member of his family plays his special role in the family drama. The roles of mother, father, husband, wife, and child are specific and individual and thus confer a unique identity to each member of the family. These roles, on the other hand, are not static. They are interdependent and must be flexible enough to meet the ever changing psychological, social and economic intricacies of family life. How well one person is able to play his role will be profoundly affected by how well every other family member is playing his role, as well as by the climate of emotion in the family. When the climate is favorable, the various members of the family can share experiences; each will give support to the affectional needs of the others; problems of discipline and the apportioning of tasks will run smoothly and in general there will be a feeling of harmony, good will, love and loyalty which gives a sense of completeness and confidence to each member in facing life outside the family. If the emotional climate, on the other hand, is one of fear, conflict, anger, distrust, tension, worry, hatred or guilt, no member of the family can escape its blighting and stultifying effects. No personality can flourish and grow in such a soil. It becomes trapped into unproductive, unimaginative, stereotyped patterns of behavior, too rigid to respond to intellectual, emotional, aesthetic or spiritual values; there is a sense of unfulfillment, inferiority and boredom, if not actual hatred, which may dog the individual throughout his life (Ackerman, 1958).

Perhaps after this rather lengthy introduction of the subject of personality development in general, we will be better able to discuss the alcoholic family. As can be surmised, we cannot understand the effect of compulsive drinking on the children without considering the effect of this excess on the drinker himself and on his non-alcoholic spouse. Their roles will be profoundly affected by this illness.

PSYCHOLOGICAL DEVELOPMENT OF THE ALCOHOLIC

Whatever has been said about personality development applies universally, so that to understand the alcoholic we must also try to understand his own childhood. Were the vicissitudes of his own psychological and social background so detrimental to his development that he later on succumbed to alcoholism? Even though we don't know how much his constitution may have predisposed him to this and, even though we fully recognize the pressure of society to drink immoderately, we often find that the alcoholic *has* had a disturbed childhood himself. Often he has been deprived, emotionally starved or neglected so that he has never attained that level of self-esteem and confidence necessary to play his adult role. He may have a chronic sense of never having been loved enough and this constant state of frustration and unfulfillment may lead him to be demanding and competitive for attention. Often he has not outgrown his dependency needs so that he is constantly looking for someone else to do for him those things which he has never learned to do for himself. Being still tied emotionally to his mother or mother substitutes, he feels himself entitled to the special privileges of the infant. Often no one had time or patience or interest enough to teach him to control his impulses, helping him to accept mother's approval in their place, so that as an adult he may still be intolerant of any frustration or restriction. He may feel perpetually rebellious and defiant, brooking no interference with any wish or whim. Because a sense of reality is built up in childhood through measured and kindly meted-out doses of frustrations, as well as through the experiences of the sense organs, unreal attitudes toward life may persist so that an unconscious wish for magical gratification of all wishes interferes with the sober and persistent application to work necessary for accomplishment. Because of faulty identification with his parents, there may have been a lifelong confusion of his sexual role with a lack of self-identity and an imperfectly fused body image leading to a state of confusion and inferiority.

Thus, many alcoholics have reached physical maturity but frequently there has not been a commensurate development psychically and socially due to these adverse childhood experiences. Those alcoholics who do seem to have had a fairly stable childhood experience and who seem to have in early adult life made a good adjustment, gradually lose this advantage. As the alcoholism encroaches

further and further into their personalities there is, due to the toxic effect of the alcohol, a gradual process of regression so that they emotionally show the same infantile pattern of those more severely and more obviously traumatized in childhood.

Most of the psychoanalytic studies of the alcoholic have stressed the deep unconscious conflicts with a regressive acting out of certain forbidden aggressive and sexual drives when intoxicated. Alcohol can allow the expression of hostility otherwise repressed and is able to dissolve anxieties, guilt feelings, and the sense of inferiority and failure. It facilitates a spurious sense of self-esteem and power. It allows expression of dependency needs otherwise not acknowledged. Alcohol may come to symbolize the mother in that it makes one feel warm, accepted, loved and cared for—and, furthermore, it is a mother over whose presence the alcoholic now has the complete control he did not have but wanted in infancy. Any attempt to interfere with the drinking will be vigorously resisted with rage and sometimes violence. Between drinking benders, great anxiety is usually felt by the alcoholic because he feels totally inadequate to cope with the realistic problems of work, family, and social life. Feeling unloved, unwanted, angry and inferior because of his impotent passivity and dependence, he has not the courage to be assertive and independent except under alcohol.

We can see from this description of the alcoholic how incapable he is of playing the role expected of a mature man. Being often extremely intelligent, sensitive, gifted and talented, the alcoholic feels profoundly disturbed by his own behavior. Feeling for a long time that he cannot live without alcohol, he tries unsuccessfully to modify his drinking, an attempt which is foredoomed. As the drinking increases, there are more and more disastrous results often with loss of job, prestige, social position and self-respect. Being deeply wounded by all this, the alcoholic may be thrown back emotionally onto his family who by now often does not want him either.

No alcoholic wishes to relinquish alcohol and will not do so until he is forced by circumstances to recognize his complete inability to drink without disastrous results. Even then he will not give it up until he can at least envision a life without alcohol as better than one with it. The deep anguish of the alcoholic as he struggles with his addiction is bound to influence every member of his family. In the alcoholic's desperate effort to endure his misery, he engages in certain defense mechanisms to ward off his intolerable anxiety. As Vogel (1958) has shown, those most commonly used are denial that he

is alcoholic, projection of the blame for his plight on others (most often the wife or the employer) and an intricate system of rationalization as to why he is in trouble or why he needs to drink. Since these defenses are all false, they serve to alienate the alcoholic further from himself, his family, society, and truth.

THE WIFE OF THE ALCOHOLIC

It has been found surprisingly often that the wife of an alcoholic is also an emotionally disturbed person. Frequently this maladjustment antedated the marriage, with the choice of an alcoholic mate often having been determined by some neurotic need of her own. Bullock and Mudd (1958), in a study of 20 couples in which the husband was alcoholic, found that 70 percent of the men described marked unhappiness and conflict in their family backgrounds, with over 50 percent having had a heavy drinker in the immediate family. Consistently this was the father, but in a few cases it was also the mother. He found an unhappy family background in over 30 percent of the wives also, with difficulties in the relationship to both parents. A heavy drinker was present in the families of over 30 percent of the wives, the individual usually being the father.

A number of interesting personality studies have been made of the wives of alcoholics. Baker (1945) points out that though the wife is not responsible for the alcoholism of her husband, she may be one of the reasons for his continued drinking in spite of treatment. Since her personality disturbance may be even more serious than his, she is equally in need of psychotherapy or counseling. Futterman (1953) shows that some women seem to need to be married to weak, dependent, alcoholic males. One woman stated that she would not divorce her third alcoholic husband because she knew very well that she would only marry a fourth alcoholic.

Such a woman is often the daughter of an alcoholic father and a dominating mother. Her ego ideal, through identification with the mother, is that of the powerful woman. She sees herself as indispensable, as capable of playing the role of both mother and father to her children, and tends to push the drinking husband further and further out of the family. Though this is her conscious picture of herself, unconsciously she feels inadequate to live up to her ego ideal as either wife or mother. It is only by feeling superior to her husband and keeping him inferior to her that she can deny her own basic inadequacy. Frequently, as the alcoholic becomes abstinent,

this type of woman no longer has her foil and may decompensate emotionally herself, reacting with severe depression or other neurotic disturbance.

Boggs also stresses the need to treat the "alcoholic marriage," since each of the partners seems to be striving to make the other play the role which would meet his individual needs. According to this author, good adjustment in the wife of an alcoholic is rare indeed. "The uncanny ability of the alcoholic to seek in marriage an equally immature and needful person" is emphasized (Boggs, 1944, p. 562).

Pointing out that the wife often tries to keep her husband inadequate to justify what seems to be a lack of love for her on his part, Price describes the wives of alcoholics as basically dependent people, nervous and hostile, despite an appearance of adequacy and capability (Price, 1945). These women marry hoping to find strong, supportive, dependable persons on whom to lean. On discovering how incapable the alcoholic is of filling this role, they react to the apparent rejection with hostility and resentment. Unable to consider the spouse as a person with needs and wishes separate from her own, the wife tends to put more and more demands on her husband, making him feel and actually become less and less adequate.

Whelan, in a perceptive way, goes into considerably more detail in describing the various types of wives of alcoholics found in a family service agency (Whelan, 1953). She describes the martyr, the wife who seems to have a "need to be miserable." She is generally responsible, self-effacing, and is "meek and good." Often she is so practical that she runs an efficient but completely joyless household with emphasis on neatness, orderliness and repression of normal feelings of anger. Being just too good to be true, she is quite difficult for an alcoholic husband to feel close to. In spite of her patient, conforming manner, her lack of humor and the general cheerlessness may keep the alcoholic away from home as much as he can manage. The children may be over-conforming and good or they may rebel against her as well as their father.

Whelan then describes the controlling wife, the "boss lady," who is often resentful of men in general and her husband in particular. Feeling that men have all the breaks, she married a man whom she could control and secretly look down on. Underneath this cloak of superiority is often an insecure woman who cannot function unless she feels superior and on top. She is unforgiving, hard, and self-righteous on the surface but underneath she is often fearful, anxious and dependent. She brings her daughters up to distrust human re-

lationships and to reject their femininity. The sons, who have no strong, masculine father with whom to identify, worry about their masculinity and, in an effort to deny their lack, they may become aggressive and antisocial. If the children turn out badly, the world thinks it is because of the alcoholic father but the mother is equally to blame in this kind of family.

The third type of wife is often an efficient manager who "picks up the pieces and holds the family together during sprees." Eventually she loses patience, becomes furious and despairing, may leave her husband or call in the police, but soon relents when her husband pleads with her. On the surface she is usually likable, good natured and pleasant but underneath she too is insecure and does not think much of herself. She has a great need to be loved but feels that no one will love her unless he needs her. She will try to marry a man who cannot get along without her and binds him to her because of his helplessness. This type of woman may unconsciously block treatment for her husband, fearing that if he does not need her desperately, he will not love her any more. With this strong need to be loved, she may not want the children to grow up to independent status and she may tie them too closely to her. She unconsciously keeps both her husband and the children passive and dependent.

The fourth type of wife described by Whelan is the punitive one. She is often more successful than her alcoholic husband and often rubs it in. She is usually the breadwinner, sometimes a career woman. She feels intense rivalry and envy and is usually aggressive. She is quite willing to shoulder most of the responsibility—to buy the clothes, pay the bills, and supply the TV set, so long as her husband and children obey her. She will give her husband anything he wants except his manhood. To drink may be his only way to assert his masculinity or, at any rate, he *thinks so* and this makes her furious. Her role of indulgent mother to him changes to that of punishing mother and she acts as though she were married to a small boy. The children suffer dreadfully in such a marriage. Added to the rejection by the father is the fact that this mother is too busy making a name for herself in business, profession, politics, or with a women's club to get to know her children. She is rarely there when they need her. When they turn out badly, as they frequently do, the townspeople say, "But of course, what else can you expect with an alcoholic father." The mother here is as damaging to her children as the alcoholic, and sometimes even more so.

What the alcoholic contributes to a disturbed family situation may be all too obvious in terms of noise, angry neighbors, delinquent children, irate landlords and visits from the police. All this turmoil may give the impression that the wife is the innocent victim. Actually, the alcoholism may be a red herring for the neighbors; the neurotic wife may bear equal responsibility for the unhappy marriage.

Wives such as those described by the above investigators may consciously or unconsciously block the treatment of their husbands' alcoholism if their own emotional adjustment depends upon the need to dominate a weak man, to control, be on top, or to mother, to take care of, or to punish. McDonald (1956) has described how these women may decompensate when their husbands do sober up.

That not all wives of alcoholics are necessarily neurotic has been stressed by Joan Jackson (1958). According to her the high divorce rate of alcoholic marriages (four times that of non-alcoholic marriages) suggests that most women married to alcoholics divorce them. Also, she points out that the above samples of wives studied were "actively blocking the treatment of their husbands, had entered mental hospitals after their husbands' sobriety, were themselves seeking psychiatric care, or were in the process of manipulating social agencies to provide services" (Jackson, 1958, p. 93). The same writer also finds it difficult to know whether the personality difficulties of the wives antedated or postdated the alcoholism of their husbands. These disturbances, though nearly always present, are often merely the result of the recurrent crises and cumulative stresses of living with an alcoholic.

Jackson (1954) worked with a group of over 100 wives of alcoholics who were attending Al-Anon meetings and were therefore, in spite of their confusion, anxiety, and ambivalent feelings, oriented toward changing themselves and the situation rather than escaping from it. I, myself, in my work with the wives of alcoholics, have been impressed with the profound change that Al-Anon (1958) can effect in these unhappy, angry, bitter, hopeless and hostile women. The cathartic effect of sharing their experiences, the practical advice on how to cope, and the kindling of their alcoholic mates' hopes of recovery and betterment of themselves and family, go a long way toward wiping out what had seemed to be a deep-seated neurotic attitude toward life and their husbands.

THE ALCOHOLIC MOTHER

The woman alcoholic is not psychodynamically different from the alcoholic male, though the presence of the still existing double standard does influence her pattern of drinking. Heavy drinking by men is more readily condoned than is that of women so that the latter feel more shame and guilt when they do overindulge. This, and their protected position at home, makes for solitary drinking. Housewives may be able to hide their drinking from their husbands for quite some time. Not being subject to the discipline of fixed hours at an outside job, they may drink small amounts all day long. For a long time such a woman can continue with her household duties, her shopping and the care of her children, all the while being just a little befuddled. Her drinking is usually a closely guarded secret, with the money for the alcohol taken from the household budget. I believe that alcoholism progresses more rapidly in women than in men. Perhaps this is merely because men are protected from drinking somewhat during their hours on the job.

I do not believe alcoholic women to be more promiscuous than alcoholic men. In their utter despair and loneliness either sex may seek surcease and the affection they do not get at home in these transitory and generally unsatisfactory episodes of infidelity. By the time the alcoholism has reached a certain depth, both men and women lose interest in sex, except in fantasy. Women are, of course, in much greater danger of sexual exploitation than men because they are often too ill and weak to resist advances and because of the danger of pregnancy.

The emotional withdrawal of the alcoholic wife from her husband, children and friends may be so gradual that the husband does not suspect a thing. Although somewhat uneasy at the way the marriage seems to be slipping away, he may accept his wife's explanation that she is overworked or that the children are too much for her. It may be an enormous shock to him to come home one day and find her drunk, with the work undone and the children afraid or running wild. Because of the double standard, the husband is usually disgusted and angry.

A good deal of therapy may be necessary for him, as well as for his wife, before he will accept her condition as an illness. I have found men generally less patient and accepting of alcoholism and less willing to learn about it than are the wives of alcoholic men.

They are more apt to pack up and leave an alcoholic wife whom they feel they can no longer love. Sometimes the children too are abandoned along with the wife, but battles in the courts over custody of the children are frequent. The wives of alcoholic men, on the other hand, will make almost any sacrifice to help their husbands once they have learned to look upon them as sick individuals. This is partly because of their greater tendency to mother and sympathize with the husband, sensing that he cannot help himself, and is also due to the greater permissiveness in our culture toward drinking among males. Also, there is the fact that the wife is usually financially dependent on the husband for her own and the children's support.

Among the husbands of alcoholic women I have found the following types: the long-suffering martyr who mothers and spoils his child-wife, the husband who leaves furiously but comes running back, the unforgiving and self-righteous husband, and the punishing, sadistic variety. There is also the dependent male who expected to find another mother in his wife and who is hurt and bewildered at finding that the woman he married—the one who put up such a show of self-confidence—has become just as dependent as he through her alcoholism. Then, of course, there is the "normal" man who wakes up in dismay to find himself with an alcoholic wife.

THE FAMILY OF THE ALCOHOLIC

Alcoholism is profoundly disturbing to the entire family structure and can plant the seeds of mental illness, not only in the children in their formative years but in each adult present in such a family. But the alcoholic is influenced too, just as much by the attitude of his family toward him and his illness as he influences them. His recovery may even depend upon their patience and understanding help in guiding him to therapy. How difficult it is for the man or woman without a family to recover we can see from the plight of the family-less Skid Row derelict whose only contacts outside of drinking buddies may be the impersonal police or court attendants. Loneliness after divorce or death may be precipitating or perpetuating factors in alcoholism. For the alcoholic whose family's attitude is negative, condemning, punishing and hopeless, the chances of recovery are decidedly not good. It is for this reason that treatment is most effective when not only the alcoholic but the wife and children are included in the treatment program.

How do the children fare in an alcoholic family? As stated above,

it will depend on many variables; the intelligence, education, economic status, mental health and age of the parents being of paramount importance, as well as the stage and degree of the alcoholism. Jackson (1954) has delineated the various stages through which an alcoholic family passes. In the early stage of alcoholism, both the husband and wife are apt to deny its presence, finding excuses for the occasional overstepping of bounds with heavy drinking. This may be embarrassing but is not considered too serious, and both partners tend to minimize its importance. As the frequency of such occurrences increases, the wife begins to feel humiliated and ashamed. She curtails their social life, hoping in that way to diminish her husband's temptation to drink. As a result, invitations are received less often and the ensuing social isolation leads to too-close family interactions. The wife is under the impression that she has somehow failed in her marriage, and both partners begin to feel deep resentment.

What Marty Mann (1958) calls the "home remedies" are persistently tried, despite their evident failure to control drinking. Liquor is locked up and bottles hidden. Money is withheld and charge accounts canceled. The family tries moving from the city to the country, or vice versa. At first the couple discuss the situation with "sweet reasonableness," later with anger and recrimination. Emotional appeals—"How can you do this to me?" "Where is your self-respect?" "Think of the children"—are as ineffective as everything else. This is because the alcoholic, though sincere in his promises, is unable to stop without outside, expert help.

Jackson (1954) states that during this stage all is chaos. The children become involved and are bewildered. There is hostility, frustration, fighting, threats of leaving. The wife reacts to the alcoholic's violence by cringing in terror, retaliating, or calling the police. There is economic anxiety, for often in this phase the alcoholic works only intermittently. The wife may fear for her sanity and the emotional effect on the children. The alcoholic himself begins to think he is "insane," since he cannot understand why he does the things he does.

Becoming too ill to recover at home, the alcoholic begins the trek to hospitals or sanatoria or doctors. He is frequently arrested for disorderly conduct or chronic drunkenness. Finally, when he has "hit bottom," he may try Alcoholics Anonymous. The wife may go with him to the A.A. meetings or to the meetings of the A.A. Family Groups. She begins to learn techniques of management and gets

much support from identifying herself with other wives who have had the same problem.

If the alcoholic husband does not recover through A.A., psychiatry, Antabuse or the Church, the wife may find courage enough to take some constructive long-range steps. She may precipitate the crisis necessary to "bring her husband to his senses" and force him into treatment by separation or divorce. The husband may be very difficult at this time—physically violent, threatening to kidnap the children, turning up drunk at the wife's place of employment, withholding all support if the wife is not working, or pinning her down with threats of suicide.

It requires great fortitude and courage for the wife to carry through her plan, but it is often necessary to do so for her husband's recovery. This need to interrupt the dependency pattern of certain male alcoholics by withdrawal of emotional, physical and financial support is well described by Myerson (1953). The woman who is being leaned on may be the mother, sister, or wife, sometimes a friend. In any case, shielding the patient against the consequences of his drinking may seriously impede his recovery.

If the husband does sober up and the family does take him back, there may be unsuspected basic problems still to solve. Having been in charge for so long, the wife may dislike relinquishing her power. Then, too, the children are not used to including their father in their plans and may resent his sudden assumption of authority over them. They may hesitate to go to him for advice, and, if they do, the mother may feel left out and resentful.

In his new sobriety the husband may expect endless praise from his wife for his "brave comeback." Yet she may continue to berate and belittle him for his past actions, being unable wholly to forgive him. If he spends too much time at A.A. meetings, she may grow angry and again feel rejected and abused. However, with the help of psychotherapy or A.A. for both husband and wife, it is remarkable how many families do manage to attain a large measure of happiness. While sobriety is a prerequisite, it is not the total goal. The whole family may need help in reorienting itself to a new way of life. In this regard, the wife must bear in mind that in our culture the man should be at least an equal if not the master. He cannot function successfully without a sense of personal dignity.

THE CHILDREN OF THE ALCOHOLIC

The effect of an alcoholic father on young children may be more indirect than direct. If the mother is loving and relaxed the child will thrive, but if she is neurotic herself, or angry, exhausted, hostile, and worried the child will suffer. Even her milk can disagree with the infant at such a time. The tension she feels will infect her child and there will be a serious disturbance of the empathy between them. If this negative state lasts too long, the development of the child's ego can be seriously interfered with. Because of an overwhelming disappointment in a marriage, some mothers will reject their children, especially if they happen to look or act like the father. They are apt to become over-solicitous with these children because of their guilt feelings. Others will turn to the children for a satisfaction of all their love needs, pushing the alcoholic father completely out of the picture. Most mothers feel guilty about this too, though they may not be aware of it.

The effects of an alcoholic mother on a young infant can be disastrous. Though she may sincerely love the child when not drinking she will frequently be so guilt-laden that she also becomes over-solicitous. Since she frequently is not living in harmony with her husband and because she has withdrawn from much of her social life and interests outside of the home, she may turn all of her unsatisfied love and yearning onto the child and build an unhealthy, clinging, overdependent attitude in the child.

When the mother is drinking she cannot help but neglect the child. She may not wake up when he cries, may forget to feed him or feed him impatiently or with poorly prepared food, she may leave him cold and wet, slap him when he continues to cry, or leave him alone for long periods. Quarreling parents can deeply disturb a child of even a few weeks, causing gastro-intestinal upsets, asthma, skin rashes, etc. When the father takes over and cares for the child the mother may become jealous and spiteful, competing with the child for the father's attention. When the drinking bender is over the mother, being deeply ashamed, may try to make it up to the infant, becoming maudlin and overindulgent. With such unpredictability the smooth flow of symbiotic communication between mother and child on which the future sense of confidence, self-esteem, and trust are founded is shattered. Into the child's character may be built a fundamental and permanent mistrust and sense of having been

cheated. This may be central to the later development of psychopathic, psychotic, neurotic or alcoholic trends.

As the child enters the next phase of development, any thwarting of his drives to grow, to explore, to master the environment realistically through talking and walking, to gain a sense of reality and personal identity and to internalize the do's and don'ts of the parents into a conscience will hamper his orderly development. The role of the father becomes as important as that of the mother in this and subsequent stages of development. How each parent plays his various roles will determine to a great extent the child's future mental health.

The child needs secure, predictable, tolerant and understanding adults who will guide him patiently in his growing up. As Frank says,

> He faces a series of unavoidable life tasks, including the persistent problem of how to get along in an organized group life. To the young child the world around him is indeed precarious and ambiguous. He faces a natural world often dangerous and always puzzling even to adults; his own organism, with its many functions and needs which must conform to parental and social patterning; obscure, often unconscious, impulses that impel him to actions that frequently he cannot understand, and that others usually resent, rebuke, and often retaliate for; a social or cultural world organized into patterns of behavior and regulated by symbols, such as language, that are subtly differentiated and variable; a constellation of human relationships, in the immediate family, the wider kinship group, the neighborhood, and the school, among which he must find personality fulfillment and security despite the capricious and disparate character of all these impinging personalities; and finally an immense body of tradition and folklore, knowledge, skills, and play (Frank, 1938, p. 373).

In the acculturation process, every child must learn to accept certain deprivations, repressions and redirection of his instinctual impulses but he cannot learn them alone. When he is taught by loving and patient parents who do not distort, frighten or condemn him for his mistakes, he will be glad to learn the rules of our culture. The alcoholic parent often has not learned these rules very well himself, or has forgotten them if he had, and is therefore unable to be a good teacher. His capriciousness, his impatience, and his own insecurity and egocentricity render him incapable of the calm stable orderliness necessary for smooth learning. Training through engendering fear and anxiety and through coercion, and arbitrary force, will lead inevitably to resentment, mistrust, and a wish for revenge which can cripple a child for life. Though outwardly conforming, there may be a lifelong inner rebellion against all authority leading to self-defeat-

ing neurotic behavior, or the rebellion may be directly expressed in delinquent and antisocial behavior.

Battles over disciplining of the children are almost always present in an alcoholic family, leading to a real confusion in the child regarding what is expected of him. He may play one parent against the other, ending up with little respect for either one. A frustrated parent may take out his anger against his wife on the innocent child who cannot retaliate. Or an angry parent may overindulge a child to win him away from the spouse, not because he loves the child but to spite the other. Derogating the child, and not the unacceptable act he perpetrates, can lead to a persistent feeling of inadequacy, guilt and worthlessness. It also prevents the child from learning *why* a certain act is not acceptable so that he may never learn to recognize the impersonal authority inherent in certain situations. Children, as well as many adults, need a large measure of direction and many rules for behavior, so that responses in certain situations can become automatic. "These learned patterns and repressions are the chief factors in man's ability to go beyond a purely organic existence. It is not the ordering of life that damages the child, but the distortion, the fears, anxieties, and permanent frustrations and inhibitions that parental and educational practices unnecessarily inflict upon the child in the process of establishing these socially and individually necessary repressions" (Frank, 1938, p. 374).

How well can an alcoholic father play his role in the family? Nancy Newell states that

> the more subtle implications of the alcoholic father differ qualitatively from those of the father who is just rough, unkind and indifferent. In his periods of sobriety, the alcoholic father frequently is charming, affectionate, understanding and penitent. He inspires the natural love of his offspring who build therefrom an ideal father image of omnipotence and loving kindness. The disillusionment of a drunken episode is shattering to the frail, superego structure of the child. He is forthwith subjected to alternating experiences of exalted hopes and blighted disappointments. He may be compared to the hungry experimental animal which is tempted with food and frustrated by sudden barriers. Such a process may produce convulsions or "nervous breakdown" in the animal. It is surely dangerous to the highly organized human creature who, in the formative period of childhood, is just becoming aware of social and cultural standards, as well as of the interpersonal relationships of his home. It is not surprising that a child thus exposed presents a bewildering array of ambivalence, inconsistencies, antagonisms and touching overtures of affection" (Newell, 1950, p. 92).

The picture the alcoholic male has of himself as a father is a confused one. Ackerman (1958) has shown how in the past century the image of the father has changed from that of the "man of vigor, strength and courage, the unchallenged leader and governor of his family" to that of "the father weak, immature, dependent, frightened of competitive injury by stronger men." The image of the mother has also changed—no longer is she helpless and dependent on and subservient to the male but is now "strong, self-sufficient, aggressive, and shaping the fate of the family." But the same author finds the aggresiveness and mastery to be merely a façade, "an effort at compensation, an effort to console herself for her inability to depend safely on the man" (Ackerman, 1958, p. 179).

Certainly many of our alcoholic families show this configuration of father and mother in extreme caricature. Is it any wonder their children grow up with a confused picture of sex roles? Being unsure of his sexual role or being dissatisfied with the sex constitutionally his, the father makes a poor model—but so does the mother because of her own fears regarding the adequacy of her feminine role.

Few alcoholic males are able to maintain adequately their various and complicated roles. Some may be good in their work but poor as either husbands or fathers. Some can relate to women only as though they were children, in which case they compete with their own children for the wife's attention. The child feels unloved and often blames himself for the fights between the parents. During quarrels the child most often sides with the non-drinking parent because it is safer, but in so doing he feels disloyal to the other parent and fears the loss of his love. The child may even feel that he is to blame for the drinking episode itself because of some of his own shortcomings. Thus, the child lends himself to the role of scapegoat and can be unmercifully punished. Instead of a united family, hostile alignments occur. A boy in a family is more often the target of a drinking father than a girl. A seductive preference shown the daughter may even occur and bind her too close to the drinking father, so that she sides with him against the mother. If she is basically dependent on the mother, her guilt and confusion may be tragic. This pairing off in families may take many forms—father and daughter against mother and son, father and son against mother and daughter, or the children against both parents. In some families the allegiances may shift with in-laws and grandparents playing important roles in the battle. From these warring camps, one member may be totally isolated and alone.

It has been shown that some delinquent behavior in childhood is a response to unconscious expectations of the parents. The children are tacitly encouraged to carry out some of the acts the parents would enjoy doing themselves but cannot because of inhibitions. Some alcoholics so encourage antisocial behavior in their children when they are drinking, and so punish them for it when they are not, that it is difficult for a child to develop consistent standards of behavior. An alcoholic when sober may feel or be made to feel so inferior to his wife that he goads the son into the antisocial behavior against her which he does not dare carry out himself in order to punish her. When the mother retaliates against the child for this behavior, he is further confirmed in his belief that he is "no good" anyway and suffers from deep feelings of frustration and guilt.

A neurotic personality can sometimes make some kind of an adjustment by victimizing those around him. The alcoholic can do this by forcing his family to accede to his wishes with the unspoken threat that he will drink if they do not. Underneath the outward compliance of the family, however, there can be deep and bitter rebellion and hatred. Revenge fantasies alternate with feelings of pity, helplessness and confusion. The demands made by the alcoholic are unpredictable and often contradictory, so that the child does not know how to behave or what is expected of him. At one moment he is asked to shoulder big responsibilities, the next he is told to get out. The injustice and severity of the punishment meted out to the child for his misdemeanors contrasts glaringly with the violent speech or acts of the father when drunk, which go largely unpunished. Learning that one is not held responsible for what one does when drinking may have an unconscious appeal to the child so that in later life he may use the same tactic.

The breakdown and disorganization within the family makes it impossible for the child to have the emotional warmth and support he needs in order to develop his sense of self and worth. His great need to belong will often drive him away from home to the "gang," where he can feel that he does belong. His model then will be the gang leader instead of the father. Other children in an alcoholic family may feel too frightened of the outside world to make such a transfer and remain hopelessly trapped in the hostile, growth-inhibiting isolation of the battling family. The former group of children take the path of delinquency, the latter the path of neurosis. Such interdependency within the isolated family does not denote a healthy

"togetherness." It is defensive and compensatory in character and means a retreat from life and the outside world. Shame, fear of ridicule, and humiliation may keep such a family together but at the expense of growth-promoting experiences in the larger society. The interaction within the family becomes so close that it stultifies and inhibits development. There is little of the tenderness and mutual support which give courage to each member of a family to be receptive to new and broadening experiences.

Yet, in spite of the problems within an alcoholic family, many of the children do turn out well. Much depends on the personality of the alcoholic when he is not drinking for he can be lovable and supporting at such times and undo much of the harm. Equally as much depends on the personality of the non-drinking parent and his or her acceptance of alcoholism as a disease. How can we best help the alcoholic, the spouse and the children?

HELP FOR THE FAMILY OF THE ALCOHOLIC

It is not easy to help the children of alcoholics without the cooperation of the family in a total rehabilitative program. It has been shown (Holden, 1945) that the results of therapy depend more on an improved relationship between the parents and the child than on the relationship between the child and the treating psychiatrist. Rarely do the children improve much while there is a continuing state of insecurity at home, no matter how good the therapist. For this reason, it is best to concentrate first on the alcoholic problem itself, next on the disturbed family unit, and third on the individual personality maladjustments which may have resulted.

In the most serious cases, the first steps may represent emergency measures and may entail hospitalization or even jail if the alcoholic has become dangerously violent. Or the situation may require that the children be removed temporarily from the home, with or without the non-alcoholic parent. As serious as food, shelter, clothes, and heat may be at times, the emotional effect of chronic bitter quarreling may be far more damaging and frightening to the child. Since the alcoholic is often too ill to judge the situation correctly, it is incumbent on the non-drinking spouse to make and carry through these steps. Much outside support and help may be needed which may come from a doctor, a minister, the courts, or social agencies. Such steps, though often seemingly drastic, may be the essential first step

necessary before a real appraisal of the situation is possible. If done without rancor and hostility, it will help the alcoholic to see the situation as it honestly is—a necessary prerequisite to change.

If the alcoholic then begins to make a sincere effort, every encouragement should be given to him. The disease nature of the condition should be understood by not only the patient but the family members as well. Patience will be needed and tolerance for the occasional slips which are to be expected at first. Treatment of the alcoholic should be multifaceted and directed at his physical, emotional and social state. Alcoholics Anonymous, or group therapy, or counselling, or Antabuse, or all combined may be needed. It is best to use a team approach, bringing in the doctor, the minister, close friends, and sometimes the employer in the total approach. Concomitant treatment of the families through Al-Anon Family Groups, group therapy, or counselling enhances the results enormously.

If the alcoholic consistently refuses to undergo therapy and continues to drink, separation or divorce may be necessary. Though this should not be done lightly, it may be the only possible solution for the children and it may have a powerful effect on the drinker himself in forcing him to face the consequences of his drinking. The threatened or actual loss of a job, of health, or prestige may also be powerful deterrents to continuing the drinking career and may need to be suffered before treatment is even considered by the patient.

Sometimes we find alcoholism in both partners of a marriage. No deeper tragedy could befall their children. All is chaotic and unpredictable, with frequent violent and bitter quarrels. The pattern varies greatly in these marriages. When one is sober, the other may drink out of retaliation or relief when the partner sobers up. Both partners may start drinking together socially and end up in bitter quarreling. Not infrequently a spouse becomes alcoholic in an attempt to keep his or her alcoholic partner company.

If both are alcoholic, one may recover and find himself or herself just as intolerant of the other's drinking as those who had never been alcoholic. Many persons in Alcoholics Anonymous have partners who are still drinking but refuse to recognize it as a problem. In some cases they are alcoholic; in others, merely heavy social drinkers. In either case the alcoholic finds it difficult to continue abstaining.

These parents can both recover and become good parents but the children should not be left too long in such a family. Relatives or foster homes temporarily or permanently may be the only way to bring

order into the lives of their children. It often takes the authority of the court to assure these children the protection they need.

When the alcoholic is undergoing therapy and has stopped drinking—or drinking less, many problems clear up almost overnight, it seems. The tendency to blame all the ills of the family on the drinking, however, has obscured many of the non-alcoholic problems which then assert themselves and need to be worked on. It is here that the family approach to therapy is so helpful. Conferences with each member separately, with the husband and wife together, and finally with the whole family together may be needed. Various types of groups are helpful, too—for couples, for wives, for husbands and for teenagers. Visiting from one group to another can also be helpful in expanding horizons and gaining deeper insight into each other's points of view.

Fortunately, the child of the alcoholic has usually experienced love—sometimes in generous amounts—but he has also experienced such bewildering and often repeated rejections that he has become wary, suspicious, and distrustful, hiding behind a defensive barricade. He is fortunate if one parent is consistently loving and dependable but as we have stated above, oftentimes the non-drinking parent is unable, because of his or her own hurts and disappointments, to be this kind of a person. The therapist must serve as auxiliary or substitute parent for the child, helping him to build a new trust, faith, and understanding; to find substitute expressions for his pent-up hostilities; to control his aberrant impulses; to improve his techniques of reality testing; and finally to help him know how to return the love he has finally learned to accept.

Adolescent children in an alcoholic family represent a particularly delicate but not insoluble situation. The personal pride of the adolescent has frequently been so outraged by an alcoholic parent, that a truly devastating hatred has grown up. This, added to the natural antagonisms engendered by the breaking away from a dependent status, the need to conform to the newly emerging attitudes and standards of the peer group, the turbulence of the physical and emotional changes of sexual maturation, and the social anxieties, all together can make this a touchy period. The therapist may be called on here, too, to be the substitute parent, protecting the adolescent against the abuse of his real parent as well as against his own undermining feelings of anxiety, inadequacy, fear, loneliness, hostility, guilt and shame. Not having had a consistent parental figure with whom to

identify, the therapist may be made the model without which a sense of personal identity and worth cannot be built up.

Group work is especially effective for adolescents if it can be kept flexible enough. Problems of dependency, anger, sexual and aggressive impulses, hopes, ambitions, inadequacies, frustrations, rivalries, jealousies and especially problems with authority are played out in the interaction between group members.

The Al-Ateen movement, though not large enough to have much influence so far, shows great promise. This is a fellowship of the teenage children of alcoholics and is an outgrowth of Alcoholics Anonymous and Al-Anon. The meetings are informal discussion groups with usually an invited speaker from A.A. or Al-Anon. It is a relief to see these youngsters—bewildered and afraid at home—free enough to discuss their many problems and their often frightening feelings with sincerity, honesty, understanding and even humor. Since there is an expectancy of alcoholism in 25-50 percent of the children of alcoholics, this group could become of great importance in the field of prevention.

One might ask what are the goals of therapy. For each individual in the family, we hope for a basic growth of the personality structure toward a healthier and more mature outlook, signifying

> not only increased adaptive strength and capacity for resistance to illness but, in a positive sense, the ability to realize potential, to capitalize on personal resources so as to feel free and happy, satisfy personal needs, and be an efficient, productive person. Finally, cure may also mean that the individual, freed of crippling anxieties, can now unfold his capacity for loving others, can share with them both pleasure and responsibility, and can experience the full gamut of satisfaction in making a positive contribution to the welfare of family, friends, and community" (Ackerman, 1958, p. 298).

As the separate individuals in a family learn to play their various roles effectively, they can with help attain many of these goals. When made up of such individuals, the family then can realize its collective goals of mutual support, security, pleasure, self-expression, tolerance of differences, respect of individuality, and the sharing of responsibility and authority. When this is attained, there can develop a sense of values and an ethical code as well as an appreciation of a spiritual life. It is probable that alcoholism is merely one expression of a culture which falls far short of these goals. Ultimate and complete prevention may be possible only when mankind has evolved a

more rewarding life than we now have. Even now, however, we can offer real hope to the children of alcoholics if we will but make the effort.

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Teenage Drinking and Community Organizations

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Recent experiences are demonstrating that effective research can productively utilize cooperative relationships with action programs.

* Appreciation is expressed for permission to use segments from the following in this paper: Sower, C., Teenage drinking and the school. *In mental health aspects of alcohol education.* Boston: Massachusetts Office of the Commissioner of Alcoholism, 1959.

Likewise, it is apparent that community organizations such as schools and churches can profit from working arrangements with the extensive developments in theory and research methods which have occurred in the social sciences, especially during the last decade. Recent research on teenage drinking has direct implications for communities. The primary objective of this paper is to present the portions of theory, research method, and findings of this research which educational, religious, and other community leaders would find useful.

One way of looking at the problem of theory versus practice is to take seriously the guide: "If there is anything worse than theory without practice, it is practice without a theory." The situations which communities must face in dealing with young people have changed so extensively during the last decade that benefit may be derived from an intensive investigation of the body of assumptions and theories upon which practices are based.

Adult interest in teenage drinking is indicative of two important facts which American communities can hardly avoid facing in the coming decades. The first is the established fact that many elements of adult life are patterned in youth stages, and are predictable. Increased predictability in late childhood and early teenage of certain kinds of deviancy is possible by new knowledge and methods. Studies of drinking, for instance, show indications that much problem drinking, including pre-alcoholism, may be predictable by the high school age. Other research developments show that early prediction can be made for delinquency and criminal careers, as well as those related to dependency and mental maladjustment. It seems clear, also, that many of the personality and social performance disabilities of basically handicapped persons are more related to childhood experiences than to the original physical handicap. Research is on the verge of demonstrating the practical application of such predictive methods.

These developments have implications for the organizations which deal with the young people of the community. What these organizations do or do not do is related directly to future adult development and performance. Present evidence is indicating the importance of late childhood and teenage in the development of either useful or liability adult roles. Earlier theories of the all-powerful influence of early childhood are being seriously re-examined.

The second fact that American community organizations can hardly avoid facing is that the total actions of its young people have

a direct reflection upon the school, the church, and other organizations. When young people achieve in academic matters, music, athletics, or community service, the school, the church and the community are given favorable credit. Likewise, they are discredited when their young members get into difficulty.

THE MICHIGAN STATE UNIVERSITY RESEARCH

Before turning to the findings, it is important to point out that the research to be reported represents a cooperative relationship between the Social Research Service of Michigan State University, the State Board of Alcoholism, and the high schools in several communities. Such cooperative working relationships would appear to have considerable potential in helping community agencies understand and solve certain problems, as well as provide research agencies with effective research opportunities.

In designing the research on teenage drinking, it was possible to develop two major hypotheses from the existing literature. The first was that drinking in any society is culturally patterned and socially controlled action. This means that drinking in any social setting is controlled by different beliefs and sentiments, as well as by established rules of who should drink, the times and places of drinking, with whom, as well as the reasons for drinking. There are different rules in most societies, for instance, for persons occupying positions such as those based on age, sex, and social class.

The second general hypothesis was that teenage drinking would have some symbolic meaning for the passage from youth to adult roles in our society. As will be shown, this was found to be of greater significance for young males than for girls.

Teenage drinking cannot be understood outside its setting in the American community, which contains two distinct and inconsistent patterns of drinking. One set of Americans believes that there are many personal and social advantages to drinking when it is not excessive. On the other hand, there is another segment of most communities which believes that drinking is morally wrong. The difference between these two positions in the American community seems wider, less compatible, and more equally divided than in most other societies.

Briefly stated, the findings of the research information from more than 2,000 junior and senior students from six Michigan high schools in three communities are as follows:

About one in ten students indicates that he considers himself to be a "person who drinks." Higher proportions of males than females are in this category; also, more from the highest and the lowest social classes in the commmunities.

About one-third of the young people indicate that they drink with some degree of regularity, either sometimes or often. (The Gallup Poll of American adults shows an increase in the proportion of total abstainers from 33 percent in 1945 to 42 percent in 1957.)

Ninety percent of the students have tasted beverage alcohol. About one-half tasted it first when with their parents.

The "drinkers" performed more adult roles than the "non-drinkers." They were older, earned more of their own spending money, etc.

Two findings about the characteristics of teenage drinking are of particular importance: (1) For at least some young men, drinking shows a distinct relationship to the passage from youth into young male adult roles in our society; (2) Teenage drinking is not only culturally patterned and socially controlled behavior, it is almost entirely a group act. Young people understand quite clearly that some adult drinking consists of the "lone drinker" and the "problem drinker," but they do not perceive that these apply to young people. In fact, the drinking of teenagers is almost exclusively "partying action" (Sower, 1959).

The trend of the last few decades for young people to enter adult roles at earlier ages has particular implications for education. The marriage age has lowered; young people drive cars and hold adult jobs; and there is also evidence that American young people mature earlier in physical growth and puberty. The most symbolic adult action for late teenagers is compulsory military service. Laws which do not permit young people to make the adult decision to drink or not drink before age 21 essentially say that young people who are old enough to fight wars are not old enough to decide whether or not they should drink. This paper will not attempt to solve any problems which may develop because of this passage from youth to adult roles at younger ages; it is sufficient merely to point up the problem as it applies to drinking.

The finding that teenage drinking is group action shows again the importance of the peer group in patterning the behavior of young people. The teenage group is extremely important to its members. Frequently it provides the training ground for learning necessary adult skills. While the finding that youth drinking is group action is not surprising, it does have some important implications for dealing

with the kind of drinking which results in problems either to the individual or to the community. As with "social delinquency," persons interested in exercising any control over actions must deal with the group, and not just with the individual (New York City Youth Board, 1952).

The research shows that there are four different types of behavior pertaining to drinking and non-drinking. The drinker can be a normative drinker—one who believes that drinking is all right and has many advantages; or he can be a reference group drinker, the social drinker who drinks largely because of social obligation. The normative non-drinker believes that drinking is wrong. The research has shown another type of non-drinking which we have labeled reference group non-drinking. In this, even with a belief that the use of alcohol may have some positive advantages, the decision of non-drinking is based on the belief that the use of alcohol has more potentially negative than positive consequences. It interferes with driving ability, and even involves the risk of losing the driving license. It has possible involvement with groups which drink to excess and get themselves into trouble. In general, reference group non-drinkers believe that the disadvantages of drinking outweigh any possible benefits.

While the number of young people who engage in group drinking may be in a minority in any given community, frequently they create the most difficulty. Some understanding of the total involvement patterns of the group drinking act may be of assistance in understanding the problems which result from such action. Three sets of social relationships are involved: (1) those of the young people's groups, (2) those of the adults representing the school and the community, including parents, and (3) the interrelationships between the adults and the young people. Two types of sociological theory are useful in understanding these relationships: social system theory (Parsons, 1951; Timasheff, 1955; Loomis and Beegle, 1950, 1957), and social involvement or group action theory (Miller, 1953; Kimball, Pearsall, & Bill, 1954; Hunter, Schaffer & Sheps, 1956; Sower, Holland, Tiedke, & Freeman, 1957).

There are two major systems involved in teenage drinking: the youth systems and the adult systems. They must be considered as separate entities in order to understand the relationships between the two. Each has its own sets of beliefs and sentiments, ends, roles, norms, ranking patterns, means of exercising power, sanctions, and facilities. Frequently there are some very real inconsistencies between the action patterns which can be justified as legitimate behavior

within each respective system. For instance, adults may assume the right to exercise some control over youth actions by the use of authority. While youth systems may be able to accept such adult authority in some areas, the more the youth system perceives itself as adult, the more it will obligate its members to resist adult authoritative controls. Some youth systems, as shown in the novel, *The Blackboard Jungle,* may reject any attempts by adults to exercise control by the use of authority. The ends of these two social systems can be completely inconsistent, even when they are in close proximity, as students and teachers.

Social involvement theory provides a set of categories for understanding the relationships between systems, especially those in which one system is attempting to initiate action to another. An initiating system can use authority methods when it possesses sufficient sanctions to either punish for failure to obey, or reward for compliance. An initiating system can use influence when it proposes action which the recipient system is able to justify as legitimate action. This can lead to a convergence of interest and joint or cooperative action. This set of problems leads to a consideration of some possible consequences when adult systems initiate action to teenage drinking groups.

POTENTIAL CONSEQUENCES OF THE USE OF AUTHORITY

The findings indicate the probability that adult rules based on the use of authority, prohibiting drinking by late teenagers are not enforceable. Young people are able to obtain drinks through the cooperation of other adults. Also, many adults, including law enforcement personnel, do not agree with the attempts to make or enforce such rules. As long as young people have the use of automobiles, the enforcement of such detailed rules of behavior is difficult. In fact, secret drinking parties may be the direct result of attempts by adults to enforce abstinence rules.

Youth group reaction to use of authority can be understood through the social system concept of boundary maintenance (Parsons, 1951, Ch. 11). This describes a characteristic of a social system in which it will justify goals of defense when its basic rights or existence is threatened. In such instances, it will obligate its members to come to the defense of the system. In times of war, for instance, a national social system obligates its members to defend the system even to the point of death.

The young people of this study have indicated that some of their secret drinking parties at isolated locations were demonstrations that they were adult enough to plan their own actions in such a manner as to prevent school and law enforcement officials from interfering with teenagers' perceptions of their own rights. Such actions serve to demonstrate to young people their superior skill in circumventing adult authority and hold adults up for personal and public ridicule. This is especially the case when news of the occasion spreads through the community, and adults are held publicly accountable for the actions of the young people. The issue is complicated further when youth parties involving drinking are conducted in the homes of some upper status families in the community. Within the public opinion of many communities it is probable that rules banning youth drinking often are not enforced unless the drinking is accompanied by other public nuisance behavior, such as auto driving or violations of sex rules. This leads to the question of whether there are any alternatives to the use of authority.

POTENTIAL CONSEQUENCES OF THE USE OF INFLUENCE

Influence has one important difference from authority in that the recipients of influence must give consent to the exercise of control over their actions. This consent may be subconscious or even unknown, but at least there is little likelihood that initiation will be accepted if the recipients have an overt rejection of either the initiators or the proposed ideas.

Although we now are getting beyond the available data on teenage drinking, sufficient research has been done in the area of group action and community involvement to justify asking the following question: Is it possible to theoretically model and experimentally produce cooperative linkage between adult systems and youth systems in such a manner as to exercise control over youth drinking actions through the use of influence? *

There are three major problems to be considered in answering this question: *First,* are there ideas or goals which can be accepted as

* This is merely another form of a much broader worldwide problem of understanding how any complex, formal organization gains access to and exercises influence over systems based primarily on community settings. Such a problem as this represents the core idea in much adult education in the whole area of community development and national planning in underdeveloped as well as developed countries, and in the vast area of urban, regional, and community planning.

common to both systems? *Second,* are there sufficient existing or potential linkages between the two systems for the communication to take place? *Third,* what are the most feasible involvement processes to establish communication and involvement between the two systems? A specific problem is that of determining who should initiate what ideas or action and to whom, so that it is possible to predict acceptance rather than rejection. There is time to deal only briefly with these problems.

The following process of reasoning may provide clues for determining answers to the first question, whether it is possible to design actions about drinking or non-drinking which can be justified as legitimate by youth and adult systems. In the American community, both young people and adults tend to have a loyalty to their schools and churches. They likewise have one characteristic in common: Both receive praise from the community for achievement or blame for unapproved actions. When students or adults achieve commendable goals, all receive credit; likewise for criticism. Such public reactions affect many relationships between the community and its organizations, including cooperation, budgets, etc. Without going further into the details, it does seem feasible to conclude that there are sufficient common interests between adults and teenagers to use as a base for planning for community praise and for avoiding community blame.

The next problem presents more of a dilemma. Are there sufficient linkages between adult and youth systems for the former to exert influence upon the latter? It would seem very difficult, despite all the theorizing of progressive education, to perceive an adult-youth relationship in which the adult did not have to exercise some authority over the young person. Almost by definition, the adult must give high rewards to those who achieve at the highest levels, lower rewards for lesser achievement, and blame for those who fail to achieve to the level of their abilities. This right and obligation of the teacher, the parent, the police, and the minister to exercise sanctions is an integral part of the adult role, hence it is authority. The adult does not obtain the permission of the young person in order to exercise such power.

As has been discussed above, group drinking is quite different. Here no adult positions in the American community appear to have access to sufficient authority-type rewards and punishments to prevent young people from having secret drinking parties at isolated locations. The main question is whether the adult systems in the community can establish the necessary linkage to exercise sufficient influ-

ence to keep such youth groups from getting themselves into difficulty through actions like auto driving and sexual freedoms following drinking.

While there is not sufficient evidence to provide demonstrated answers to the question posed, there are some leads for experimental design which might prove fruitful. Evidence shows that in most communities some teachers, clergy and police officers are perceived by the young people as more friendly than others. The young people perceive these adults as having a primary and genuine interest in their welfare and viewpoints; they will defend the teenagers' interests; they will go beyond the line of duty to work for their welfare. As in many types of linkage between official systems and community type systems, officials who are perceived as having a genuine dedication to the recipient systems are allocated the right to influence. Such adults may represent a potential linkage to youth groups, even to deviant groups who engage in secret drinking parties. Also, it is conceivable that there are adults or slightly older youths in the community who could become "third party" influence links to the teenagers, and who could establish sufficient access to youth systems to exercise some leadership control over their actions.

After establishing that there are potential areas of common interest and potential linkages between the adult and the youth systems, the third major problem comes into focus. What is the potentially effective process for initiating common action between the two systems? How can legitimate and acceptable access be established from the adult to the youth systems so as to achieve a common perception of goals which can be justified as legitimate by both systems? In this action pattern, it would seem necessary for each system to have the opportunity to achieve important goals and have the least possible sacrifice of other goals.

It is plausible that one of the most important youth system goals is to be accepted as responsible young adults and to be given the right to exercise, at least, limited adult rights. Yet, one of the greatest difficulties for adult systems will be to concede that there are limitations in the rights of adults to attempt to exercise authoritative controls over the young people's drinking actions. The problem is further complicated by state laws which prohibit the use of alcohol before age 21. A general principle to be considered is the possibility that action which is initiated either jointly by both systems or only by young people is more likely to be accepted by youth systems than is adult-initiated action.

The above discussion presents the essential element of the social involvement problems between youth and adult systems: Can common goals be established between youth and adult systems? Can sufficient linkage be patterned for the flow of influence? Can action be initiated in such a manner so as to be acceptable by youth drinking groups?

In summary, such involvement seems possible in the American community. Young people do not desire to get into trouble with the community. The research interviews show clearly that they understand the dangers of drinking—especially those pertaining to sexual laxity, auto driving, and community reputations. When approached from adults by means of authority, the leaders of youth drinking systems will move to defend their system boundaries by appropriate actions. There would seem to be evidence that adults in schools and communities could plan their actions so as to establish common goals which would give them the necessary access—based on influence—and the working relationships to effect cooperative actions with youth groups. At least, the theory for designing such experiments now is available.

One final problem needs to be mentioned. The planning of such action involves some alteration in the traditional role of the adult in relation to the young person. Even though social role theory is becoming more soundly established, little systematic effort has been directed to establishing through serious research a comprehensive working knowledge of specific adult roles in the American community (Gross, Mason, and McEachern, 1958). Such a body of information would be of very great assistance in understanding how role alteration can be experimentally designed. However, there is sufficient knowledge about teacher and clergy roles to proceed with some experimental alteration.

A final idea pertains to the relationship between research and action agencies. The social research role is well-established. Its task is to provide the necessary theoretical frame of reference and research methodology for analysis. It can design action experiments, but does not become valuably involved in planning or conducting action programs. Considering the extensive development in social science theory and research methods during the last decade, it now is possible to plan working relationships between research and action agencies which have possibilities of making effective contributions to the problems of action programs, as well as to basic knowledge. Usually such research has to have a university orientation in order to maintain its

independence, as well as sufficient access to theoretical developments to remain creative.

This paper represents merely the first step in such an analysis. The most important element in effective research in problem solving is continuity of research effort. The social sciences have been characterized by shorter-time "project type" research planning. Yet, such fields as medicine and agriculture have demonstrated the effectiveness of problem-solving research when theoretical and research methods can be confident of spending long periods of time on problems in which they have a real personal dedication. At this point, the social sciences do not necessarily need more funds, but more long-time continuity of personnel and research effort with a close linkage to basic theory developments. An important part of such a research plan would be to have some effort directed to consultation roles, with action program leaders to help them learn to use new theory and research findings.

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Women and Alcoholism

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The literature concerning alcoholism in women is relatively lean. Its main contributions consist of case histories, clinical observations, hypothesis and opinion. Yet this is not to say that they are without value. But they do point up at least two facts. First, that there is an overwhelming need for systematic, scientific study of this complex problem from which generalizations and judgments are more properly derived. (I might add parenthetically, that the absence of these

studies will probably not keep me, no more than it has other workers in the field, from such generalizations and judgments.) Second, that there is no more homogeneity to the alcoholic woman than to the alcoholic man. It is sheer sensationalism to suggest, as some writers have, that there is anything like a composite which can be called the alcoholic woman. Yet alcoholic women in their femaleness and in their use of, and response to, alcoholic beverages do constitute a group with distinct, separate and unique problems. To be fully understood these problems must be analyzed and interpreted temporally and spatially.

EXTENT OF THE PROBLEM

In the very first place how much and how urgent a problem is alcoholism in women? A few years ago Edith Lisansky summarized this situation as follows:

> While a small increase may have occurred, the available statistical information does not show any sharp dramatic rise over the last two decades. Among the factors that must be considered in evaluating alleged increases in female alcoholism are contemporaneous changes in medical diagnosis and recording, the greater rate of emergence of formerly hidden alcoholism among women . . . and an increase in the number of women drinkers since World War II. Drinking by women in public places is more common now than it was 20 years ago and it is likely that drunkenness is more frequently seen. But drinking and even drunkenness do not constitute alcoholism and the increase in drinking among women in the last several decades probably relates more significantly to changes in the role and status of women and the changing norms of acceptable feminine behavior than to increased rates of alcoholism. Whether alcoholism is increasing among women or not, the fact that nearly three-fourths of a million women are involved makes this an important social and medical problem (Lisansky, 1957, p. 589).

In point of fact the importance of this problem derives far less from its putative dimensions than from the tragic intensity of individual cases of alcoholism, the generalized threat implicit in them and society's consequent response to the drinking and the drunken woman.

Prior to World War I the highest incidence of alcoholism in women fell in the lower socio-economic and cultural levels, in such cultural deviants as the highly promiscuous and prostitutes—which made for one of the more common current stereotypes, to be discussed later. In middle and upper class society women alcoholics were relatively few in number and were either hidden within, protected by the

group, or were driven out only to become social deviants. The same customs and taboos dictating general forms of female behavior molded the profile of drinking and drunken women in the Lydia Pinkham-consuming mid-Victorian America.

With the violent emancipation of women in the Jazz Age their drinking profile changed. Customs changed. More women drank more—and openly. What did not change, however, were the unspoken restraints and reservations about the forms of public drinking —to which many women with a kind of inbuilt radar, have an unusual sensitivity, whether drunk or sober. Thus they knew that they could not drink with the same impunity and freedom as men—even in the less censorious large urban centers. No "respectable" woman, even in such cosmopolitan centers as New York or San Francisco, went to a bar alone. She might go with another man or a woman. Alone she was considered a social deviant and subject to overtures or censure, hence the notion that women in bars are promiscuous.

The profile of contemporaneous drinking woman is molded by centuries of biological and cultural conditioning to the wife-mother role, a role which emphasizes interpersonal relationships far more intensely than the husband-father role does. Women's lives are lived primarily in relationships to their husbands, children and relatives. Their prestige and status derive from the love, respect and support within the family constellation. Failure to achieve these in itself may lead to alcoholism in some women. And, on the other hand, if excessive drinking begins to affect, as it inevitably must, her essential interpersonal relationships, it is bound to disintegrate the very bedrock upon which her status and prestige rest. This chain-reaction may explain the seriousness of alcoholism in women not only to themselves but also to everyone about them, as we shall discuss presently.

With the emergence of the career girl in the years flanking the second World War the profile of drinking women took on different and stronger accentuations. One wonders whether the pediatrician of 1959, perhaps even more than the psychiatrist, projects the profile of drinking women of the next decade more accurately when he complains that his tiny patients are more threatened by their inebriated mothers than by microbes. It may be because of their continued emancipation and greater independence, because more of them are seen to be drinking openly, because more are seen intoxicated, and because more of them with alcoholism were coming to treatment, that the dimensions of the problem of alcoholism in women appear to be magnified. The change in the profile of modern drinking women has

still not altered society's response to the drunken woman, which is traditional in its judgment.

The moral cloud which has always surrounded female drunkenness continues to do so. Publicly, a drunken woman is still regarded as much of a pitifully tragic or particularly revolting spectacle, as she always was. And it is her awareness of this condemnation, however dim it may be, that makes her inebriety or her alcoholism different and more difficult. Traditionally, the male inebriate has always been a stock-in-trade in cartoons, novels, plays and the movies. Never so the woman—and with good reason. She represents important social and moral symbols that are the bedrock of society. And when angels fall, they fall disturbingly far. We would rather have them in their place, which is another way of saying that they define and make our own place possible and even more comfortable.

EFFECTS OF EXCESSIVE DRINKING IN WOMEN

The effects of excessive drinking in women, let alone their alcoholism, are generally more insidious, more pervasive, more devastating than in their masculine counterpart—not only to the individual but to all those coming within their orbit. Alcoholic husbands and fathers may demonstrate their hostility, their frustration and their failure by overt cruelty, by extra-marital affairs, by nonsupport or desertion. There is rarely anything subtle about any of those traumatizations. Families learn how to deal with them in one way or another. The husband-father alcoholic, moreover, usually does his heavy drinking away from home, returning to vent his rages, nurse his frustrations or disappointments and sleep it off. Between bouts he is likely to be warm, affectionate and lovable.

Not so women alcoholics. In the first place, they tend to do most of their drinking at home. The social taboos are still too strong for them to drink elsewhere. Most of them, moreover, are usually in an economically dependent position and simply do not have the money necessary to public drinking. Since the home is the bio-social core for most women (which is not the case with men), any attack—self-inflicted or from without—is pervasive in its destructiveness. Thus, when women drink heavily in the home, hence destructively, the impact is doubly felt on their children, their husbands and themselves. Children, laboring under the same taboos as adults, are more affected by a drunken mother than a drunken father. (How often does one hear the unfinished charge, "It's bad enough to see a drunken woman,

but a drunken mother . . . !") Hence, the greater, additional, compounded guilt on sobering up when she sees the stricken eyes of her children, the anxious, worried, questioning, recriminatory looks of her husband and the feeble, pathetic attempts they make to keep her sober. Her recourse, therefore, is to get as drunk as possible as soon as possible, which may account for the fact that more women drink to achieve coma than men.

The catastrophic consequences of female alcoholism are felt not only by herself and her immediate family in episodic crises and the broken home but in their long-range impact. Bleuler's (1955) study, among others, indicates that more patients evolute to alcoholism in those families in which a female alcoholic, and particularly an alcoholic mother, is present. Her influence in the formation of personality patterns, predisposing or conducive to alcoholism, is considered to be even more potent than that exerted by the father. In this sense she is more truly, more insidiously and more consistently a "disease carrier."

Durfee, who has had a large experience with alcoholic women, states that "Both physiology and psychological condition weight the odds against the woman problem drinker. . . ." (Durfee, 1946, p. 237). The homemaker, he notes, has not had "the brakes of a job or business or professional responsibility which may operate favorably in the therapeutic situation in the case of a man. . . ." (Durfee, 1946, pp. 237-238). On the other hand, he feels that these very responsibilities in cases of career women he has treated only tend to complicate their biological and social ambivalence and to heighten their emotional quandary which often seeks release or solution via a bottle.

There are two other orientations—one spatial and the other clinical—which may give additional dimensions to alcoholism in women. In the spatial context drinking women have various profiles which appear to be less a function of their bio-social heritage and makeup and more of their locale. They seem to be shaped by and to reflect such common, hence almost typed, characteristics as the anonymity of the large city with its weakened or absent relational systems, the patterned fashionability, social pressures and the inbreeding of suburbia and, in its own way, of exurbia, or the rigid secretiveness imposed by certain rural communities. To what extent these exogenous factors shape different drinking patterns and alcoholism in women than in men have not been studied, but if the demography of alcohol-

ism in women is to be elaborated such studies must be made. They must include much more on the roles that sex, marital status, occupation and religion play in the genesis and dynamics of this disease. Clearly the external setting of disease must be understood no less than its internal mechanisms. We can no longer leave to chance or casual opinion the role that these factors play in the etiology and progress of alcoholism, and in the rapidity or slowness with which patients come to treatment.

CLINICAL PICTURE OF THE WOMAN ALCOHOLIC

While clinical medicine presently offers us limited demographic data on alcoholism in women, its contribution to our understanding of the dynamics of the disease is far more significant. One of the classic studies of the contemporary period was undertaken by Wall (1937).

Fifty women patients whose family background (in half of the patients) showed a strong alcoholic history for the two preceding generations were studied over a fourteen-year period. His findings have since been corroborated by a number of others, hence are worth summarizing.

Excessive drinking seemed to be an important pattern in relationship to menstrual difficulties. Dysmenorrhea without apparent pathology was present in 40 of the 50 patients. Menstruation as such was regarded as an injury or insult to many of these narcissistic personalities. In six of them excessive drinking began before the age of 20, hit peaks before the menstrual period.

The average age that drinking began was 28. Excessive drinking apparently did not grow out of ordinary social indulgence. Rather it started with the emergence of some problem, with its chain of traumatic consequence, such as dysmenorrhea, abortion, desertion by lover or husband.

For most of these patients their psycho-sexual lives were marked by incompatibility in marriage, guilt and conflict over extra-marital affairs, jealousy, and problems concerning childbirth. Other difficulties included physical disease, and anxiety over death of close relatives.

The precise role that sexuality plays in alcoholism in women as distinguished from that in men is not fully understood—and this despite the fact that the literature would suggest that there is a stronger

convergence of sexual problems in female alcoholics than in male alcoholics. The promiscuous alcoholic woman may be a stereotype or a projection of sensationalism, magnified by society's disapproval of the drunken woman displaying limited or no restraints, and who in the extreme may get into difficulty with the law. Her male counterpart under precisely the same conditions would not be as loosely judged promiscuous, licentious, or abandoned, but far more benignly, as a "man of the world" or a "man about town."

The literature further suggests that there is a strong association between alcoholism and female physiological functions, i.e., menstruation, childbirth and menopause. The more one probes this matter the more one wonders whether alcoholism really interlocks with a particular physiological, or for that matter a particular psychological, function. Does it not relate more properly to the total organism's response; in this case to the failure of women alcoholics to accept themselves as women? While a similar argument might be made in general for men, alcoholism in women *is* different. These differences may be summed (Hirsh, 1956) up as follows.

First, from the onset of moderate social drinking it usually takes far less time for a woman to become an alcoholic. Second, although they may not consume as much as men, they tend to become more intoxicated, more frequently, more quickly and, in the final stages, they become sicker alcoholics. Third, their psycho-sexual life appears to be more frequently and more complexly involved in their alcoholism. Fourth, they show more "acting out" and impulsive "living out" of underlying personality and instinctual problems when intoxicated than men do. (Few women alcoholics behave much the same drunk as when they are sober, as is the case with many men alcoholics. Their intoxicated behavior is not only different and intrapsychically more intense but much more devastating in effect.) Fifth, they not only make more suicidal attempts but actually more women alcoholics suicide successfully. Sixth, if their alcoholism is checked, they more frequently develop other serious psycho-pathological states of symptoms, so that they remain chronically ill.

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Pastoral Treatment

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Pastoral *treatment* is only a metaphor. What priests are trying to do, and clergymen generally, is to bring men back to God, or bring them closer to God. We don't think of religion as one of the tools of treatment, something that is applied here and applied there, where indicated, in order to cure alcoholism. We think of the religious relationship of the person to God as something utterly transcendent, an invitation from God to love, and an acceptance of the invitation, an acknowledgment of utter dependence on a loving Father.

LIMITATIONS OF THE PRIEST-COUNSELOR

With that prefatory remark, the first thing I would say about a priest-counselor or a clergyman counselor of an alcoholic, is this: We ought to realize our limitations. If it is true that alcoholism is a triple sickness—a sickness of body, mind, and soul—then we cannot handle the whole thing. It is a mistake to take over a case of alcoholism as if "This is now my baby—I'll take care of him. I'll sober him up." I don't believe we should think of it that way. We should think of it as a cooperative effort. We cannot hope to do the whole job ourselves, ordinarily, and so we ought to realize our own limitations.

Now the fact that we do recognize alcoholism as an illness does not deny at all, to my mind, that part of the illness which afflicts the alcoholic is the illness of the soul. If it is a sickness of the body, mind, and soul, the sickness of the soul includes the idea of sin. And I think it is very bad tactics for a priest to say to an alcoholic when he comes to see him, "Well, of course, you are not a sinner, you are a sick man." That is ridiculous! Everybody is a sinner. What we have to offer this alcoholic sinner, like other sinners, is that we are empowered by Christ to forgive his sins. In addition to that, we can provide some very important reassurance. Since we realize that alcoholism is an illness, we can assure this individual that he is not as guilty as he thought he was. You can relieve a great deal of anxiety and mistaken feelings of guilt by assuring a person that he is not as guilty as he thought he was. Alcoholics are very mistaken about the degree of their responsibility. Many people have very primitive ideas about what subjective responsibility is. They have false consciences.

GUILT OF THE ALCOHOLIC

Among alcoholics, I imagine, you have also a great deal of neurotic guilt, a great deal of guilt that is based on unconscious factors and is entirely unreasonable. I do not consider myself an authority on distinguishing that kind of guilt from the real kind. But I do think that, with a certain amount of fundamental orientation, the confessor or counselor can keep his ear cocked for signs of neurotic guilt, and can at least suspect its presence.

This question of guilt in the case of the alcoholic must be handled carefully. If you tell him he is not a sinner and that he is not guilty, he will not believe you; and I don't blame him, because he is a sin-

ner, and he is guilty. It is a question of determining how guilty, and then of helping him see the reasonableness of the sickness concept of alcoholism. We show him that he has a sickness, that he wasn't as responsible as he thought he was, that there are such things as compulsions which diminish or even eliminate sin. Of course the matter is all, finally, in the judgment of Almighty God, not in our judgment. But I do think we can help alcoholics a great deal as long as we stick to our own side of the problem which is real guilt, and offer him the only remedy for real guilt, which is God's forgiveness through the grace of Christ.

Incidentally, if an alcoholic feels guiltier than he should, that doesn't necessarily mean that his guilt is neurotic. It may be a guilty feeling based on a mistaken idea of what his responsibility was. You have real objective guilt in the case of a person who commits a sin, knows he did it, and feels correspondingly guilty. That is called real objective guilt. But let's take the case of an alcoholic who does something wrong under the influence of drinking, and, not knowing that he couldn't help doing it, feels guilty about it. That is not neurotic guilt, to my mind. There is a perfectly obvious explanation as to why he feels guilty—he is mistaken as to what his responsibility was. I would call it mistaken guilt, not neurotic guilt. As for neurotic guilt, I prefer to leave it to the psychiatrists to explain just what they mean by it. At least, I do not think that it is my place to try to explain it.

PASTORAL APPROACH

With regard to the pastoral aspect of the care of the alcoholic, bringing him closer to God, or bringing him back to God if he is away from God, can be put under two headings, removing the obstacles to grace, and administering the means of grace to the alcoholic.

First with regard to removing the obstacles to grace. It seems to me that a very large number of alcoholics are afflicted with a very peculiar blindness as to what is wrong with them. They don't understand the nature of their own problem. It is simply fantastic the extent to which they can rationalize the things that happen to them, and give rationalized explanations in order to avoid the conclusion that drinking is the problem. I could entertain you with examples of that kind, and anybody who has dealt with alcoholics knows that it is a fact. That blindness is an obstacle to grace; they do not see them-

selves as they are; they do not see what the situation obviously requires.

In our theology, actual grace is a special enlightenment of the mind by Almighty God, and an inspiration of the will, as a result of which the person sees himself in a different light from what he did before; or he sees what he ought to do in a different way, and then has that extra strength, that extra push, needed to accomplish it. Theologians speak of actual grace as an illumination of the mind, and an inspiration of the will.

Now I think that we can help to remove some of the obstacles to grace by helping the alcoholic to see himself as he is. We can help him to arrive at the point of self-diagnosis, so that he will see with his own eyes what his problem really is. But how do you do this? I do not think you do it by saying: "Look here, old man, you're an alcoholic." I said already, and I think we are agreed on the point, that most alcoholics see red at the word alcoholic. It's a good word to avoid. I think that one way of helping a person to see what his own problem is, is to listen to him. Let him talk. He will talk himself into it if you will listen intelligently, actively, and helpfully.

My experience is that a great many of the alcoholics who come to see me, and come because of a drinking problem, but who are dragged in by the wife, or by some friend, or by the boss, or by another priest, do not believe that alcoholism is their problem at all. One way to start a conversation with them is to find out what they do think the problem is. Obviously there is some problem, or they would not be there. If you can get your visitor to tell you what he thinks the problem is, at least you have something to start talking about. In the course of the conversation very often he finds himself confronted by facts. When he puts the cards on the table, it does turn out that drink has something to do with it, after all. Drinking is in there as a big factor in his problem. He brings this out himself if you win his confidence and let him talk. But I still would avoid using the word "alcoholic." It is better to speak of a drinking problem, once you and your consultant are agreed that drink has something to do with it.

I've also found it useful to employ some of the popular diagnostic aids. Mr. Gardner mentioned one of them yesterday, based on E. M. Jellinek's *Phases in the drinking history of alcoholics* (1946). In its popular form this material can be obtained from the National Council on Alcoholism.* There is also the A.A. leaflet, *Is A.A. for you?*

* 2 East 102nd Street, New York 29, N.Y.

*Twelve questions only you can answer.** Another popular leaflet, *Who . . . me?,* which contains the so-called "Forty questions test" can be obtained from the Hornell Committee for Education on Alcoholism.† This latter item is also contained in *The pastoral counseling of the alcoholic: a kit for the busy priest,* now obtainable from the National Clergy Conference on Alcoholism (NCCA).‡

The above-mentioned diagnostic aids are helpful, I think, in many cases. You can't use them mechanically. There is no rule of thumb. I've seen a man take up one of those tests, and go through it and check off all the things that have happened to him, so that instead of answering "Yes" to five of the questions, he answers "Yes" to ten or fifteen. But after he is all through, he says, "Well, that's interesting, isn't it?" But he didn't believe he was an alcoholic when he started, and he doesn't believe it when he gets through. That is part of the blindness. But these tests have also worked successfully in many cases.

Another means of removing obstacles to grace is to make use of other agencies, especially Alcoholics Anonymous.§ When a man (or woman) goes to Alcoholics Anonymous he learns a lot about himself, and he is often willing to learn things in those circumstances which he isn't willing to learn from us. I'm not talking now of the simple procedure of seeing a drunk in the parlor and telling him: "Well, now the thing for you to do is to go to A.A. Good afternoon, goodbye, etc." You don't dump people onto A.A. or onto doctors, and psychiatrists, either, for that matter. It is quite an art to refer. That's a study in itself, to learn how to cooperate effectively with A.A., how to find the right sponsor for a person before sending him to A.A. You just don't send him to A.A. by having him look it up in the phone book. You have to find the right person in A.A. to correspond to his particular needs. And you have to follow up later, because A.A. is not going to be specifically aimed at bringing him closer to God, or restoring the religious life of the person. They don't save souls; all they do is wring them out. After that, it's up to us to follow up. And our part of the follow-up is to take care of the spiritual life of the individual.

* A.A. World Services, Inc., P.O. Box 459, Grand Central Station, N.Y. 17, N.Y.

† P.O. Box 221, Hornell, N.Y.

‡ P.O. Box 1194, Indianapolis 6, Ind. (Price: $1.00)

§ The Alcoholic Foundation, P.O. Box 459, Grand Central Annex, New York 17, N.Y. This is the Alcoholics Anonymous organization headquarters. It publishes A.A. books and pamphlets, and is the service center and clearing

I'd like to mention here an organization called NCCA—the National Clergy Conference on Alcoholism,* which specializes in helping priests to deal professionally with drinking problems that come to their attention. One of the main purposes of the organization is to help priests deal with these cases in their pastoral ministry. This organization runs a pastoral institute in a different diocese every year during Easter week. The proceedings are published annually in *The Blue Book,* which is available only to priests.

Well, so much for removing the obstacles to grace. A word about administering the means of grace. I'm not going to say much about this aspect, because there isn't any need to enlarge on it. There is no difference here from any other case in which we try to help a sinner get back to God, or help a person who isn't such a great sinner to get closer and closer to God. We make use of prayer, we make use of the sacraments. We encourage people to make retreats where they will receive further instruction and enlightenment in their faith, and further enrichment of their spiritual life. A.A. makes no pretence of taking the place of religion.

USE OF THE PLEDGE

I want to say a word about the pledge, because it is a religious means which has been used in connection with alcoholism, and questions about it are asked so often.

Here is a wrong idea about the pledge: "Alcoholics need it, and other people do not." If anything is true, it is just the opposite of that. It isn't particularly good or effective for alcoholics, but it is often good and effective for other people, this pledge of total abstinence. In other words, I am distinguishing between the pledge as a measure of *rehabilitation and recovery* for alcoholics, and the pledge as a means of *prevention* of excess, and of alcoholism. As a rehabilitative measure, especially when used by itself, it is not very effective with alcoholics. I do not think it is a good idea to give the pledge to alcoholics as a rule. Occasionally, I have used it by giving the pledge for a very short period of time to a person who is well motivated religiously. But I always explain that the pledge of itself does not oblige under pain of sin. I don't want the violation of the pledge to be hanging over the alcoholic's neck like the sword of Damocles with a new threat of mortal sin, which will not keep him from drinking but only increase his guilt. No, I make it clear that this is a religious resolution, a sacred resolution made for religious, supernatural motives,

* P.O. Box 1194, Indianapolis 6, Ind.

but it is not a vow, and it should not bind under pain of sin. I believe that is the way the pledge is usually administered nowadays, when it is administered.

So occasionally I've used it with an alcoholic for a very short period of time, perhaps a week, or two weeks, or five or six weeks. I remember one case where it was very effective. The man sobered up when he took the pledge. He stopped drinking and we were able to talk sense to him. He wasn't entirely sensible when he took it, but he kept it, and then we were able to talk sense to him. We got him into A.A. That was in 1947 and he hasn't had a drink since. So I don't want to exclude the pledge; but I do think the more serious the alcoholism is, the farther advanced it is, the less likely it is that the pledge alone will be of any avail. As a rule I would discourage its use as a means of rehabilitating alcoholics.

But prevention of excessive drinking and of alcoholism is another matter. I do believe that the pledge has been very effective, for instance among the Pioneers in Ireland, and in the Catholic Total Abstinence Union of America, and in other total abstinence organizations, as a preventive of alcoholic excess. Total abstinence is the surest preventive there is. I think that a vigorous and popular total abstinence movement would be a most valuable part of a preventive program, although I am a little uncertain just how such a program can be made popular and effective at the present time. Consequently it is very important to institute popular education as to the true meaning of the word moderation, and the exercise of the virtue of Christian sobriety through the practice of true moderation. That also is an essential part of a program of prevention.

DISTINCTION BETWEEN PREVENTION AND RECOVERY

Prevention and recovery are two different fields. It is not likely that the people who are engaged in preventive work are going to get along too well with people who are engaged in recovery work. Their mentality is too different. Besides, you are working with two entirely different groups of people. When you are helping alcoholics to recovery they are generally older people, who have been through the mill. Many are somewhat defeated and even cynical. They are sick. When you are dealing with the problem of prevention your clients and prospects are healthy young people who are enthusiastic and idealistic. You can propose very high and generous ideals to them

and get results. The success of the Pioneers among young people in Ireland is an example. But do not be misled by the fact that total abstinence is the only means of recovery for the alcoholic and is therefore the aim of every recovery program. It is a different kind of total abstinence—a total abstinence which is mandatory if the man is to survive as a normal human being. The total abstinence of a preventive program is altogether different. It is a work of supererogation, chosen freely out of generous devotion to Christ, not out of desperate necessity. We should not try to handle recovery techniques and preventive techniques in one confused program where the persons involved have nothing in common but the word alcohol. They are oil and water and will not mix.

MISTAKEN APPROACHES

Another mistake we, as clerical counselors, sometimes make in dealing with an alcoholic is this. We insist too much on will power. I might say that the medical profession occasionally makes the same mistake. We say: "Use your will power. Get in there and fight." Or, "Just make up your mind and you won't drink any more." Or the doctor says: "Well, now I've got you sober, it's your job to stay sober. It's up to you. Use your will power."

The reason why I am against that kind of advice is that it doesn't work. Alcoholics are sick and tired of hearing it. It is bad tactics to keep telling them to use their will power when they resent the very sound of that phrase.

Furthermore, it is misleading. The vast majority of alcoholics do not stay sober unaided. *They need continuing help with their problem* if they are going to persevere. They can get this kind of help in A.A. It is very misleading to let them think that they are going to succeed on will power alone. They may need continuing medical help. Some will profit from continuing psychiatric help. Most all will need continuing spiritual help.

Still more fundamentally, alcoholics suffer from a compulsion to drink. I am using this word compulsion as a moralist would use it. Compulsions do not operate with mechanical, predictable necessity. They operate with more or less frequency and more or less force. Only at times are they utterly compelling and completely uncontrollable. But a person who suffers from a compulsion either cannot help doing what he is doing, or at least his freedom not to do it is

seriously impaired. In the case of alcoholics there are indefinite degrees of compulsion. It is weaker in some, stronger in others. In many it operates only after they have started drinking. In others there is often a compulsive factor in the first drink. But anyone who acts through compulsion has no will power, or has greatly impaired will power with regard to the object of the compulsion, while the compulsion is actually operating. It is the very nature of an alcoholic's compulsion that it interferes seriously with his will power, and can even destroy it, where drink is concerned. When you tell him to use his will power in order to stop drinking and stay sober, you are telling him to use the very thing he hasn't got or at least the very thing that is pathologically impaired.

You cannot attack compulsion head on. You have to circumvent it. It can be circumvented by natural means and by supernatural means. The alcoholic can use his will power to take the means. There is a mysterious interplay between free will and divine grace. The surrender to grace and the psychological surrender to the realities of the situation seem curiously intermingled.

I think one of the reasons A.A. is so successful with so many alcoholics is that they use various practical, psychological techniques to help the alcoholic to circumvent that compulsion to drink, to head it off, to get around it, to substitute ahead of time other thoughts and interests that will take up his mind and attention and exclude the obsessive urge to drink, or prevent that insidious, fascinated way of thinking about a drink from getting a real hold on his mind. A.A. newcomers, whether they realize it or not, are being given some practical, amateur mental hygiene. They are being taught how to live with their resentments, how to keep from nourishing anger, how to get rid of it without drinking. And this takes place in an atmosphere of sympathetic, almost affectionate, acceptance, surrounded by successful examples of people who have done it. For an alcoholic, getting rid of resentments is an essential means of circumventing the compulsion to drink.

SPIRITUAL CONSIDERATIONS

As for the supernatural means of circumventing compulsion, it is part of our theology that actual grace can and does change our thinking. Almighty God, by a special intervention of a supernatural kind, can help us and will help us, if we ask Him, to have the right

thoughts and to exclude the wrong thoughts. When we receive the sacraments we receive along with the sacramental grace a claim on God for the special actual graces that we need.

There is an interior struggle going on within all of us. In the alcoholic it has assumed pathological proportions. But it is a kind of struggle which is vividly illustrated in a passage St. Paul wrote to the Romans in which he describes the conflict that was going on within his own soul. He says:

> The law, as we know, is something spiritual. I am a thing of flesh and blood, sold into the slavery of sin. My own actions bewilder me; what I do is not what I wish to do, but something which I hate. . . . Praiseworthy intentions are always ready to hand, but I cannot find my way to the performance of them; it is not the good my will prefers, but the evil my will disapproves that I find myself doing. . . . Inwardly, I applaud God's disposition, but I observe another disposition in my lower self, which raises war against the disposition of my conscience, and so I am handed over as a captive to that disposition toward sin which my lower self contains. Pitiable creature that I am, who is to set me free from a nature thus doomed to death? Nothing else than the grace of God, through Jesus Christ Our Lord. (Romans 7:14-25)

We never know, in our own lives or in the lives of others, just how much of what is happening is due to divine grace and just how much is due to the effort of the will. That is the eternal mystery of the interplay between divine grace and human free will.

Perhaps I can illustrate this point by an example. I talked with an alcoholic years ago who told me that he had stopped drinking several years before. This occurred some years before A.A. had been established, though he was now in A.A. This is how it happened. He came home from work one day, a little the worse for wear, went into the dining room and heard his wife and his little girl, who was 12 years old, out in the kitchen. The daughter was crying, and the mother asked her why she was crying. She said: "The kids say Daddy is a drunk." He told me that when he heard those words they went through his heart. He never took another drink. Now the A.A.'s might say that at that point he hit bottom, psychologically. Maybe that was a natural experience. Perhaps psychology can explain why he suddenly saw himself in a completely different light, and never took another drink. But I am inclined to think that divine grace had something to do with it.

We talk about external graces in theology. God makes use of external events to touch our hearts and move us to the good. I just

don't know where grace leaves off and nature begins. And so I think we can profit by following the advice of a great saint who said that we ought to pray as if the whole thing depended on God, and then work and act as if the whole thing depended on ourselves.

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A Clergyman's Viewpoint

FREDERICK G. LAWRENCE, M.S.SS.T.

Father Frederick G. Lawrence, M.S.SS.T. is the Custodian of St. Joseph's Villa in Stirling, N. J., which is "an in-patient long-term clinic" devoted to work with clergymen who have become victims of alcoholism. Father Lawrence was ordained to the priesthood in 1944, and has from the first devoted himself to work with alcoholics. He frankly admits to being an ardent admirer of Alcoholics Anonymous, and has spoken at hundreds of their meetings in every part of the country. He attended the Yale School of Alcohol Studies in 1955, and is a member of the Board of Directors of the National Clergy Conference on Alcoholism. From 1953 to 1957 he was Director, Curé of Ars Hospice, Clarks Summit, Pa., and has written a series of articles entitled: "A Priest Looks at A.A." which appeared in the spring of 1955 in Catholic Light, *the newspaper of the Scranton diocese.*

The title of this paper is very important. I have been asked to give *one* Clergyman's viewpoint on Alcoholics Anonymous. I shall endeavour to do just that. Not any other clergyman's viewpoint. Just mine. It shall differ, I am sorry to say, from what you may have heard or read expressed as the viewpoint of other clergymen on this subject. But I can speak for no one save myself. My opinion, my viewpoint is the result of many years of close association with Alcoholics Anonymous, a little formal education in regard to the problem of alcoholism, but mostly, it has been formed by the edification and in-

spiration, the veritable miracles I have seen wrought, in the Alcoholics Anonymous fellowship. At the end of the paper, I have listed some of the chief references to the work of Alcoholics Anonymous.

ALCOHOLICS ANONYMOUS BEST THERAPY

First of all, therefore, let me express my viewpoint on Alcoholics Anonymous. Then will follow the "why" of this opinion. TO ME, ALCOHOLICS ANONYMOUS IS THE BEST THERAPY EXISTING TODAY FOR ASSISTING MOST ACTIVE ALCOHOLICS TO A MAINTAINED AND A HAPPY SOBRIETY.

I say it is the "best" therapy, because there are others that have achieved, if even in a lesser degree, some success in the treatment of sick alcoholics. And the adjective "most" precedes the words "active alcoholics" because some, due to a neurotic condition, a deep-seated psychosis, or definite brain damage, need professional medical care, which A.A. as such, cannot offer. Finally, the words "maintained" and "happy" condition the noun "sobriety," for I see little value in sobriety that is not lasting, and even less value in sobriety that is not enjoyed or happy.

Now—an explanation on why I entertain such a viewpoint. May I beg your indulgences as I tell you how my interest in A.A. first came to be? It was born of gratitude; gratitude to God for an answer to a seemingly insoluble problem. One year after ordination, filled with the zeal of St. Paul, I was placed in charge of a geographically large, numerically small parish in southeastern Alabama. Of the 65,000 souls who lived in the 3,500 square miles serviced by our parish, only some 35 to 40 were Catholics. Yet, into this small number God tucked one very, very sick alcoholic. I tried to help her to correct her problem. Every spiritual aid I could think of was suggested and tried—the pledge, novenas, the rosary, aspirations, spiritual communions, frequent visits to the Blessed Sacrament, even daily Mass and Communion. Nothing seemed to effect the desired results. As a matter of fact, the problem grew worse instead of better. Six months after I had been introduced to this poor woman, she, on her own, joined A.A. When, after a period of a month's sobriety, she invited me to attend an open meeting, I was so grateful to God for the success she was having, and so curious to see what caused it, that I went. It was definitely a case of "I went; I saw; I was conquered," for I have been going to A.A. meetings ever since, and that first one

was in January of 1946. And—lest you wonder—my parishioner who joined at that time is still sober and active in A.A.

Generally, in speaking with clergymen about my interest in Alcoholics Anonymous, I am asked a series of questions. I feel the answers to these questions will very well cover my viewpoint on Alcoholics Anonymous, and therefore I would like to present them to you today.

First of all—*Did I find anything new in A.A.?* Not exactly. What I heard, read, and saw had a very familiar note in the beginning. Later I realized that the A.A. philosophy was basically nothing more than a Christian way of life, presented in a little different fashion, perhaps, and disguised in a new vocabulary, but fundamentally the teachings of Jesus Christ. Undoubtedly, this is what made it, from the very outset, so attractive to me.

Did I find in A.A. some overpowering, perplexing philosophy? Again the answer is "no." It is a simple program, with twelve simple suggested steps, and simple mottoes, such as "Think"—"Easy Does It"—"A Day at a Time"—"Live and Let Live"—"But for the grace of God." I found the members to be as simple as children, as sincere as saints, and I remembered that a requisite for sanctity is that we become as little children.

Did I find anything un-Christian, or un-Catholic about A.A.? Most decidedly not! Rather did I find in A.A. a wonderful specific alignment of Christ's teachings as applying to THIS PROBLEM. This program not only does not contradict any Faith of any adherent, it actually complements their faith. I found that Catholics who lived the A.A. program were better Catholics because of A.A. As a matter of record, I might say I have never seen the virtue of charity, the great commandment of love of neighbor, more universally practiced than I have seen it lived by the members of A.A.

Why has A.A. been successful when so many other programs have failed? I believe that the first among these reasons is the recognition on the part of A.A. that alcoholism is a threefold sickness. For centuries, the human race has considered, accepted, and discussed alcoholism as being basically, essentially, if not exclusively, a moral problem; an evidence of lack of will power on the part of those afflicted. It is my considered opinion that most people *still* view it in this light.

Alcoholics Anonymous, on the other hand, maintains that alcoholism is a sickness of the body and mind, as well as of the soul. Thus

the A.A. therapy suggests a correcting and eliminating of the spiritual problem that afflicts all alcoholics to a greater or lesser degree. A.A. members further maintain that neither the physiologist, nor the psychiatrist, nor the clergyman *alone* has the answer, but all three must work together. A threefold correcting must be affected or *no* lasting results can be produced.

To draw an analogy with the famous story of "The Leak in the Dike," had there been three leaks, instead of one, the little lad's finger could not have averted the disaster. Three fingers would have been necessary or destruction would have ensued.

Why do I think A.A. works? Because it is a positive program of rehabilitation, and every alcoholic needs, in some degree to be rehabilitated, not imprisoned or incarcerated, not condemned or ridiculed, not shunned or over-protected. A.A. does not simply ask the alcoholic to stop drinking, as we do when we administer a pledge. A.A. suggests a new way of life to the alcoholic, and then makes suggestions as to how he may follow it. Sobriety is basic, essential, a "sine qua non," if you will, but like Baptism—it is only the beginning. The twelve suggested steps lead to a serenity for which the Alcoholic Anonymous members plead in the very first line of their so-called "A.A. Prayer";—"God grant me serenity." And the effectiveness of the A.A. program in the life of its members is in direct proportion to the success they have in accepting, understanding, and applying these twelve steps to their lives.

A.A. is a simple program, but it definitely is not an easy program. "Easy does it," but the alcoholic has to *do it!* The twelve steps are but tools to be used by the alcoholic in sculpturing from the clay of a broken life, a new existence. But, *he* must do it! No one can do it for him. He is simply presented with the tools. He produces their effectiveness. Gathering dust from lack of use, growing dull from lack of understanding, the steps are useless. But taken one by one, and applied to daily living, they can make of the most desperate derelict, an edifying image of the God Who dwells within us all.

What is the nature of the A.A. therapy? A.A. is a program of education, or introspection, if you will. It borrows from the ancient Greek philosophers the admonition, "Know thyself," when it suggests each member take a "searching and fearless moral inventory." Being creatures of habit, it is important that the member of A.A. recognize the habits that rule his life. He must decide which habits are good, and which are evil; how the good can be developed, and the evil eliminated. Thus A.A. members talk of removing "wrongs, short-

comings, defects of character." The desired goal is the *habit of sobriety*. It is acquired only by much practice, much determined action, much accentuation of the positive and eliminating of the negative.

A study of the twelve suggested steps will reveal that each required the practice of a virtue where once vice or imperfection ruled. Thus the first step suggests humility be substituted for pride; the second, faith in God for self-conceit; the third, trust in God for despair; the fourth, truthfulness for falsehood; the fifth, simplicity for duplicity; the sixth, sincerity for sham; the seventh, meekness for arrogance; the eighth, love of God for love of self; the ninth, honesty for hypocrisy; the tenth, fortitude for insincerity; the eleventh, prayerfulness for godlessness; and the twelfth, love of neighbor for intolerance.

Finally, *what is the secret of continued success in A.A.?* I think it depends upon the member's ability to maintain his "sense of awareness." He cannot afford to forget. For him, it takes a lifetime to be a success, just a second to suffer a relapse. His creed is: "Once an alcoholic, always an alcoholic." His is a sickness that can be arrested, but never cured. One drink shall always be too many, a thousand never enough. And this "sense of awareness" is best maintained, all A.A. members will tell you, by attendance at meetings; associating with other members; reading the A.A. literature; applying the twelve step program to their lives twenty-four hours of every day, a day at a time.

This, therefore, is my viewpoint on Alcoholics Anonymous. It is the best therapy existing today for assisting most active alcoholics to a maintained and a happy sobriety. I hope the reasons given have been sufficiently sound to induce you to agree with me. If so, then my admiration and enthusiasm for this Christlike fellowship will have won it new friends among the clergy. If so, then more alcoholics will receive the understanding, sympathy and counsel that they need from those of us who have been ordained to help all men attain their eternal destiny—to be happy with God forever. It is my prayer that all of you will allow the fellowship of Alcoholics Anonymous to assist you in helping all alcoholics achieve this goal.

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A Psychiatrist's Viewpoint

ADELE E. STREESEMAN

Adele E. Streeseman, M.D. is President of the New York Medical Committee on Alcoholism, and Medical Adviser and Psychiatric Consultant to the Women's Prison Association, New York City. Her A.B. degree is from Hunter College, and she has an M.A. degree from Columbia University, and an M.D. degree from Women's Medical College in Pennsylvania. Dr. Streeseman is a member of the American Psychiatric Association, the American Medical Association, and the New York Medical Society on Alcoholism. For almost 15 years Dr. Streeseman has served as psychiatric examiner for candidates for the ministry in the Protestant Episcopal Diocese of Long Island. She is the author of the book You're Human Too *(1958).*

My particular relationship to Alcoholics Anonymous is that of a psychiatrist who has seen their miracles at first hand. We psychiatrists are used to miracles. There is, for a doctor, no joy like that of watching the slow growth into health and confidence of a miserably unhappy, confused and panic-ridden patient. As an analyst, I see every year the deep emotional re-education we call psychoanalysis take hold, grow and endure to maturity.

Why cannot we do this with the acute alcoholic? Why can A.A. do it? Why is it so often true that the active, heavy drinking alcoholic —angry, confused, often without money, usually drunk, belligerent, hopeless, hiding a deep conviction of worthlessness behind an

offensive arrogance—why is he no candidate for psychotherapy? He needs help. Why does he resist it?

WHAT A.A. DOES FOR THE ALCOHOLIC

It is astonishing to me, now, that we psychiatrists did not see the "why" right away. It is because he cannot trust us—he cannot trust anyone, really. Our first step in any psychotherapy is establishing what we call a transference. The patient transfers to us, for the purpose of a similar emotional education to that of early childhood, an abiding faith in us—so that he takes again the faltering steps of daring to live, of daring to be himself, of daring to make a mistake, of daring to question, of daring to learn, of daring to believe that we will not desert him, and that we will not let him fall as he starts on his journey of growing up all over again.

The alcoholic, as he begins his climb to sobriety, cannot possibly do all this. He trusts, implicitly, no one. It is often even hard for him to trust and love God, his fear of Him is so great. Also, I am reminded of the deep truth of the ancient question: "If a man love not his brother, whom he hath seen, how can he love God whom he hath not seen?" The alcoholic cannot establish a transference—cannot easily love and trust his brother, and relate, as a child, to the strange doctor, labeled psychiatrist.

But the alcoholic *can,* even in his despair, open the door of his personality just a little crack, tentatively, to another alcoholic. He does not fear moral condemnation, nor the equally obnoxious saintly, stooping, forgiveness, if it comes from another drinker who has lived in the same hell as himself. He can feel a kinship with another human being, and he has been alone so long. Hence we have the beginnings of that valuable thing we psychiatrists (who love to label things) have labelled "interpersonal relationship." This is, to me, the essence and firm foundation of A.A. It establishes and maintains relationships.

The next big step toward health is the gradual loss of that sense of uniqueness most patients have. As you go to A.A. meetings and meet more and more people, suddenly the world is full of problem drinkers, of alcoholics. Among your friends and family, you have been a leper, a pariah, an unbelievable catastrophe. But in A.A. meetings, you hear your own story over and over. You begin to feel free to explore this strange phrase "compulsive drinker." Even being called an "addictive personality" by another in the same boat does not make you fighting mad. With lots of company, you dare to

take inventory, to explore your own personality, to find out your soft spots, to read the danger signals and to recognize and accept a limitation in living that you share with all other true alcoholics, that you cannot take the first drink, because you are an addict.

ALCOHOLISM IS AN ADDICTION

A.A. has done a wonderful job in establishing clearly that fact—that alcoholism is an addiction. No doctor, no psychiatrist would tell a heroin or morphine addict that now, since he has been off the drug for 4 or 5 years, he can take a little now and then. But I still see patients in my office, alcoholics, who have been told by well meaning psychiatrists that they can become social drinkers after they solve the conflict underlying their drinking problem.

Fortunately, more and more doctors are learning about alcoholism. The New York Medical Society on Alcoholism is both learning and trying to spread learning in this field and fewer patients are chasing the mirage of "social drinking." We have long known "once an addict, always an addict"—and since we now understand alcoholism as an addiction, it follows inevitably that "once an alcoholic, always an alcoholic." Perhaps some day, in the dim and distant future of greater knowledge, this may not be so, but for us now, with our present light, it is clearly established.

This fact—that total abstinence is for always—brings in its wake another need—the need of continued vigilance, of renewed reminders. If the far-away causes of alcoholism in the personality have not been removed (and we certainly do not yet know how to do that), then the danger of those old sleeping conflicts being stirred up and reactivated will always remain. This is true—but this is not frightening. A.A. is ever available and most A.A.'s sense the need for continued fellowship in A.A.

THE SPIRITUAL ELEMENT IN A.A.

Moreover, something else—something big and wonderful and unbelievable happens as one goes along in A.A. The fight gets easier as the fighter gets stronger. An imperceptible change is seen in the alcoholic. No one is trying to convert him to anything, but he is changing, spiritually. The A.A. program has no credal affiliation, but it insists that you call upon your God, as you know Him, to help you in your struggle for significance and dignity.

In my opinion, not only as a believer in a living God—but as a psychiatrist, there is no significance or dignity for man in a materialistic, godless world. In my experience as a psychiatrist, a patient must always come to grips with his own deepest personal philosophy of life—its ultimate meaning and significance, before he is whole. What that philosophy is, be he Jew or Gentile or what-have-you, is none of my business. But find it for himself, he must. I have had patients of all faiths, as A.A. has members of all faiths. I must not determine the goal, but I must help him find his own goal, however he spells it.

Learning how to live seems very unimportant if there is no meaning in living, nothing to live for but the little immediate material joys—no bigness, no significance. If man is just a little blob of protoplasm, mushrooming up to full size and then fading out, wallowing meanwhile in a sea of self-made miseries and fighting the elements, it all doesn't seem worth a long psychotherapy program, or even a striving to sober up. It must be remembered that science and psychiatry concerns itself with method, with "How to," never with objectives to be reached, never with "Why." This is the business of the patient himself—but we psychiatrists have been too slow in saying that that last touch of synthesis after analysis, that last job of spelling it all out in terms of meanings—is imperative. I always like to pay tribute to one psychiatrist, Smiley Blanton, who dared to spell it out—who did not content himself with just teaching a patient how to love, maturely—but gave mature loving its inescapable alternative in the superb title of his book *Love or perish* (Blanton, 1956).

The glory of A.A. and, to me, the deepest and strongest reason for its success, lies in its insistence on the spiritual growth of the alcoholic. Like the psychiatrist, it does not chart creeds—but it suggests, over and over, that you find your own chart, your own pathway, to what you call God.

I heard a distinguished teacher of psychiatry, in a lecture on alcoholism, say that the addictive personality is a pigmy at heart—who uses alcohol over and over, to turn himself into a giant, and who needed ever more and more of the stuff in order to accomplish that feat. He gave no formula for cure, for reversal of trend. I ask, in rebuttal, what turns all of us pigmies into giants, automatically? The answer is simple, the fatherhood of a living God—living today and loving us.

I think often of the alcoholic when I remember Paul saying—as says the alcoholic in his despairing heart "of myself I am nothing"—

but then goes on to say, with a leap into the grandiose "but I can do all things (*all* mind you) through Christ who strengtheneth me." This is to me the secret of A.A.'s steady growth—whether you worship the God of Paul, or the God of Moses and Abraham, or whether you call him Allah. You achieve dignity and significance and you hold on to it and grow quietly because you are rooted in a firm, no-longer-debatable conviction of your own worth and your own potential.

SUMMARY

In summary, I would recapitulate. To a psychiatrist who has had close contact with A.A., and we have had many alcoholics as patients, A.A. appears theoretically sound and impressively successful in achieving and maintaining true sobriety. It attacks the drinking problem directly, head on. No therapy of any kind is possible while the patient is in an alcoholic fog. It offers the alcoholic a desperately-needed opportunity to relate to other human beings on a more-or-less equal basis. It continues to provide the means of maintaining sobriety, after achieving it. Finally, it insists on the importance of spiritual growth and spiritual health as the sine qua non of any true health at all. It is not a religion, but it values the objectives of religion—that is, it sets its sights far higher than just keeping one sober and alive and functioning. It aims at helping others, it accepts the responsibility to help others through twelve-step work and thus gives altruism and dignity to all of its effort. It lifts the work of A.A. beyond self-preservation into nobility.

Truly I believe "God works in mysterious ways—His wonders to perform" and truly I believe A.A. is one of His modern miracles, worked, as so many of His miracles were, through His favorite medium, mankind.

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Educational Approach

JOHN J. PASCIUTTI

John J. Pasciutti is Supervisor of Alcohol Education for the Vermont State Department of Education. He is a graduate of Columbia University where he received the degrees of Bachelor and Master of Arts. Mr. Pasciutti is an alumnus of the Yale Summer School of Alcohol Studies and has returned to Yale to lead seminars in educational methods related to this problem and has been serving regularly as a member of the Summer School staff. He has also directed workshops and courses in Alcohol Education at the University of Vermont, and has served as lecturer or consultant in similar programs in other states including Oregon, Massachusetts, Michigan, New York and Rhode Island. Mr. Pasciutti is President of the Association for the Advancement of Instruction About Alcohol and Narcotics, a national professional organization, which encourages and assists professional educators to offer improved instruction about alcohol in the public schools.

Even with advancing years it is an awesome responsibility to speak to an audience whose talents, grasp and experience in human affairs far overshadow my own. Fortunately, addressing you also affords me a certain amount of freedom. What I say will be weighed, and accepted or discarded, on the basis of values and careers which have been sternly tested.

Our Chairman, Dr. Harry McNeill, is much better qualified, as are many other people in the audience, than I to deal with the child development and mental health aspects of this subject. Father John C. Ford possesses a deeper knowledge of the subjects of alcohol and alcoholism and their moral and ethical implications than I do. Nor am I schooled in matters ecclesiastical. The only reason for my being here, I suppose, is that I have had some experience in working with the subject at a statewide level (in a small state) and have struggled to learn what alcohol education can be in several stages of growth, in the elementary, junior high, and high school, and at the college level also. If what I have to say can be adapted to your own interests, I will be very thankful.

When working in alcohol education it seems important to distinguish between an area of interest (some people call it a problem area) called alcoholism and one of still wider scope (alcohol problems, of which alcoholism is one) where the consequences of drinking have a more direct impact on society than on the individual. Drinking and driving, teenage drinking, the policing of traffic in alcoholic beverages, the implications for society of a large investment in industrial, agricultural, and commercial enterprises by the producers of alcoholic beverages and many other social consequences of drinking are examples. Comparable distinctions apply also to the ethical and moral aspects of drinking, to the way we spend our incomes, personal and public, and the way in which a society regards the place and use of beverage alcohol. We have alcohol problems aplenty and, to some people they seem very critical problems.

There are numerous definitions of alcoholism and I can give you some if you want them but what is the point of defining something, the cause of which eludes us? What are we defining? Alcoholism has to do with the inability of an individual to control his drinking or to make his drinking conform to his needs and goals. He seems to go to a point in his drinking beyond which he intended and beyond which his intimates and the society around him find agreeable. Loss of control is the factor which differentiates the alcoholic.

There are those who feel that there is an easy solution to the problems of alcohol. Just put an end to social drinking! All the sorrow and misery could be avoided if people didn't take the first drink. Social drinking is the real evil. (No doubt the same purpose could be achieved by abolishing sin!)

Father Ford (1958) points out that it is not quite true to say that all alcoholics started as moderate drinkers. Actually, he says, all

alcoholics started as total abstainers and some drank excessively from their very first drink. And, he adds, it must be remembered that, just as the total abstainer never becomes an alcoholic as long as he remains a total abstainer, so it is equally true that no truly moderate drinker ever becomes an alcoholic, as long as he remains a truly moderate drinker. The reasons why two people from the same family leave the ranks of the total abstainers and go their separate ways, one inevitably on the road to excess, the other to controlled use of alcohol, remain a mystery. The information we have relates to case studies of individuals who have suffered from uncontrolled drinking and research studies on the use and function of alcohol in society. Comparisons of problem drinkers with others after they present a problem are unsatisfactory. What we need to know is what the person was like before he began to drink excessively and, if possible, what triggered his alcoholism.

PERSONALITY DEVELOPMENT IN ALCOHOL PROBLEMS

Our philosophy of teaching and learning seems to play as large a role as what we know about alcohol and alcoholism in determining how we approach the work of education for the prevention of alcoholism. If we think of education as a didactic, preceptorial process by which we communicate needed and important knowledge to our audience then, presumably, our job is to tell people what they need to know concerning alcohol and alcoholism. There is just one hitch here: some very gifted and "knowing" people have a lot of trouble with alcohol. On the other hand, if we are concerned with the welfare of developing children in terms of needed, growing experiences—if our aim is to keep healthy children healthy, then it may well be that alcohol education consists of something quite other than lectures about alcohol.

Research makes it clear that the use of alcohol to excess by adults may be a symptom of deep unhappiness, of tension, strong feelings of frustration, shyness, isolation, worry over failures, and the feeling that childhood and youth have been wasted. One of the most important things we can do in alcohol education then is to help children grow up happy, healthy people who adjust without too much strain to their fellow men and to the busy society in which they must take their places. To put it another way, the use of alcohol is not necessarily the fundamental problem. A major part of education relating to this problem consists in helping children meet their growing needs.

It follows that a daily program that helps to build well-rounded persons, with the mental, moral, and emotional stability needed to face life and all its complexities, is an important first step in alcohol and alcoholism education.

Before going further I would like to point out that there is an area of disagreement here about the roots of the problem. American authors pretty generally declare that feelings of anxiety play an important part in alcoholism; that alcoholics are trying to relieve and to forget that anxiety through alcohol. This is not true in all countries studied. French alcoholism is first of all an alcoholism of custom and above all of the facility with which people can acquire alcoholic drinks. This is true of the majority of Yugoslav male alcoholics although the majority of female alcoholics there took to alcohol from internal psychic motives only. The need for chemicals to deal with the presence of psychic problems in the United States is well supported by the financial success of the drug companies.

From this vantage point the work of education, or prevention, consists in part, in helping children grow up without the kind of strains and conflicts that make some people take to drinking for relief or to be able to function. To put it another way, alcohol education is education in healthy living and comfortable relationships with other people. The family has the primary role in this situation and Dr. R. G. Bell of Toronto tells us how this relates to alcohol education.

> Those childhood situations that mold the child in such a way that as an adult he experiences both tension and loneliness provide part of their "seed bed" (for later alcoholism). For example, let us consider the over-disciplined child. He is hurt by his own parents. If he could not turn to them in times of need you can be sure he is not going to turn to other people for help when he needs it as an adult . . . If the person is psychologically crippled or hurt as a child, so that he cannot turn to other people in times of stress, he has to turn to something; and he may turn to chemicals . . . which will reduce his awareness of a world to which he reacts with too much tension and in which he experiences too much loneliness (Bell, 1956).

It appears here that alcohol education in the school or in the church will consist of providing the child with better socializing experiences. When the personality is not there is it enough for the culture to provide a substitute in the regular or the giant size bottle, or by the fifth, the six-pack or the twelve-pack? The Proceedings of the Second Institute for the clergy (Bier and Schneiders, 1958), which you held in 1957 (section on marriage and family living), sustain this thesis. The breakdown in family living, marital discord, personal in-

security and anxiety, job instability, all tend to undermine, not only the socialization but also the emotional development of the child.

Alcohol has many roles in our society. Its present importance is best understood if we realize that our people use it to help them live with other people, live with themselves, do their work, carry on their sex roles. What does it do for people that they cannot apparently do for themselves?

If a man needs a drink in order to get through the day's work, or to digest his dinner after it, or to make the sale, or to talk up to the boss, he is in trouble. Those husbands who, after a few years of married life, cannot comfortably return after a day's work to the nest which they have struggled so hard to build and to the intimacy of the family, without bending an elbow on the way are in trouble. And so is the good woman who reinforces herself for the happy return! Alcohol, disguised as a social drink, is used by some to ease the pain created by their inability to play their sex roles. Alcohol is also used to help one live with oneself. Fears, tensions, diffuse anxiety, feelings of rejection, of inadequacy, all that gamut of emotions that continually assail all of us to a greater or lesser degree, can be put at rest, at least for a time, with alcohol. Here it is merely the first and oldest of tranquilizers that I know about; and considering all the jobs it is asked to do, it is a wonder drug indeed. It is plain that to make a success of life we must live with other people, live with ourselves, work and procreate. If we cannot do these things without a sedative we are in trouble. A society which is unwilling or unable to provide an adequate setting for the maturation of its children and substitutes sedatives or anesthetics is also in trouble. Where our responsibility lies is clear to a group with your understanding and experience.

THE ROLE OF FACT-GIVING

The above reference to the behavioral sciences probably raises more questions than it answers. I do hope it points a direction you can explore on your own. We do not have very much more than working intuitions on what to do anyway.

Those of you who are subject-matter oriented and committed to the importance of knowing as a way of proceeding in education will find comfort in the fact that a strong case can also be made for the role of knowledge in alcohol education. I read from the "President's Review" of the *Rockefeller Foundation Annual Report, 1954,* the

following statement: "Underlying the program (of the Foundation) has been the idea that man is so constituted as to prefer wise decisions to foolish ones if he could know enough to be wise; that he would prefer to care for his own needs in cooperation with others rather than in conflict; and that he would prefer a large measure of freedom to restrictive coercion" (Rockefeller Foundation, 1954, pp. 43-44).

From an editorial in the *Brattleboro Reformer* I have extracted the following material, which I have paraphrased.

The *Christian Science Monitor* very aptly points out that what has licked the communists in the United States in the last twenty-five years could well lick alcoholism. The decline of communists in this country was due to education, through which the evils of communism were exposed, and have been driven home to the people. The fact that alcohol has played a large part in the increase of crime, of insanity, and of motor vehicle accidents goes without saying. Other economic and social wastes attributable to alcohol are extensive and increasing. Yet little is done to point out the dangers of drinking or to help avoid the penalties which alcohol extracts from individuals and society as a whole. Somewhere along the line there must be found ways of employing education as vigorously against the curses of alcoholic beverages as it was used against communism.

One psychiatrist, Dr. David Zapella, Director of the Alcoholic Rehabilitation Clinic at Highland Hospital, Oakland, California, in his efforts to help alcoholics gain insight into their problems, usually asks the following question: "What did you know about alcohol and alcoholic beverages before you began to drink?" He reports that with very few exceptions, at the time of the initial drinking episode, into which he inquires very carefully, the factual knowledge of his patients regarding alcohol and alcoholic beverages was practically zero. He adds that this lack of factual knowledge about alcohol existed at the same time that very specific attitudes regarding drinking were present. These attitudes were ordinarily the result of first-hand experiences these individuals had in their family environment. It had something to do with who drank, how he or she drank, what were the consequences of his or her drinking in the family environment, and in general what were the current attitudes in the family regarding drinking.

Knowledge of the facts about alcohol seems like an important missing link in the lives of problem drinkers. If they could be taught early enough what the danger points are, it is possible that some people would be helped to avoid the pitfalls.

Father Ford also underlines the importance of knowledge in any program of prevention. "In a program for the prevention of alcoholism and prevention of excess in the use of alcoholic beverages, the scientific facts about alcohol should be taught along with the moral principles concerning its use and abuse . . . and in any event the moral and spiritual values involved in the use and abuse of alcoholic beverage cannot be appreciated except in the light of pertinent, scientific information." He believes, consequently, that "A program of prevention, especially in the education of young people, should have this two-fold basis, the basis of scientific fact, and the basis of Christian principles by which to measure the moral and spiritual values involved in man's use of beverage alcohol" (Ford, 1958, p. 4).

Information-giving in this area is not in itself a simple matter. It is obvious that people should know that alcohol is a depressant, an anesthetic, that they should know its role in our society, the way it affects physical reaction and psychological behavior, and the economic facts as well as those relating to health. The difficulty is that there are apt to be as many answers to questions as there are people, answers based on truth, falsehood, half-truths, misinformation, and even imagination. Some answers are "dry" and some are "wet" and still others are only "half wet." Another interesting question would be: Why do we, through state governments, provide social sanction, active reinforcement, legislative protection, and state distribution for a powerful drug?

Our culture does not know what it believes about alcohol and there is no agreement about what is right. This situation merely reinforces the importance of some fearless teaching of objective facts. There is much culture conflict in this area. No two religions agree exactly and social groups are divided along the lines of ethnic derivation, economic interest, and moral and ethical considerations. Our range of attitudes stretches all the way from regarding the use of alcohol as a sin to looking upon it as one of God's gifts to man provided for his use and comfort. We are dealing with folkways on the one hand and with the findings of scientific research on the other, two forces which are not always in agreement. The findings of the laboratory when they are in conflict with folkways will have to be translated into blindly accepted values, habits, and customs at the level of parish socials to be effective. "Facts" over which there is disagreement add only one more item to the many conflicts in this field.

There are some facts about alcohol that should be part of the

intellectual bag and baggage of every youth journeying into the adult world. Everyone should know that alcohol is not a stimulant, but a depressant. Its sedative effects on the central nervous system in small quantities should be underlined. As the superego is soluble in alcohol the latter relieves the drinker of conflict between feeling and purpose. He sees double but feels single. It seems important that some people should know that alcohol is often used as an adjustment mechanism and as a painkiller. Psychological and physiologial effects are of prime importance to everyone living in a mechanized, drinking society. The implications of social drinking for those who drive can no longer be ignored. In keeping with this point it is important to recognize that with modern mechanization and the crowded conditions under which we live, there is no conflict between the practical and the moral implications of drinking. Father Ford believes that a prevention program under church auspices should have the positive, immediate, and explicit aim of the practice of the virtue of sobriety, and that this virtue can be practiced by total abstinence or by drinking in moderation. That we should avoid negative approaches, intimidation, exhortation, and fear techniques goes without saying.

Until such time as some certainty is developed and accepted as part of our mores it is probably desirable to take a problem solving approach with young people. Instead of laying down the law along sectarian lines or based on personal opinion or on pseudo-science, we should perhaps try to develop a conscious awareness of a problem and an intention to deal with it. This step can be followed by a consideration of the facts and the probable direction a solution or solutions will take. Both students and teachers will each, individually, arrive at some solution based upon the conscious act of fact-giving and subsequent student discussion. Closely related are also the inner needs of the individual and the influence of parental mores, the peer models, priests, ministers, rabbis, and teachers. Here unconscious factors in regard to instinctual needs and unconscious identifications play a prominent part in the decisions young people make. By way of providing healthy models church people and teachers play an important role, especially if they have a good relationship with young people and are sensitive to their needs.

Says the *Rutland Herald,* one of the leading newspapers in the State of Vermont editorially

> Values are relative; and in the sphere of personal preference they are perhaps nowhere more so than in relation to the use of alcohol . . .

> The director of the program is on the right track when he says that what has been wrong with alcohol education in the past is that "we have taught answers instead of problem solving." When . . . there is obviously no complete agreement among all substantial citizens on exactly what the 'right' answers are there can be nothing but confusion left in the minds of many students who are taught one thing and observe their parents, friends, and other respected members of the community in apparent disregard of the teaching. Their real education in the use of alcohol will begin when they learn the facts and are encouraged to use them in choosing their own behavior, fitting it to the pattern of their family and community life. Just as in mathematics, where they learn that two and two make four but are reminded that two oranges and two apples do not make four of either, so they must learn that there are no simple and absolute answers to many personal and social problems involved in drinking. There are no such answers, that is, for all; but each individual can develop his own scale of values that will provide a clear and effective guide to his own use or abstinence (*Rutland Herald,* 1951).

Our nation is made up of people from many ethnic groups, religious faiths, and geographic regions with differences based on these factors in relation to drinking. No matter what practice young people adopt they will be wrong in the eyes of some important group in the community. It follows that a problem solving technique is more appropriate than preaching or the lecture method. I doubt that it is good teaching to range one belief or custom against another. There is recognition of this factor in Father Ford's paper when he pleads for a positive approach based on the virtue of sobriety which may be practiced by abstaining from the use of alcohol or by using it in true moderation and this from supernatural motives. Nothing is more disconcerting and confusing to young people, I imagine, than to learn of the wide range of belief and conflict of attitude on religious grounds which exists. If this is added to the other conflicts we will see that it is merely another "fact" which adds confusion in an area where grave doubts already exist.

Many people seem to enjoy the effect of slight intoxication, the gaiety of a party, the conviviality of a good meal with a bottle of wine, the quiet talk over a drink or two. Some of these people, over the years, may develop an inability to drink or to leave it alone. They then become one of a group called "primary alcoholics." Some timely teaching of the facts and the danger signals which are a prelude to alcoholism might influence some of these young people who are susceptible to crossing that invisible line called "loss of control" which, for them, is the point of no return.

Another type of alcoholism is designated as "secondary" alcoholism. People with mental conditions, troubles, conflicts, drink, not for pleasure, but to escape their troubles. These expressions "primary" and "secondary" are also called, respectively, exogenic (alcoholics who are made, not born) and endogenic (those who use alcohol for its sedation action as a means of escape from reality and in particular from their personal problems).

We must be watchful to cope with life's problems. Such persons, immature in certain respects, weak in certain attributes, are likely to turn to alcohol or some other escape when a crisis arises. Correction of any physical, mental, emotional, or moral weaknesses during childhood helps to prevent breakdowns, delinquency, or alcoholism later in life.

Straus and Bacon (1953) in their book, *Drinking in College,* point to three levels of action in a preventive program. They suggest that (1) there are levels of drinking behavior dominated by socio-cultural forces; (2) there are other levels which can be manipulated by guidance and the tools of reason; and (3) still other levels which may be reached only by emotional and social restructuring of the individual, i.e., psychotherapy or psychoanalysis.

They point out that it is important to avoid the waste involved in making every approach on all levels, or on the wrong level; that we should develop techniques for a defined purpose, and that the more effective a technique is for one level the less effective it is likely to be for the others.

Wattenberg and Moir (1956) in their study of teenage drinking, which they feel throws considerable light on the basic personality structure of the teenager who is in trouble with drinking, applied intensive psychological testing under similar circumstances to a group of boys charged with felonious assaults and boys in detention because of heavy drinking. The finding was that the boys involved in heavy drinking had personality characteristics similar to those most frequently found in juvenile delinquents, whether the complaint against them be alcoholism, car stealing, or any other type of complaint.

On the other hand, Giorgio Lolli in his study, "The Addictive Drinker," has this to say: "The importance of the childhood background is confirmed by clinical experience. From this emerges a concept of alcohol addiction which maximizes the role played by the pre-alcoholic personality at the expense of the role played by alcohol. The quality which characterizes the addict is his 'disposition' to react to the effects of alcohol in such a way that some of his anoma-

lous and pressing needs are satisfied, albeit briefly and inadequately" (Lolli, 1949, p. 405).

Dr. Jellinek advanced the theory that loss of control over drinking will appear in drinkers who have a constitutional liability factor of a physical nature which may be either hereditary or congenital. The presence of such a physical liability factor may produce alcohol addiction only if psychological tensions should lead to a prolonged heavy use of alcoholic beverages as a sedative. Such heavy use will come about only in the presence of certain social and economic factors.

Despite the controversy over the possible existence of a prealcoholic personality it appears to us more important to recognize that the potential problem drinker, whether he has a physical or a psychological predisposition or not, can be detected. Straus and Bacon (1953) are in agreement with this. They suggest as a means of detection the following questionnaire seeking information in three areas:

A. Social Complications Associated with Drinking—
   1. Failure to meet academic or social obligations because of drinking
   2. Loss of friends or damage to friendships
   3. Accident or injury to himself or others
   4. Formal punishment or discipline—loss of job, arrest, coming before college authorities
B. Special Stress on Drinking (importance attached to drinking)—
   1. Drink in anticipation of not getting enough
   2. Surreptitious drinkers
   3. Reactions to whether or not alcohol served at party where it might be expected
   4. Foregoes other things because of cost of liquor
C. Additional Warning Signs—
   1. Blackout
   2. Intoxicated when alone
   3. Early morning drinking
   4. Aggressive or wantonly destructive or malicious behavior

All four forms of behavior under C suggest an abnormal reaction to, or desire for, alcohol or an asocial drinking pattern. "The data of our college study," say Straus and Bacon, "suggest that a large segment of those students whose drinking patterns display some of the warning signs, are already, when still quite young, worried about the consequences of their drinking. Constructive counselling at this early stage might contribute effectively towards preventing future progression into alcoholism" (Straus & Bacon, 1953, p. 169).

Because of the emphasis, earlier in this paper, upon the early years of a child's life, it appears worth considering, that alcohol "education" is really a misnomer. We should perhaps speak about alcohol re-education. Drinking alcoholic beverages is a folkway like eating or dancing. Folkways are learned during the first six to ten years of life. Early learning influences later learning. By the time the school becomes active in this field of alcohol education (some never do), the child usually has absorbed from his culture its pattern of thinking and feeling in regard to alcohol. In alcohol education we are not dealing with a *tabula rasa* but with a mind which has already an outlook and perhaps some background experiences in our subject.

Re-education, according to Lewin (1948), is a process which is functionally similar to a change in culture. It is a process in which changes of knowledge and beliefs, changes of values and standards, changes of emotional attachments and needs, and changes of everyday conduct, occur not piecemeal and independently of each other, but within the framework of the individual's total life in the group. Re-education in this sense is equivalent to the process by which the individual, in growing into the culture in which he finds himself, acquires a system of values and a set of facts which later come to govern his thinking and conduct. According to this same author this is not a simple task. "The re-educative process affects the individual in three ways. It changes his cognitive structure, and the way he sees the physical and social worlds, including all his facts, concepts, beliefs, and expectations. It modifies his valences and values, and these embrace both his attractions and aversions to groups and group standards, his feelings in regard to status differences, and his reactions to sources of approval or disapproval. And it affects motoric action, involving to a degree the individual's control over his physical and social movements" (Lewin, 1948, p. 59).

It can be seen, therefore, that alcohol education or re-education cannot be merely a rational process based on sound precept and the lecture method and that we have here something much more complicated and pervasive. This is, as earlier indicated, due to our mental apparatus consisting of both a conscious and an unconscious part. Aristotle had some awareness of this when, centuries before Freud, he said of children:

> Since we wish them to live the good life, practice virtue and moderation, and follow reason in all they do, we must give them an education directed to those ends . . . Purely military education, such as the Spartans have, is not enough; for it does not develop all of

> man's powers and conspicuously neglects the virtues of peace, which are temperance, justice, and intellectual culture. We must train the body, the appetites, and the mind, thus making the well-rounded man.

We have perhaps unduly complicated the understanding of alcohol education, but it is not a simple task in which we are involved. It has to do with social conventions, personality, pain, tensions, habit, cradle experiences, child rearing, feelings of belongingness, and feelings of adequacy. All of these factors and many more are further complicated by the fact that we seem to be living in an immature society, an anxious time, a time when there is a breakdown in family living and when the pattern of American life is changing. The modern school, like the little red school house, has as its objective, the making of good, healthy, human personalities out of the children who come to it. It is imperative that the churches, parents, communities, and the devoted, but humble teaching profession, all work together in an effort at building these healthy personalities.

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PART II

DRUG ADDICTION

The General Problem

KENNETH W. CHAPMAN *

Kenneth W. Chapman, M.D., at the time of the Institute was Associate Director, Clinical Center, National Institutes of Health, Public Health Service, U. S. Department of Health, Education and Welfare, Bethesda, Maryland. From 1955 to 1957 he served as consultant on Drug Addiction to the same National Institutes of Mental Health. Dr. Chapman received his B.S. and M.S. degrees from the University of Massachusetts, and an M.D. degree from Yale University. He was a Fellow of the American College of Physicians and a Fellow of the American Psychiatric Association. Dr. Chapman died shortly after the Institute, on September 18, 1959, and it is to his memory and in recognition of his significant contributions in the area of drug addiction that the present volume is dedicated.

Each generation thinks of its problems as worse than those of preceding generations. This is only one of the misconceptions which arises from a failure to view a social problem from the perspective of history or in relation to other problems. Drug addiction is no exception. An historical review, based on a few classic works in this field, causes one to realize that in reality there is, in the words of the Psalmist, "no new thing under the sun." Thirty years ago, Terry and Pellens (1928) in their book *The Opium Problem* wrote as follows:

> The problem of chronic opium intoxication, as occidental countries have come to know it of recent years, is so extremely complex and

* Deceased, Sept. 18, 1959.

> far-reaching, so intimately interwoven with public health, commerce and trade, and social customs, and has been evolved so insidiously that we may well ask if the use of opium ever was confined to its sole valuable function; namely, that of a therapeutic agent. So very complex, indeed, is the problem that it would be impossible and needless, at the present time, to attempt to delineate it in its entirety. . . .
>
> Among the western nations, the United States seems to have acquired the reputation—whether deservedly or not need not be considered here—of being more widely and harmfully affected than any other. Certainly, in this country there has been much more interest evinced in control measures both of an international and national character than elsewhere. Whether the problem is really greater in the United States than in other countries or whether, perhaps, the question simply has been more agitated here by virtue of a better appreciation of its extent are matters for speculation. Certainly, our news agencies have not minimized the importance of the problem or lessened the public's interest in it and today, on almost every hand, individuals, local organizations, scientific bodies, and legislative groups have become aroused to what is considered generally a health and social peril of magnitude.
>
> Unfortunately, among those who have become interested from a professional, legislative, administrative, sociologic, commercial, or other point of view, there has been an almost continuous controversy as to practically every phase of the narcotic situation, with the result that all the way from the cause on through the development, course, and treatment of the condition, to say nothing of its underlying nature and methods of control, there has been a lack of unanimity of opinion. . . . In general, students and writers appear to have approached the subject from only a limited experience—with too meager a basis of fact—and to have emphasized unduly one or another feature to the total exclusion of related data. This tendency quite naturally may have led the more or less casual reader as well as possibly legislators, administrators, and others officially or professionally connected with the individuals involved, to prejudicial attitudes and unwarranted generalization (Terry & Pellens, 1928, pp. xiii-xiv).

This statement of thirty years ago implies that: first, drug addiction is worse in the United States than elsewhere; second, there is more interest in control; third, drug addiction is a social and health peril of great magnitude; fourth, there is continuous controversy on how to manage addiction problems; fifth, there has been a development of prejudicial and biased attitudes. I think that this fairly well summarizes the situation in the United States today.

I have tried many times to arrive at some explanation for this timeless attitude, with little success. One is tempted to speculate that the use of drugs is particularly threatening to the view of ourselves derived from our religious and philosophical heritage. I have, for exam-

ple, asked myself whether drug addiction is truly as great an evil as that represented by a numerically larger problem—alcoholism. Many experts do not think so for a number of reasons which include the pharmacology of alcohol, the constellation of people with whom the alcoholic comes into disruptive relationship, the costs to the public from loss of productive work, the lives lost through drunken driving, family distress, and numerous other factors. What, then, is so very evil about narcotic drugs? What in our mores cries out "shame" on the addict and "poor fellow" to the alcoholic? Could it be, as Terry and Pellens suggested, that we are misled in the factual knowledge of drug addiction?

The very lack of clarity of opinion as to what it is that is bad about drug addiction seems to me to be at the root of the confusion. Through the years, I have attempted to reach some sort of balance in defining the problem of addiction. Admittedly, my viewpoint is biased by my professional calling and personal mission in life—to relieve suffering. Humane approaches dictate that such relief should be accomplished with a minimum of pain lest the cure be worse than the disease.

ATTITUDES TOWARD ADDICTION

Attitudes toward addiction are conditioned by public information derived from various sources. For example, during the past nine years there have been numerous reports by legislative bodies, both state and federal, on this subject. The content has become standardized. First, there is an historical review which notes with alarm the sharp rise in the number of addicts in the post-World War II period as compared with the previous two decades. Second, there are either verbatim or summary reports on the effects of drug addiction on individuals. Third, and by far the most intensive, is a discussion of the relationship between drug addiction and crime. Fourth, there is a review of the many different attempts to cope with the problem, with comments on the relative effectiveness of the methods used. Finally, there are a series of recommendations which usually reflect the particular bias of the majority members of the reporting group.

It is unusual to find a discussion of how the problem was viewed in the past and of the corrective efforts that have been made, or were once proposed but not effected. There is no mention of the periodicity of the waves of addiction. There is rarely any analysis of the rea-

sons for the failure of the variety of corrective measures attempted, except for penal provisions which, it is usually concluded, were not severe enough to be an effective deterrent.

Usually these recommendations include: (1) better law enforcement, (2) stiffer specific penalties for traffickers, (3) more research into methods for curing addiction, and (4) vague recommendations for treatment which are often a potpourri of the punitive and the therapeutic.

With the exception of the first two recommendations, little is done. As a consequence, the primary outcome is more penalties, with the other important features lost in limbo. Certainly, compared to the other alternatives, this solution costs the taxpayer relatively little in terms of increased appropriations. Is this perhaps the real answer to the problem—a "Siberia" for all addicts and long imprisonment for all peddlers? This could mean a permanent colony housing 40,000 to 50,000 addicts.

Of course, the "Siberia" theory depends on the premise that only addicts beget addicts. However, Chein's and Rosenfeld's (1957) studies, of which you will hear more later, lead us to reject the theory of contagion as the single cause of new drug addicts. Furthermore, Rayport (1954) reports that a not inconsiderable number of addicts become so through an original but not current medical illness. These findings mean that even if we lock up or otherwise permanently isolate all known addicts, new ones will continue to appear in the community. Although indefinite detention of addicts will undoubtedly reduce the incidence of new addictions—reported by the New York Committee on Narcotic Study to be 5,000 per year in New York—it will also create the problem of accommodating an ever-growing population in a hypothetical "Siberia," to say nothing of the humanitarian and other questions such a procedure would raise.

It is apparent that the problem of drug addiction is more than the matter of social taboo, the relationship to crime, the deleterious effects on the individual addict; it is a larger problem of social issues, of professional attitudes and biases of the medical and law enforcement groups, and of legislative attitudes. It is in this broader setting that I should like to present the problem of drug addiction.

MEANING OF DRUG ADDICTION

First, what are we talking about when we speak of drug addiction? I shall assume that, with the exception of my fellow specialists in this

field, most of you have some confusion in your minds as to the terms of reference.

Drug addiction, though encompassing by definition the repetitive and compulsive use of some natural or synthetic substance to the detriment of self or society, is usually limited to the use of drugs of the opium family—the narcotics. Of singular concern at this period in history is heroin, a manufactured compound of morphine. Why heroin? Heroin is somewhat more powerful grain for grain in its initial pleasurable effects than morphine, and its greater potency per unit volume thus lends itself to smuggling and large financial return in the black market. Other narcotics such as morphine, and the synthetic equivalents, like meperidine, are less common in the black market and consequently are used mostly by those addicts who are supplied more or less legally from legitimate sources.

At the risk of being pedantic, a review of the pharmacology of addiction may be in order. Narcotic drugs in legitimate medicine relieve pain and suffering. For some persons, the action includes also a positive pleasure, in the sense of feelings of euphoria or relief of emotional tensions. In either case, repetitive use results in the development of body tolerance to the initial effects.

For example, suppose a person starts with one-fourth grain of morphine. Within a half-day or a day, he wishes to reachieve the pleasure it produced. (Although in some cases there are certain temporary ill effects such as nausea.) He repeats the dose and finds before the day is over that he wants more. After a few days, he finds himself wanting the drug at four- to six-hour intervals. In a week or so, he finds that the initial effects achieved in the early dosages no longer produce the pleasurable sensation. He takes more and more. In six weeks to two months, if he has an adequate supply, he will have arrived at a fairly high level—from six to eight or ten grains a day.

The result is that the amount must be increased if one is to find relief either from pain or from emotional distress. This enslavement is the worst single feature of narcotics for, once started, the individual finds that he not only arrives at a point where, no matter how much he takes, he does not feel any better, but he is also forced to recognize that to stop makes him violently ill. This phenomenon, known as physical dependence, is manifested by predictable symptoms resulting from withdrawal—nausea, running of the eyes and nose, general malaise and numerous other signs of great discomfort. If allowed to continue without any relief from drugs, the illness lasts from three to four days.

Recapture of the initial euphoric sensations and the avoidance of this illness becomes the be-all and end-all of existence for the addict, once addicted. Unless supplied regularly, he becomes ill. Without a doubt the social effects of drug addiction hinge on this single phenomenon. To maintain his supply of drugs, the addict concentrates all his energies and attention on the quest in a virtually psychotic fashion. He will steal from his family, lie, cheat, rob others, and do almost anything to obtain drugs to stave off the illness. To repeat, most of the problems of drug addiction stem from this facet of addiction, with only a few exceptions. Needless to say, the addict becomes a relatively useless member of society in that he does not contribute in any way to its productivity or advancement. He does not even sustain himself; he is a parasite.

All of this is based on the assumption that the addict can by "hook or crook" get all the drugs he wants to achieve full tolerance. This is not so for most addicts. The cost of drugs, and the adulteration of the powder sold as drugs (the analyses usually run only 2 to 5 percent heroin), make it virtually impossible for most addicts to reach the level of full tolerance. Thus they have a double problem—the desire to achieve the pleasurable effects by increasing the dose, difficult because of the small amounts they can get, and the threat of withdrawal illness, which creates physical dependence early in the period of tolerance development.

Not all people find pleasure in narcotics as defined herein. However, anyone may become pharmacologically addicted. There are undoubtedly a great many more people who could become "pleasure-seeking" addicts than is actually the case. Think of the numbers of people with emotional problems who seek solace by other pathological means such as alcohol.

As a consequence, it is imperative that drugs be made as unavailable as possible. A brief survey of addiction prior to restrictive laws is ample evidence on this point. In the early 1900's, estimates ran into the hundreds of thousands, because of the presence of opiates in various elixirs, tonics, etc., and the ready sale of opium, heroin, laudanum, and what-not at any store.

SOCIAL ASPECTS OF ADDICTION

The problem of drug addiction, however, is not solely that of drug abuse and restriction of supplies, but also the development of healthy people or the rehabilitation of unhealthy people so that they

need have no recourse to addictive substances. Hence it is apparent that drug addiction is but a facet of the much larger problems of social and emotional maladjustment and the resultant disruptive and mentally disturbed behavior.

You will hear, as these meetings progress, of the more detailed aspects of these problems. Let me outline briefly some of these features, for they will easily bear repetition later in a more explicit fashion.

From what has been gleaned by students of addiction over the years, certain generalizations can be made, although there are of course myriad exceptions. Some broad characterizations, with allowance for all of the individual permutations and combinations of personality dysfunction, can be attributed to the bulk of the addicts with which society is concerned. Excluded from social concern and discussion here are those addicts who receive their drugs more or less legitimately, and those who can obtain drugs without violating other laws.

Most of this large group whom we are here characterizing are in the second to fourth decades of life, have manifested delinquent behavior of some type prior to addiction, and increase their delinquency during addiction. They come from depressed economic areas in large cities. Their home life has been seriously defective, with poor parental supervision and unsatisfactory authority figures to emulate. They are passive-dependent, "hangers-on" of peer groups. They suffer from weak ego development and have immature and inadequate life goals. Most have a strong fantasy life which drugs reinforce. They are a kind of junior grade "Walter Mitty" type. Not an inconsiderable number are psychotic or are on the borderline of psychosis. Paradoxically, drugs make possible some adjustment to reality.

This picture, drawn with a broad brush, gives us some idea of the people with whom we are concerned. Now, in addition to those things that drugs do for this group, what other things do drugs do for and to people? Perhaps we can clarify some of the popular misconceptions on this score.

MISCONCEPTIONS ON ADDICTION

For the moment, let us examine some of the facts and fancies. The first thing one hears from the misinformed is that drugs create "sex maniacs." Assuredly this is not true of narcotic drugs; they are so depressing to sexual impulses and sexual metabolism that erotic

desire disappears almost entirely during addiction, and in women the menses cease. In fact, many persons become addicted because they fear their erotic drives and seek to suppress them with drugs.

A second question: Do drugs make killers of normal people? Again, narcotics are depressants, slowing down all aggressive impulses. The main goal is often to relax and "goof off," in popular parlance, or to make it possible to relate better to other people. This, let me hasten to say before cases are cited in which addicts have killed policemen, etc., does not gainsay the fact that narcotics are not selective in the sense that *only* certain types use them. It is possible to find examples of every kind of person using these drugs. Unquestionably, the "killer type," the aggressive psychopath, can and does use drugs; he is however atypical. Even in these cases violent aggression is rare, and confined to periods of marked stress, as when the addict psychopath is denied his usual supply of drugs and frustrated in his attempt to find them elsewhere. Too often narcotics are equated as "drugs" with other substances such as cocaine, which has a markedly stimulating effect. As the old addict says of cocaine: "If you weren't crazy when you started, you soon will be."

Drugs contribute to crime, undoubtedly, but so does alcohol. I should know, having spent a few years in Kentucky where the moonshiners made it unsafe for decent citizens to travel certain areas at night, and where I lost a friend, a sheriff, who refused to be "bought" by illicit liquor interests. Whenever we put a premium, monetary and/or legal, on a pleasurable substance, crime enters the picture, either in the buying or selling, or, if the cost is too high, in stealing and other means of making large sums of money dishonestly in order to buy the article. Has the "black market" of World War II already dimmed in our memories?

I am sure that my law enforcement colleagues will take strong issue with these statements, and can quote dozens of "for instances" to the contrary. But remember, we are not dealing with the exceptions—the "horrible examples." If we are to face the problem of drug addiction squarely, we must see what can be done about the many. The few, the exceptions for which there is no alternative solution, will need to be dealt with as will any other seriously aggressive criminal type. The laws and systems of graded penalties were provided in our judicial system to take care of just such variations in seriousness of antisocial behavior, and they should be allowed to continue to fulfill this role.

TREATMENT AND CONTROL OF DRUG ADDICTION

The problems facing us are: what do we do about the majority, the minority, and those in between? I submit that we, and every individual or group who tries to tackle the problem of drug addiction, are creating a hopeless dilemma if we try to compress the variations within the framework of a universal panacea. There is no panacea, and indeed there is no final cure for drug addiction. Let me hasten to clarify this statement.

Drug addiction is a disease, but in the same sense that psychosis is a disease; it is not an infectious disease like pneumonia. Hence, treatment must follow the same principles as for other mental disorders. Like other sufferers from psychiatric illnesses, the emotional difficulties are deep-seated and ever present, even though after treatment the person may appear well-adjusted to himself and to life. Nevertheless, the seeds are there and can manifest themselves in further illness under the proper conditions. Yet, as in other psychiatric disorders, we can speak of recovery which may or may not be lifelong. We strive to lengthen the periods between relapse just as we do in other forms of mental illness.

There must be, then, a variety of treatment opportunities to meet the needs of a variety of people. The problem we face, and the one that confounds those who do not take into account the variety of human behavior, is to provide flexibility in handling or treatment of addicts. Once this variety is truly recognized by all persons interested in bettering the drug addiction situation there should follow greater acceptance of the fact that there is no single treatment best for all.

Unfortunately, because of legal and statutory restrictions, medicine, in whose proper province lies the treatment of addiction, is hampered in its efforts. Since so many drug addicts come into conflict with the law it is impossible to consider treatment without reviewing the legal setting within which treatment takes place.

Although 38 states have statutes providing for legal commitment of addicts for medical treatment, such methods are rarely used. This is partly because of prior claims by courts of justice for law violation, and in part because most mental hospital programs do not provide a proper framework for treating the addict. Moreover they are overcrowded with other and more serious (i.e., psychotic) types of mental disorder.

On the other hand, correctional and penal institutions in most states are rarely able to provide the kind of assistance the addict needs. The few hospitals (two federal and one state—Riverside in New York) that are devoted to treatment of addiction cannot, for many reasons, accept all addicts needing such care. California, after a lapse of almost 20 years, has reinstituted a program for treating addicts. During the 1930's a hospital was operated at Spadra, but was discontinued in 1941 due to lack of clients and lack of success in treatment. The new programs are too young to be evaluated, yet offer promise.

Laws other than the aforementioned mental health type are usually not very useful in rehabilitating the addict. Under criminal laws he receives a sentence, and may or may not be eligible for parole and finally release without regard to his individual needs. It is essential that greater latitude be permitted in the law, to make possible a useful treatment program adapted to the needs of those addicts who appear capable of being helped.

For example, there is rarely in any state law, and in no federal law, a distinction made between the non-addict peddler and the addict who peddles to provide drugs for his own habit. True, under federal statutes the addicted peddler may be sent to federal hospitals and thus receive medical treatment, but the sentence and provision for parole and release are the same whether the person convicted of peddling is himself an addict or not.

There are also addicts who either have not been caught as law violators or who seek treatment voluntarily. Again, although most states provide through mental health laws for treatment in mental hospitals, such patients are rarely accepted. A few cities provide limited opportunities for voluntary treatment. The two federal hospitals provide such programs, but are hampered by geography from being fully adequate.

It is well recognized that there is a need for involuntary treatment programs comparable to commitment under mental health laws. Again these exist in some states, but are rarely used for lack of treatment facilities. More state statutes allowing for this procedure are needed as well as an increase in facilities for treatment.

We have, then, a welter and confusion of laws covering the enforced institutionalization of drug addicts. Institutionalization usually means imprisonment. Despite their incarceration they continue to return to addiction on release. Why is this so? It is the opinion of most experts on treatment that rarely is the treatment of the proper type,

of sufficient extent, and operating under the proper circumstances for maximum effect.

An optimum program should include the following: hospital facilities for withdrawal and physical rehabilitation; psychiatric and adjunctive services of sufficient quantity and quality; opportunities for vocational training; a chance for medically determined and individualized trial periods or parole into the community and, perhaps more important, adequate aftercare; and supervision in the community with the full cooperation of all social agency and psychiatric outpatient services. In this enumeration is included the participation of all adjunctive agencies, such as churches and their service groups where such exist.

Unfortunately, no such complete program exists for any addict except for those wealthy enough to pay for it, and we are not concerned with them. Instead, all of us who are interested in the field are forced to treat addiction and addicts with only half the tools that we know how to use. We are then criticized for not effecting more cures.

Detroit, Chicago, and New York City are either dropping or so diffusing their current programs that they will soon lose their identity. Without sustained interest by some persons, such programs historically have been lost in limbo. The net result is more and more criticism that medicine has failed and that only penal measures are of any avail.

Let me illustrate. Recently, in a large city, I was on a panel with a legislator and a lawyer. The lawyer, who had become interested in the problem through a few clients, was pleading for a program of rehabilitation. I gave much the same outline, in a little more detail, as presented above. I might say, parenthetically, that some parts of such a program have been tried even under severe limitations with enough success to warrant further expansion. After I finished, the legislator proceeded to say that since we doctors had not developed a program that could *guarantee* curing addicts, he, for one, would continue to rely on stiffer penalties as the only answer. He would not even allow me to try!

We do have a problem or problems in drug addiction. We cannot solve them by any single method, and this applies quite as much to programs for dispensing free drugs as it does to enacting more punitive laws.

You have heard of proposals to provide drugs for confirmed addicts as a means to eliminate criminal and black market activities. I

do not think it would work. On this score I might mention now only that it can be quite misleading to make direct comparisons between British policies and our own. The British programs operate differently in a very different social environment. For this reason it cannot justifiably be assumed that the British procedures, or any facet of them, will necessarily be equally effective in this country.

We need to find many solutions: better methods and circumstances of treating those amenable to treatment; means of providing a variety of treatments scaled to individual needs; means for sorting out those who can best use treatment programs; and means for mobilizing all community resources not only to improve the status of those potentially addicted and thus prevent new addictions, but also to assist in the rehabilitation of recurrent addicts.

All groups, medical, legal, social, and religious, need to work hand in hand. But first there is need for mutual understanding and a united positive attitude among all parties before we can begin to cope with drug addiction. Without this kind of approach, I fear that thirty years from now future experts will say the same things of us that we are now quoting from the writings of our predecessors. I hope that this conference will provide such a medium for greater understanding of each discipline's problems and premises in coping with drug addiction.

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Etiology and Personality Factors

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In the first part of this Institute we concerned ourselves with the problem of alcoholism, and in my discussion with you two days ago I tried to outline what seemed to me to be pertinent and relevant in the various existing theories of alcohol addiction. To recapitulate briefly, we noted that there were those theories that emphasized the psychologic, the social, the cultural, or the anthropologic determinants of malignant alcoholism, and there were those that put great emphasis on physiologic factors—allergy, hormones, metabolic errors, and inherited defects of cell function. We could not delineate a uniformly acceptable theory of etiology from the many possibilities suggested, but we were inclined to the view that each of them may hold a kernel of truth, and that any final theory would have to explain the

elements emphasized by all the others. While this state of affairs was not in itself disheartening, in that it differs little from the history of progress in any field, we were disturbed by a recurring tendency among many commentators on the subject to confuse effect with cause and to presume that events which are contiguous temporarily are related etiologically.

In the area of drug addiction, we find that the same situation prevails, perhaps to an even greater degree. Most writers describe the overwhelming majority of addicts as emotionally immature, hostile, aggressive, demanding of immediate gratification, and seeking, through drugs, some relief from inner tension. The remainder are either frankly neurotic, using drugs to alleviate the anxiety produced by their neurotic conflicts, or are iatrogenic addicts who have been made so in the course of overlong or overeager treatment, with drugs, of some physical condition. Yet since not all in this latter category become addicted, it is usually stated that those who do had some pre-existing personality problem. Though such constructs may be useful as a frame of reference, I do not think it is helpful to define addiction as a personality disturbance and then conclude that any one who can become addicted must have a disordered personality. While it can be conceded that most confirmed addicts do have difficulty in getting along with society in general, with their fellows and with themselves, it is uncertain whether this is cause, or effect, or unrelated to the basic problem of addiction.

THOSE WHO BECOME DRUG ADDICTS

It might be worthwhile to approach the problem of drug addiction phenomenologically first, and try to determine, as we did with alcoholism, the extent of the problem and the sort of people who comprise the group. We shall classify as an addict any individual who, whatever the apparent reason, has become physically and emotionally dependent upon a drug so that he must maintain a certain level of intake of the substance. We might note, additionally, that the need for the drug often appears as a compulsive, overpowering craving, and that there is a tendency to use ever-increasing amounts of the drug in order to obtain the desired effect. Although a few people become addicts innocently (and there are cases of children born addicted to a drug used by the mother during pregnancy), the vast majority is introduced to the drugs knowingly. About half begin by

taking them for the relief of some unpleasant physical or emotional condition; the others begin to use them through simple curiosity. Addicts themselves often trace the beginning of the habit to use of the drug as a hangover remedy.

There are about 60,000 narcotic addicts in the nation, or about one person in every 3,000, and most of these are men, typically under 35 years of age. There was an upward trend in incidence in the first half of this decade, accounted for mainly by increasing incidence in teenagers and young adults in large cities (New York, Chicago, Washington, Detroit) and in minority groups (Negroes, Puerto Ricans) and others of relatively low socioeconomic status. It is interesting that in 1914, when the Harrison Narcotic Act was passed, there were approximately 175,000 addicts, and most of these were women (Noyes and Kolb, 1958, pp. 564-574).

The classical picture of opium addiction is one of progressive mental deterioration with intellectual inefficiency, loss of interest in the environment, and loss of self-respect. The addict is feeble, debilitated, emaciated and wasted; his complexion is sallow and grayish; his skin and hair are dry; his pupils are small and sluggish in their reaction to light; his tongue is dirty, his breath foul, his appetite poor, and his cold extremities are scarred by puncture marks and signs of injection abscesses. He is in poor physical health and, in addition, he is morally and socially bankrupt—a degenerate, in other words, and often with criminal features. This is the classical picture, as I have said, but it is far from the true picture. It is not irrelevant to point out that, as a class, physicians and nurses contribute more heavily to the addict population that any other occupational group, and many of these carry on successful and even brilliant careers. As is often the case, what has long been accepted as cause turns out on closer scrutiny to be effect. It is not moral degeneracy that leads to addiction; rather, addiction, with its dangerous bedfellow, tolerance, forces its victim to sacrifice money, social position, and finally self-respect in order to pay for the required daily dose of the drug. A pound of heroin, for example, may cost anywhere from $500 to $1,000 when purchased abroad; but by the time it goes through increasing dilutions in a long chain of pushers it will cost the addicts in this country about $384,000 (Howe, 1955). Thus the addict must often resort to stealing, pimping, prostitution, and "pushing" in order to guarantee a continuing supply.

PSYCHODYNAMICS OF DRUG ADDICTION

Psychodynamically, little differentiation is ordinarily made between the drug addict and the malignant alcoholic, and often the two conditions are thought of as existing on a continuum—a neurotic individual finds some relief from his anxiety in alcohol but with increasing sophistication discovers even more relief in drugs. But I have serious doubts that such a formulation is tenable. We have noted that alcoholism in the main is a disorder of middle life; and yet we see that addiction is a disorder of adolescence and early adulthood. If so simple a formulation were true, we might expect a reversed chronology; addicts should become alcoholics, but I know of no reports which indicate that this is often seen. And again, we have noted that the Jew is highly resistant to alcoholism, but he certainly is no more, if indeed as much, resistant to addiction than the Gentile.

Another area of difference between alcoholism and drug addiction is the type of personality disorder seen in affected individuals. As we know, alcoholic excesses may occur as a symptom of schizophrenic psychosis and this often leads to the mistaken diagnosis of alcoholism in young people. But schizophrenia is much more often noted as a concurrent condition in drug addiction than in alcoholism, where the underlying disorders pretty much run the gamut of psychiatric diagnosis. Gerard and Kornetsky (1954) noted that the opiate addicts they studied had marked adjustment disturbances independent of and preceding their use of the drugs. They were overtly schizophrenic, or borderline schizophrenics, or delinquency-dominated character disorders, or so-called "inadequate personalities." As with the alcoholic, the drug appears to be used for the prompt alleviation of otherwise unchanneled and uncontrollable anxiety, and at a superficial level this latter stems from conflicts over dependency, aggressivity and sexuality.

Adolescent heroin addicts, about whom we shall hear a great deal more from Dr. Rosenfeld, have been noted (Zimmering, Toolan, Safrin, & Wortis, 1952; Toolan, Zimmering, & Wortis, 1952) to be incredibly non-aggressive, passive, conservative, intolerant to noise, inhibited in school and work, and fearful of new situations (particularly if these require active mastery). Under the influence of the drug they become more self-confident and have phantasies of omnipotence—usually concerned with wealth and power rather than with

sex. They seem to perceive all their impulses as dangerous and find peace only when the drug suspends their sexual and aggressive drives. These addicts showed disturbances in sexual identification and in interpersonal relationships; some showed a close empathic relationship with the mother, but otherwise they were unable to enter prolonged, close or friendly relationships with their peers or adults.

The addict, in other words, appears to be more severely disturbed than the usual alcoholic, with fixation at a passive narcissistic level, a seeking for gratification without the need for making any return. For him, the drug offers hope of fulfillment of a deep, primitive, oral desire for food and warmth, without having to give and without having to consider reality. Genital sexuality is uninteresting and is by-passed in a regression to the very earliest stage in libidinal development, where libido exists only as amorphous tension-energy. Addiction represents an attempt to replace external frustrations with pleasurable phantasies, or to evade internal inhibitions (usually of a depressive nature) by drugging their source, the superego.

Yet passive-narcissism and a desire to evade frustration are hardly confined to the addictive group, so that we are led to wonder whether there is anything specific in the metabolic or physiologic constitution of the addict that determines his particular way of achieving these ends. While there has not, to my knowledge, been any attempt to apply Williams' (1952) concepts of genetotrophic disease to the problem of drug addiction, I would suggest this as a fertile field for further study. There is much to indicate that the really characteristic trait shared by addicts is a specific proneness to drugs—for not all who are exposed to drugs become addicts. Mere withdrawal of the drug and cure of the associated physical dependence does not remove the craving of the patient for the drug, and most of those who are to become addicts can sense their desire to continue taking it almost with the first dose, or at least long before true physical dependence develops. I would venture a guess that such proneness is constitutionally determined, and perhaps in the way that Williams proposes for alcoholism. I would further suggest that some attention be devoted to the differences seen within the general group, addiction.

The foregoing discussion has of necessity been based on the assumption that addicts can be considered to show fewer intragroup differences than they show in comparison to non-addicts. While this assumption may be true, I should be most interested in seeing this demonstrated. Is the sleeping pill addict the same as the benzedrine

addict, and are both the same as the opium addict? I do not know, but it is my impression that there are very definite differences between these sub-groups, and such differences merit study.

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Teenage Addiction

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Our knowledge concerning the drug-using teenager is, paradoxically, both rich and inadequate. On the one hand, we know much more about the extent, origin, and nature of teenage addiction than many, even professionally interested people, are aware of. On the other hand, few people realize how very little we know about how to control and prevent the spread of addiction, and how to rehabilitate the teenage or adult drug-user.

Most of our knowledge about the nature of the problem has been gained through a series of studies, primarily of male juvenile heroin users in New York City, conducted at the Research Center for Human Relations at New York University in the years 1952-1957.* In

* The studies were financed by USPHS research grants and conducted by an interdisciplinary team, under the general direction of Isidor Chein, including two social psychologists, Daniel Wilner and Robert S. Lee; Donald L. Gerard,

the first part of this paper I shall attempt to summarize the existing knowledge insofar as it may be relevant to the work of a clergyman as a community leader and as a person to whom an addict or his family is likely to turn for help and advice.

Our *ignorance* about handling the problem of juvenile addiction is due primarily to the fact that, so far, not a single community has made an earnest effort to handle it. Existing efforts are so pitifully inadequate that it would be premature to try and evaluate their effectiveness. And without trial and error, without testing various methods under favorable circumstances, no recommendations can be made with any degree of certainty. Prevention, cure, rehabilitation—these are things that can be learned only by *doing*—doing the best one can and assessing the outcome in an objective and systematic way. In the second part of this paper I shall expand somewhat on this vicious circle of ignorance and inaction perpetuating each other.

WHAT WE KNOW ABOUT THE TEENAGE DRUG USER

There is naturally a wide variation in the personalities and backgrounds of juvenile users and the paths that led them to addiction. But, in spite of these variations, there appears to be a certain pattern in this process by which young people become addicts; a certain similarity in their backgrounds and personalities; and a certain typical set of circumstances surrounding their difficulties in freeing themselves from the habit. In what follows, I shall concentrate on the typical patterns common or most prevalent among juvenile drug users. It is very likely that the young addict a clergyman will encounter will fit very closely into the following picture.

Let me first sketch out what is known about the *incidence* of juvenile drug use and the *areas* where it concentrates. First of all, if heroin users appear in a community, they tend to come from areas populated largely by the socially and economically underprivileged: Negroes and Puerto Ricans in New York City; Negroes in Chicago (I.I.J.R., 1953); Mexicans in Los Angeles (L. A. Police Statistical Digest, 1957).

This does not mean that all areas populated by underprivileged

a psychiatrist; and a sociologist, Eva Rosenfeld. Unpublished mimeographed reports on each study will be referred to as RCHR Reports No. I through VII. A brief summary of the method used in each study will be found under each reference. The NIMH is, of course, in no way responsible for the views and opinions expressed here.

groups are likely to be hospitable to the spread of heroin use. One of our studies (RCHR, 1954a) showed that within the almost all-Negro Harlem area in New York are sub-areas where very few juvenile users have been found. The highest concentration of juvenile drug use exists in those neighborhoods where poverty is the greatest, average education lowest, family life most disturbed, and social control of deviant behavior extremely weak. Apathy and lack of concern create a favorable climate for the perpetuation of criminal and deviant behavior in general.

In order to interpret the meaning of this fact, I must anticipate some of the findings I shall later discuss more fully on the role of personality factors in addiction. The high incidence of juvenile addiction in those areas can be explained by the convergence of two factors: the hospitality of these areas to drug peddling, and the generally greater prevalence in their population of mentally ill* and emotionally disturbed people who are both exposed to severe strain in their environment and who have little if any access to sources of help. The juvenile addicts, as we shall see, are not victims of accident or social pressure—they are sick people who welcome the drug for the relief it brings them. They became drug users because in their neighborhood drugs are available, there is little constraint against experimentation with drugs, and there are few accessible alternatives that bring relief. If the drugs were not available these youngsters would most likely develop other manifestations of their basic impairment: social isolation, violent acting-out in gangs, psychotic breakdown, or some other grossly deviant style of life, including homosexuality.

The teenage heroin user is not likely to be severely addicted (RCHR, 1957a). The habitual user is dependent on heroin to maintain equilibrium and, when deprived, may become desperately restless and unhappy, but his physiological reaction to withdrawal is not likely to be very painful. This is due mainly to the low concentration of heroin available in the street market. Also, many young users never take enough daily doses of the drug to become addicted. Many are weekend or irregular users, or have a "small habit."

* A study of prevalence of mental illness in an area of Manhattan (see "Midtown" Study) revealed a linear relationship between socioeconomic status and the prevalence of mental illness: in the highest SES class the investigators found about 70 mentally impaired adults per 100 well; in the lowest, they found about 300 impaired per 100 well. (Personal communication from Dr. Leo Srole, Director of the "Midtown" project.)

But the habitual user is very likely to be in great trouble. To begin with, he is in trouble with the law—by being an addict and through the delinquency into which he is forced in order to support the exorbitant cost of heroin. The average habitual user—one who uses at least one daily dose of heroin—in 1953 spent about forty dollars a week on the drug. He is too young and unskilled to earn this much. Most teenage users obtain this money, or part of it, by theft, cheating, "pushing" drugs, pimping, and similar crimes for profit. Most of their associations are with delinquents (RCHR, 1954c).

The teenage user is deep in trouble in other ways. The habit is a way of life that absorbs time and energy and removes him from the mainstream of legitimate preoccupations of young adulthood: vocational training, exploration of heterosexual relationships, making plans for the future. Under the spell of heroin, the young user loses interest in these normal pursuits; he removes himself from the life task of the moment. In a very real sense this is precisely what he wants. And because he wants this, cure of addiction, like cure of alcoholism, is very difficult. The juvenile drug user wants to remove himself from life because he is a very troubled youngster (Gerard and Kornetsky, 1955). And, as we get to know even the bare outlines of the young users' lives, their personalities, their families, the difficulties they have in facing up to life, drug use appears an understandable, if unhappy, way out.

To begin with, the young users come from very disturbed families (RCHR, 1956b). In many cases their families have been broken by death, divorce, or desertion. Where both parents are at home, the relations between them are either overtly hostile or empty of warmth and mutual interest. Family cohesion is low, lower even than in the homes of delinquent boys who are not users. The father, if present, has failed to establish a warm relationship with the son; his attitude is either hostile or indifferent. The mother, on the other hand, is often possessive and domineering and at the same time ambivalent, inconsistent, and erratic in her upbringing of the child. The boy grows up in an atmosphere where his individuality and his masculinity are not recognized nor respected and where he has no suitable model of a male adult with whom he can identify.*

The heroin user's family failed to provide the necessary nourishment for a healthy personality. As he comes of age the future user

* Teenage girl addicts also had been seriously maladjusted prior to their addiction and had extremely disturbed relationships with their families and peers at work and in school (RCHR, 1958).

is an inadequate and confused person. He feels in general hopeless, unsure of himself, and mistrustful of others. His lack of self-confidence is reflected in a narrowing of interests, a constriction of psychic life. His image of his own future is unclear, unreal. Planning for a career, hard work, or study appear meaningless. His inertia is considerable. In everyday language, he is lazy, passive, fatalistic, and very depressed (RCHR, 1954c).

His relations with others, peers or adults, are shallow, exploitative, impermanent. But one relationship is very strong, and that is with the mother. He appears powerless to break away, to experience himself as a separate person. He is uncertain about his sexual identity and has great anxiety in establishing relations with girls (RCHR, 1956b).

In the "street corner society" of their neighborhood, the future drug users do not occupy a clearcut social position. They are not parts of closely-knit groups; they are either isolates, or marginal, fringe members. They tend to gravitate toward the antisocial, delinquent groups not so much by preference but through inertia, and because they do not have it in them to belong to the "square" groups of law-abiding youngsters who, in spite of their deprived neighborhood, strive to stay out of trouble, utilize whatever opportunities for growth are available in schools and community centers, work hard, and plan ahead. The future user stays around with the "cats" or "hipsters"—the restless, aimless delinquent youngsters who are headed for trouble—even though he himself is neither rebellious nor violent. To the contrary, he is usually soft-spoken, well-mannered, and graceful. He likes peace and quiet and beautiful things (RCHR, 1957a).

As the future user approaches the school-leaving age, the necessity to face life—work, career, girls—adds great strain and anxiety to his already unhappy, depressed inner state. A Saturday evening dance, an interview with an employer, any situation that calls for self-confidence and self-esteem, becomes a subjectively impossible task. Yet as long as he stays in the mainstream of life, such situations cannot be avoided. It is at this time, at the age of 16 or 17, that the future user's vulnerability to heroin is greatest (RCHR, 1954c).

In the neighborhoods where heroin is available, opportunities for a first try come about easily and naturally. No shadowy peddlers seek out the innocent victim.* Very simply, in a casual group of

* This holds true also for girl addicts (RCHR, 1958). Teenage girls we studied had been introduced to heroin by female friends of the same age. They were not "seduced," nor were they ignorant about the consequences of heroin use.

youngsters on their way to a dance, someone offers some "H," or someone says that he has a "contact" and suggests that they all get high before the party. Or, two friends will sit on a stoop on a bleak Sunday afternoon and one will say: "Want to get high?"

In the crowd of "hipsters" with whom the future user consorts, chances are no one will object. Getting "high" is one of their pursuits. One lives for the day. The usual arguments about the danger of taking heroin are not very meaningful. These youngsters have little hope in the future, little faith that they can make a good life for themselves. They want to enjoy their lives here and now. So, a suggestion to get "high" is usually accepted, and the future user gets his first chance to experience the "kick" of heroin.

If he is 16 or 17 years old, chances are that his reaction to the drug will be immediately positive (RCHR, 1954c). Something "clicks." "This is for me!" he says to himself. "I always want to feel the same way." He feels "above everything" and he feels "like a sense of peace of mind—nothing bothers me—it feels good." Some, especially if they are younger, experience, at first, no pleasure; some get violently sick. But if the unhappiness, anxiety, tension are present, they will try again, and then again, and one day it will "click" for them too.

What is the meaning of this reaction? What happened? Heroin does not have any pleasurable effect on people who are comfortable, peaceful, relaxed (Lasagna, von Felsinger & Beecher, 1955). But it is a strikingly efficient tranquilizer for people who suffer from acute anxiety, tension, despair, bewilderment. The future user experiences a delightful freedom from his intense state of misery. When he says: "This is for me," he expresses the basic value of addiction: a sense of freedom from unhappiness and tension.

Most users had been intensely uncomfortable in social interactions with girls, painfully shy and inadequate in the ordinary run of adolescent activities. Those who belonged to gangs were cowardly in gang fights. Freed from anxiety by the drug, they can participate more adequately in all these activities: heroin, so it seems at first, makes them more manly.

Some occasional heroin users get the best out of the drug in precisely this way: they can function better with this occasional prop, just as many of us occasionally take a drink or a dexadrine before a difficult or unpleasant task, in order to function better.

Those who come to our attention as habitual users employ the drug differently—*not to face life better, but to withdraw from it;* not to gain strength, but to imagine it, daydream about it. They turn

their backs to "our" life and begin to live in the world of drug users. The present system of treating users as criminals and forcing them to actual criminality to pay for the cost of the drug, paves the way and maintains the isolation of the habitual user from the rest of society. The drug-user is treated as an outcast, mistrusted, feared. The public is very fond of the image of an addict as rapist and killer, in spite of all the evidences that addicts have little interest in sex or violence.

The social and psychologic consequences of addiction weaken the user's chances for a normal life. In a sense, the social ostracism suits the self-destructive impulse of the user. He can now blame all his ills on his habits, on the cruelty of the law, on the degradation and the delinquency he is forced into. Thus, he can quite easily rationalize his abandonment of the struggle for normality, for becoming a mature adult, for doing all the things he is afraid of doing (RCHR, 1957a).

At the same time, his struggle for normality is made ever so much more difficult after he becomes familiar with the experience of being "high," of feeling relaxed and feeling masterful and self-confident in his fantasy. It requires real strength to give up an immediate relief and face squarely an unhappy present for the sake of some vague future in which one has no belief, no hope. The motivation to go on using heroin is immediate, real, pressing from inside. The motivation to cure oneself of the habit is vague, distant, in response to pressures of alarmed families, social workers, hospital staff. Having touched on the question of cure and rehabilitation of teenage heroin users, let us now consider this problem more closely.

THE CURE AND REHABILITATION OF TEENAGE ADDICTS

As I have mentioned at the outset, our knowledge about this aspect of the problem is most inadequate. I have also suggested that we know so little because there is hardly any experience from which we might learn, since so little is being done to help rehabilitate the teenage user. Our knowledge concerning cure and rehabilitation is only an "educated guess," based on extrapolation from our understanding of the nature and meaning of habitual use of heroin, and from examination of the failure of the few existing facilities for the cure of addiction.* Let us start with some facts.

* In all that follows I refer to youthful heroin users who cannot free themselves of their habit on their own, by sheer exertion of will power. It

In New York City since 1947, about 500 new cases of juvenile heroin use have come to public attention each year. Nothing is done to help most of these young users. Users who are arrested sometimes receive some medical attention during withdrawal, sometimes not (RCHR, 1954d). Thus, in our sample of 94 users who were members of gangs, more than one-half were arrested at some time or another on a variety of charges, but only about nine received any medical attention while in jail.

Riverside Hospital for juvenile users in New York City has a capacity of about 140 beds and average yearly first admissions do not exceed about 250. Only users who are considered amenable to psychotherapy are admitted and treated. A large proportion of patients are released soon after withdrawal as unsuitable for the kind of treatment the hospital offers. Ideally, patients are released when the staff considers them likely to maintain abstinence; however, these constitute a very small proportion of discharged patients. In a follow-up study (RCHR, 1957a) of 30 boys released from Riverside Hospital in 1956-57, after a stay of three to eighteen months, we found that twelve relapsed to drug use within a week or two after return to their homes. Only two of the thirty stayed away from the drug as long as one year.

The experience at Riverside Hospital suggests that patients released with good prognosis relapse and return to the hospital several times in the process of rehabilitation. After several years, they have experienced repeated failure in self-control and some begin to see the need to face and to struggle with their inner problems. There are also indications that as they become 20 and older, users become more amenable to psychotherapy, more realistic about their own limitations, more mindful of the consequences of their habit. But we do not know the proportion of successful "cures" from addiction among Riverside patients, nor do we know what other forms of deviant behavior appear among those who abstain from heroin for any length of time.

Youth Board detached workers report (RCHR, 1954d) many efforts to "lay off" heroin among gang members who are users. In this effort, the users often receive help from other gang members who stay with them, treat them to wine or marijuana, and "watch"

should be stressed that some regular users do manage just that. We know little about them, but the very fact of their self-cure indicates that these are basically healthy youngsters who became habitual users at a particularly stressful time, but who later perceived correctly the dangerous consequences of the habit and made the supreme effort to shake it off.

over them at times of stress. We do not know how many of these efforts are successful, but at least some are. Significantly, one group worker reported that after the members of his gang gave up heroin, the previously peaceful gang became violently antisocial.*

A group of psychiatrists in New York, under the leadership of Dr. Marie Nyswander, treated addicts (of any age and sex) on an outpatient basis. It was hoped that, as the addicts began to use the therapists as a source of support, they would become capable of giving up the support that heroin offers (Nyswander *et al.*, 1958).

All this experience suggests that addicts are not "cured" in the traditional, medical sense; rather, like alcoholics, they are, at best, helped to function in a reasonably self-sufficient manner which is not a drain or a danger to society. This process of weaning, or rehabilitation, is long and difficult, and it predictably includes stages of relapse to drug use and regression to impaired functioning. It follows that a program of rehabilitation must include provisions for continuity, for constraint, encouragement, and support, and for emergency services in times of imminent or actual relapse.

A PROGRAM FOR REHABILITATION OF YOUTHFUL DRUG USERS

1. *Continuity: A neighborhood center.* People who are chronically in trouble need first and foremost continuity of personal contact. This need is so widely acknowledged that I shall state it as a truism. The basis of any program of rehabilitation, not only of drug users but of delinquents and post-hospitalized mental patients as well, is a neighborhood center where the troubled person may come without discomfort and in expectation of realistic help, free of red-tape, there to establish a meaningful human contact with a small staff of people whom he will know, trust, and fall back on in the long years of struggle that lie ahead. When he gets arrested, spends a term in jail or in a hospital, these people may be in touch with him and plan his return to the community. When he wishes to withdraw, they may direct him to a doctor or hospital. And throughout the years of struggle he may receive at this neighborhood center the various services he will need.

2. *Services.* He will need, first of all, a place where he feels accepted and understood—a club room where, in addition to leisure activities, he can meet and get to know people who will help him with both his inner and his objective problems: a psychotherapist, a

* Personal communication.

vocational counselor, a placement worker, a physician, and a social worker. This does not mean that the neighborhood center must be staffed with a full team of professional workers on a full-time basis: their work hours will depend on the number of young people they will serve. But these professional staff members must be visibly available, and the services they offer must be readily available without red-tape whenever he is ready to use them.

The position of the staff should be clear. They will not facilitate illegal access to drugs; and, while not attempting to conceal their views as to the undesirability of heroin use, they will not preach nor stand in judgment of anyone as a person. On the contrary, they will try to convey a feeling of respect for the essential dignity of every human being.

3. *Emergency housing.* Since most of these troubled teenagers have severe problems in family adjustment and, being young, usually still live with their families, it is often necessary to offer them a refuge from unbearable strain. Sometimes an opportunity to stay a couple of nights at the center will suffice. In some cases more permanent living arrangements are necessary. Some small residential facility should be a part of the neighborhood center, although not necessarily on the same premises.

4. *Medical withdrawal.* Medical withdrawal has different meanings in the process of rehabilitation. It may be the first step of a serious effort at giving up the habit and, in such a case, it might best be a part of treatment at Riverside Hospital. It may be an effort at recovery from a series of minor relapses, or to bring the habit within manageable limits when it might best be handled without hospitalization and without disrupting an otherwise adequate vocational and personal adjustment. Facilities for withdrawal in the community require medical check-up and supervision, plus a visiting nurse or non-professional volunteer chaperone to stay with or visit the addict during his withdrawal period.

5. *Drug therapy.* There will be occasional periods in the process of rehabilitation when, in the judgment of the medical staff, the post-addict might best be helped by providing him with some type of tranquilizing or sedative drugs, and continue this from time to time until he is capable of abstaining from drugs altogether.*

* It should be clear from the content of the program I suggest that this provision for drug therapy should not be confused with the often discussed proposals for making drugs cheaply and routinely available to all registered addicts in order to abolish the black market in heroin.

All these suggestions for a community-based program for rehabilitation of drug-users—the continuity of contact, the special and emergency services, the facilities for withdrawal—are based, as I have indicated, on the best "educated guess" concerning the realities of the process of rehabilitation and the reality needs of the young addict, as these have been explored by our studies. This "guess" is not, however, an isolated theoretical extrapolation of academic knowledge. Other groups who have worked closely with addicts have reached similar conclusions on the basis of their experience in trying to help and rehabilitate them.

One of these groups is involved in the narcotics program of the East Harlem Protestant Parish under the direction of Rev. Norman Eddy. This program, based on a decade of first-hand experience with the drug addict in the community, includes provisions for medical withdrawal under supervision, a club room, job placement, spiritual guidance, psychotherapy, and, most importantly, the continuity of human contact with a small group of dedicated people working in an informal, friendly setting. Other community organizations in New York City are planning to follow the model set up by the East Harlem group. The lower East Side Neighborhood Association contemplates the possibility of opening a half-way house—a residential unit capable of housing six patients and one staff member who, with the help of a daytime housemother, would offer the continuity of personal contact with addicts in the process of rehabilitation. The Center would offer withdrawal help, guidance and counseling, and residence when necessary, and would be a social center and lounge as well. Thus we in New York now have an opportunity to learn by experience. In another few years, we should be able to speak with more authority about the best ways of helping a young addict.

Another group actively interested in rehabilitation of convicted addicts is in the State of California Department of Corrections. After an investigation of the narcotics problem in California, the Department of Corrections recently sponsored and the State Assembly passed, a bill offering a program for the rehabilitation of paroled ex-addicts. The program recommends small caseloads for parole officers, the use of tranquilizers in the immediate period after release, and a half-way house in Los Angeles where parolees who relapse may be kept for as long as three months in an effort to help them give up addiction without taking the drastic step of sending them back to prison. In addition, this program is to be evaluated in order to assess changes in the rate of relapse in groups of parolees treated under the

various provisions of the program. The official aim of the California program is to save society from some of the consequences of addiction in terms of prison maintenance costs and the costs of addiction in terms of related crime for profit. The grass-roots programs in New York City are concerned directly with helping the addict as a person. But both efforts lead to the same kind of a program of rehabilitation—a program that is based on the realities of the addict's personality and the conditions of his life as an addict.

PREVENTION AND CONTROL

Community action designed to prevent and control the spread of juvenile drug use must be focused around the main danger point in the process of addiction, namely, experimentation. As we know, not all teenagers who experiment with heroin become regular users or addicts—probably most do not. But for every group of teenagers who try the drug for a "kick," there are likely to be some for whom this will become the first step to addiction; for their sake, we must assure that opportunities for experimentation with drugs are less likely to take place. It follows that the locus of preventive efforts should be the alienated "tough" street-corner groups and their hangers-on, for there the favorable attitude to experimentation for "kicks" is widespread.

While we know that these groups are reachable through appropriate means—by detached group workers or therapists acting as discussion leaders in schools—we know very little about the specific approach these intervening adults may use best on the problem of experimentation with drugs. Here, as in the program of rehabilitation, research is most urgently needed.

A study of seventh-grade boys in this city (RCHR, 1956a) suggests that a favorable attitude to experimentation with marijuana, heroin, or any other medium for getting "high" is a part of a cultural climate—a syndrome of attitudes which one might call "a delinquent orientation." This is a general orientation to life in which pessimism, unhappiness, and a pervasive sense of futility are combined with defiance, negativism, and mistrust. The young people who are open to experimentation with drugs are those who believe that no one gives a damn, that everyone is out to outwit everyone else, that one cannot win in a legitimate way, and that, consequently, the only thing that makes sense is to enjoy life from day to day by any means that are handy. This orientation, we found, is especially widespread in "adjustment classes" in the most deprived neighborhoods of New

York, which have a high concentration of pupils with severe behavior and learning problems.

An attempt to dissuade these youngsters from experimentation with drugs must, consequently, concern itself with the whole syndrome of socially alienative attitudes of which experimentation is an integral part. A program for preventing the spread of drug use makes sense only as a part of a larger program for antisocial and self-destructive youth who are alienated from the mainstream of our culture and its legitimate pursuits.

It would be impossible even to outline such a program here.* Suffice it to say that it would have to include numerous provisions for proving to the youth in deprived and high delinquency areas that society cares about them and their futures and that legitimate effort pays off. Provisions would have to be made for the learning and exercise of social skills which are necessary for self-confidence and mastery of the environment. In the framework of this program, the following efforts for control of experimentation with drugs would be worth trying.

Detached workers assigned to antisocial gangs are probably best suited for discussion of drugs. In fact, the workers' task in this respect is not their most difficult one. Fighting gangs are not hospitable to addictive use of heroin. (Wilner, *et al,* 1957); while they condone experimentation, they lose respect for those who become addicted; and addicted members lose their leadership position in the gang.

This is especially true of the younger fighting gangs. As the gang members grow older, gang fights and hell-raising become "kid stuff" and are given up by the most healthy gang members who develop concerns about work, steady girls, or careers. The more disturbed members find it too difficult to face the future as adults, and, at this point, slide into more frequent use of drugs and, eventually, into addiction.

If the gang worker can establish contact with the younger gangs, at a time when the group's *pro-experimentation* attitude is still combined with a strong *anti-addiction* attitude, he will be in the best strategic position for changing attitudes toward experimentation. This he can do by supporting natural leaders who are not interested in experimentation; by offering preventive guidance to those who appear susceptible; by spreading information about the pitfalls of

* A somewhat more detailed outline of this program has been given by the writer (Rosenfeld, 1959). The program has been spelled out in even greater detail in a dittoed manuscript (RSHR, 1957b).

experimentation; and by turning the group's mistrust and anger toward the peddler of drugs.

Another preventive measure should be directed at the "captive audience" of pre-adolescent youngsters in high-delinquency areas, especially at those in "adjustment" classes and special schools for problem children. A program of education aimed at developing defenses against experimentation with drugs might be effective if carefully developed and evaluated by testing the children's reactions. In testing their reactions, one would wish to know whether they accept the educational program; whether they integrate the anti-drug attitudes with their general attitudes; whether the anti-drug "propaganda line" boomerangs and evokes curiosity or stimulates the self-destructive wishes to defy and provoke the adults and to bring harm to themselves. Rather than conduct an educational program without evaluation, it is better not to conduct such a program at all. Careful evaluation of any such program is necessary because many of these children have distorted relations with adults and, as a rule, their initial attitude is one of mistrust, ridicule, or deprecation of any "message" that may be contained in education. The person who provides the information or leads discussions on the use of drugs should probably be a popular teacher or guidance worker, rather than a professional lecturer.

THE ROLE OF COMMUNITY LEADERS

In conclusion, I would like to say a few words about the role of community leaders in controlling the evils of drug addiction among teenagers and young adults.

I think we would all agree that community leaders have a high responsibility to maintain and promote a *rational* approach to solving community problems. This implies, first, making an effort to discover the facts of the case and freeing one's mind from irrational prejudices and unfounded popular myths; second, consideration of alternative methods of handling the problem in terms of their *consequences* for the physical and moral well-being of the people involved; and third, pressing for social action in a *calm spirit* of trial-and-error and objective evaluation of the effects.

One aspect of our attitudes to heroin addiction requires particular re-examination, namely, the nature of the moral evil that we tend to associate with heroin use. I would like to suggest that, in re-examin-

ing our feelings about it, we consider the following facts: (1) We do not become horrified at the thought of drinking coffee, which in some countries, in the not-too-distant past, was forbidden by law and its drinkers cruelly punished. Even highly excessive and virtually addictive use of coffee is regarded by us with complete indulgence. (2) We are not horrified at the thought of smoking cigarettes, which have been shown to contribute significantly to lung cancer, and we drink alcohol, which has definite ill effects if taken in large quantities; yet heroin use (to say nothing of marijuana) has no comparable known pathogenic effect. (3) We are not scandalized at advertising agencies for their skillful propaganda aimed at seducing people into the use of alcohol and tobacco. (4) Many of us take various tranquilizing, stimulating, and depressant drugs habitually, for essentially the same reasons as heroin is taken: to function better. Some of these drugs have still untested pathogenic effects, while the effects of heroin are reasonably well-known and are not considered by experts to be dangerous to health. (5) Some of us are horrified by the dependency aspect of addictive use of heroin. Yet dependency, as such, does not disturb us in the cases of diabetics and other medical disturbances whose victims are equally "at the mercy of their suppliers." To be sure, this dependency is not self-induced, but as far as the dependency itself is concerned, the difference between heroin addicts and diabetics has to do with the legality and ease of obtaining the drugs.

Let us consider the fact that many heroin addicts use the drug to escape from real life and from society; this is, in the eyes of most societies, a social sin. But then, not all heroin addicts do that: some use the drug to bolster self-confidence and face life. And what of those who use heroin to escape from facing life? Suppose we prevent them from escape via heroin? Have we really prevented all escape, or will they find some other way? I shall not attempt to answer all these questions, but will leave them for your consideration.

Finally, there is one other aspect of the control of teenage addiction which concerns church leaders especially. This is the part that human concern and personal contact must play in the rehabilitation of addicts. There is something in the enormity and complexity and over-organization of our big cities, where the heroin problem mostly exists, that puts a premium on these personal, human factors. The larger the organizations for people's welfare, the fewer are the people who care personally and directly. One would hope that the philosophy

of pastoral service would be particularly suited to the development of such human contacts which are so crucial for the rehabilitation of deeply troubled young people.

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Research Center for Human Relations. Report No. 1. The ecology of juvenile drug use, 1949-1952. Unpublished report, New York Univer., 1954. (a)

An ecological analysis of involvement with drugs by males, aged sixteen to twenty, in three boroughs in New York City, between 1949 and 1952. Data were collected from magistrates' courts, city hospitals, and the Youth Council Bureau. Duplications of cases as a consequence of the same case being known to more than one source, or more than once to the same source, were eliminated. Incidence rates were computed for census tracts and health areas. Certain data based on interviews with addicts are also included in this report, but fuller treatment is given in Report No. 2.

Research Center for Human Relations. Report No. 1-A. Delinquency trends. Unpublished report, New York Univer., 1954. (b)

A comparison of trends in juvenile delinquency (other than drug involvement) in high and low drug-use neighborhoods in Manhattan for 1949-1952. Rates of various types of offenses were computed on the basis of court charges for males, aged sixteen to twenty.

Research Center for Human Relations. Report No. 2. Personal background of drug users, delinquents, and controls. Unpublished report, New York Univer., 1954. (c)

An exploration by means of interviews and review of case records of the social backgrounds and personal experiences of male heroin-users and nonusers, aged sixteen to twenty, living in relatively high drug-use neighborhoods of New York City. Four groups of about fifty cases each were studied: delinquents who became heroin users, nondelinquents who became users, delinquents who did not become users, and nonusers who were also not otherwise delinquent. Special attention was paid to the social processes involved in becoming an addict, and, in the case of the last group, to the way in which such boys manage to avoid delinquency and drug use while growing up in hazardous neighborhoods.

Research Center for Human Relations. Report No. 3. Heroin use and street gangs. Unpublished report, New York Univer., 1954. (d)

Data were collected from detached workers of the New York City Youth Board who had worked with eighteen antisocial street gangs, to study the nature and extent of drug use in these gangs and to compare the characteristics of gang members who use and do not use drugs. The role of the gang in the spread of drug use or resistance to it was examined.

Research Center for Human Relations. Report No. 4. The cultural climate of juvenile drug use. Unpublished report, New York Univer., 1956. (a)

A comparative analysis of the attitude-value-belief climate of thought among eighth-grade boys in three neighborhoods in New York City which vary in prevalence of drug use. This population, younger than the usual age at which users first experiment with drugs, was selected because it represents a potential target group for preventive efforts. Anonymous questionnaires were administered to 925 boys. A cluster analysis of their responses was performed separately for each neighborhood. This type of analysis permits a comparison of the nature of an orientation to delinquency in the three neighborhoods, especially as this relates to favorable attitudes to narcotics, accuracy of information about drugs, and exposure to drug users.

Research Center for Human Relations. Report No. 5. The family of the addict. Unpublished report, New York Univer., 1956. (b)

Lengthy interviews were conducted with mothers and fathers of thirty addicts and twenty-nine control boys living in neighborhoods of high drug-use in New York City. The two groups were compared as to patterns of family background which are likely to lead to weak ego structure, defective superego development, inadequate masculine identification, lack of realistic middle-class orientation, and distrust of major social institutions.

Research Center for Human Relations. Report No. 6. Post-hospitalization adjustment of addicts treated at Riverside Hospital. Unpublished report, New York Univer., 1957. (a)

Post-hospitalization adjustment of thirty male addicts in work, family relationships, leisure time activities, peer relationships, drug use, and ability to communicate to a therapist in the after-care clinic was compared with the prehospitalization adjustment in these areas. Change in adjustment was also studied as it was related to independent measures of the hospital experience, the family background, and psychiatric diagnosis. One year follow-up.

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chological testing, and home visits by advanced social work students with the families.

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The Medical Viewpoint

KENNETH W. CHAPMAN *

Kenneth W. Chapman, M.D., at the time of the Institute was Associate Director, Clinical Center, National Institutes of Health, Public Health Service, U. S. Department of Health, Education and Welfare, Bethesda, Maryland. From 1955 to 1957 he served as consultant on Drug Addiction to the same National Institutes of Mental Health. Dr. Chapman received his B.S. and M.S. degree from the University of Massachusetts, and an M.D. degree from Yale University. He was a Fellow of the American College of Physicians and a Fellow of the American Psychiatric Association. Dr. Chapman died shortly after the Institute, on September 18, 1959, and it is to his memory and in recognition of his significant contributions in the area of drug addiction that the present volume is dedicated.

Efforts to partition the management of drug addiction into medical, legal, and social approaches have led to some of the major misunderstandings in this whole problem. Partisans of the medical and legal viewpoints each believe theirs is the sole answer.

GREATER LATITUDE IN TREATMENT

Leaders of the medical profession and those within it who are students and experts in drug addiction do not feel that there is only a

* Deceased, Sept. 18, 1959.

medical answer. A summary of this attitude is best expressed in the report of the Joint Committee of the American Bar Association and the American Medical Association on narcotic drugs. This Committee recommended research in five major areas:

1. An experimental facility for the outpatient treatment of drug addicts to explore the possibilities of dealing with at least some types of addicted persons in the community rather than in institutions;
2. An extensive study of causative factors and relapse in drug addiction;
3. The development of sound and authoritative techniques and programs for the prevention of drug addiction;
4. A critical evaluation of present legislation on narcotic drugs and drug addiction;
5. A study and analysis of the administration of present narcotic laws.

It is apparent from this broad series of recommendations that there is need for an opportunity for medicine to have a greater voice in the treatment of addicts, more latitude to study methods advocated, more opportunity to put into wider practice some techniques which, on the basis of experience, show some promise.

Inherent in the medical attitude is the premise that each addict is an individual and, as such, must have a program especially tailored to his needs. Generalizations regarding types of addicts and their problems have hampered this approach. The World Health Organization Study Group (1957) succinctly summarizes the medical viewpoint:

> Comprehensive medical treatment of the drug addict should be total—that is, somatic, psychological, and social rehabilitation of the individual. . . . The treatment consists of three phases—the preparatory phase, withdrawal, and continued treatment—all of which should be part of a continuing process which may have to extend over several years. Experience has shown that when the addict continues under the care of one physician and his team of workers, it is much easier to check his progress or his relapses than if he comes under the supervision of a variety of people working without relation to one another.
>
> The preparatory phase of treatment should include an assessment of the drug used, the degree and duration of addiction, and the addict's personality structure and problems. Reference is made in the section on the addict to personality structure and problems and to some of the underlying causes. In many cases careful investigation of the addict's social and family situation and relationship will assist not only in the above assessment, but also in ascertaining how far it can be used to further treatment. At this stage a plan of treatment should be outlined and discussed with the patient in order to allay his anxiety and

in the hope of promoting his motivation to recovery. The physician-patient relationship established at this point may colour and influence the rest of the treatment programme.

For certain co-operative addicts, there should be provision for complete treatment outside as well as inside institutions. Newer knowledge of the psychology of human behavior, experience gained by physicians in treating addicts, and parallel experience with the treatment of other psychiatric disorders led the Study Group to agree that traditional concepts of treating the first and second phases of addiction in closed institutions only should not necessarily be followed in all cases. There should be provision, legal and otherwise, for the treatment in the home, physician's office, or out-patient clinic of properly selected cases, so judged by competent medical authority (World Health Organization, 1957, pp. 8 and 11).

While it is true that the majority of addicts appear to have similar environmental backgrounds, histories of delinquent behavior, and emotional problems, each must be dealt with in reference to a person. To be sure, there are many common denominators which lend themselves to general treatment programs, but within these there must be latitude for the personal approach.

For example, consider the matter of withdrawal treatment. While most addicts could not withstand the temptations to cheat on the physician, there are a few who could, and most experienced physicians feel that such a plan should be allowed. On the other hand, the majority will require hospitalization and a restricted environment in order to be successfully withdrawn. For this latter group, many will require extended periods of a restrictive environment in order to effect success in the early phases of rehabilitation, including physical and psychiatric. There is need for latitude within such programs for early release to the community for certain addicts whereby they could be helped to readjust to their problems in a more real situation.

PUBLIC ENDORSEMENT OF TREATMENT

Unfortunately, there are a number of deterrents to such a program, not the least of which are the few places available for intramural treatment in the locale of highest incidence of addiction. Other factors such as geography work against the Federal hospital programs in this regard.

A major deterrent confounding all these efforts is the singular lack of community programs to carry on a serious, continued, and

intensive after-care program for most addicts, no matter when or under what circumstances they are released to the community.

To return for a moment to the matter of suitable periods of intramural treatment, the circumstances of this treatment are a major factor. The addict sentenced to a period of penal servitude for a law violation related to his addiction has statutory limits to his early freedom. Unfortunately these limits are imposed regardless of the needs of the individual. There is a need for greater latitude for medical judgment in this area as outlined in the Report of the Interdepartmental Committee on Narcotics to the President (1956).

> The Department of Health, Education and Welfare, because of its long experience with and responsibility for the treatment of addicts, further recommends for consideration a legislative step designed to provide for greater opportunity for the rehabilitation of certain addict-violators, particularly . . . [those] . . . whose criminal activity is secondary to their addiction. Under this proposal, wider latitude would be given to the courts by authorizing them, in the case of such addict-violators, to commit the convicted offender for a period of hospital treatment, followed by an extended period of conditional release under close supervision by specially trained personnel. This procedure would be limited to those with the best prospects for rehabilitation, and would be applicable only under optimal conditions of post-hospital supervision. A few cases could be selected immediately for this procedure, to be supervised in the few communities where adequate personnel and services for effective supervision and rehabilitation are available. The plan could be gradually extended to additional communities as effective local rehabilitation programs are developed (Report of Interdepartmental Committee on Narcotics, 1956, p. 16).

Within the framework of more latitude for institutional treatment is a recommendation that there be greater use made of mental health commitment procedures. Some 37 States have enabling laws on the books which could be used without further legislation. Such laws would, as in the case of other mentally ill persons, allow for parole on medical determinations with opportunities for rapid and uncomplicated return to institutional care in the event of relapse or impending relapse.

These are the broad circumstances in which addicts could be treated. More specifically, the programs should encompass adequately staffed facilities for proper withdrawal and rehabilitation. The withdrawal should be humane and gradual. Nothing is to be gained by the primitive approach of abrupt withdrawal or "cold turkey" methods. These only serve to increase the hostile attitude of the addict who, at this time, is sick in every sense of the word. Ex-

perienced observers believe that nothing is to be gained by the use of tranquilizers, barbiturates or any other non-narcotic during this period. In fact, to use drugs other than narcotics places undue emphasis on a relatively unimportant phase of the treatment. As Kolb and Ossenfort (1938) suggested, any method will work providing it does not kill the patient. In brief, there has been too much preoccupation with a relatively simple procedure.

More important are the rehabilitation programs. These include total physical evaluation (all too often overlooked), and psychiatric study to determine the resources and liabilities of the individual. Programs should be designed to rehabilitate the whole person. It is often necessary to provide vocational training in order to offset feelings of inadequacy—in short, to give the person a sense of socially productive worth.

Psychiatric treatment may be superficial or profound. This depends on a number of factors such as age, degree of insight, ego strength, to name a few. Different approaches are needed for the 18-year-old as compared with the 30-year-old. There is nothing new or radical in this program. Basically, it is the accepted pattern of rehabilitation for many psychiatric disorders.

At some point in time—two weeks, one month, three months, a year—the addict should be given a trial in the community, and he should return to the community from which he came. To change his environment too radically is a disservice to him. It must be borne in mind that eventually he must face his problems where they started. Intermediate programs—half-way houses—have possibilities and should be used.

Community assets must be mobilized. The family physician may be a focal point in some instances; but by and large treatment will depend on a social agency, family, or welfare group. Outpatient psychotherapy may be needed. The Church is of great value in some cases. With some persons vocational training should be pursued. Carefully oriented employers should be encouraged to work with addicts. In short, all community resources should be utilized when necessary.

I am fully aware that there are a number of problems entailed in such programs. For example, where do the law enforcement people fit into the picture when there are signs of antisocial activity such as drug use, stealing, and consorting with other addicts and peddlers? These have been worked out in a number of cases where there has been a spirit of cooperation on the part of all concerned. There is no reason to believe that this policy cannot be extended.

There have been a number of references in recent years to other forms of treatment. One of these (California Health and Safety Code, Section 11722) advocates the periodic use of the narcotic antagonist, N-allylnormorphine (Nalline). This drug in small quantities precipitates withdrawal in the regular users in a matter of minutes. It is a potent drug and in unskilled hands may make the individual extremely ill, or even endanger his life. The procedure, though it sounds simple, is rather complicated if an honest evaluation of its effect is to be gained when a person is taking only small quantities of drugs. As a voluntary procedure, it may be of value during the rehabilitation period in the community. By voluntary I do not mean that the addict "volunteers" or else parole is withheld. This I hold as immoral.

Finally, you have heard and will hear of proposals for providing addicts temporarily with drugs during the early phases of rehabilitation outside the hospital. Another more drastic suggestion is that narcotics be provided free or at a nominal cost to the confirmed user for the rest of his life. Such a plan is repugnant to most authorities. In my experience, there is not one addict in one hundred whom I would consider as incurable. Not until we have honestly and sincerely bent every conceivable effort to rehabilitate, should we even consider an experiment in this direction. Briefly, then, medicine would argue for greater latitude and public endorsement of existing programs, medically oriented, as a first great step in further reducing the narcotic problem.

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The Policeman's Viewpoint

ARTHUR M. GRENNAN

Lieutenant Arthur M. Grennan has been a member of the New York City Police Department for 19 years and has been assigned to the Narcotics Bureau since 1951. He is a graduate of the Federal Bureau of Narcotics Training in Washington, D. C. His primary duty in the Narcotics Bureau is the supervision of detectives investigating violations of the narcotics laws. He has lectured on narcotics and addiction in the New York City Police Academy and has conducted training schools on Narcotic Law Enforcement for police officers from neighboring police departments. In addition, Lieutenant Grennan has frequently represented the Police Department on panel discussions on the subject of narcotic addiction, and is a frequent speaker before social, fraternal and professional groups in the New York metropolitan area.

The most recent statistics released by the Federal Narcotics Bureau show a total of 45,692 drug addicts in the United States. Though this figure is 25 percent less than it was three years ago, it is still startling when we consider that in New York City, in the borough of Manhattan, one person out of every 130 is addicted to the use of narcotic drugs.

Police officers have long been aware of the seriousness of this condition since it is reflected in the increase in the crime rate in the areas of high addiction, resulting from the fact that the addict, being unable

to hold a job, must turn to crime to support his habit. This increase in addict crime, coupled with the necessity of enforcing the laws relating to the traffic in narcotic drugs, has been one of the major police problems in recent years.

Realizing that there is little that the police can do in eliminating the psychological and physiological weaknesses which cause an individual to be addiction prone, we have exerted our efforts towards eliminating the catalysts which change these individuals into addicts. In our opinion, these are, first, the drug peddlers, through whose efforts narcotic drugs become available, and second, the addict himself.

DRUG PEDDLERS

We feel that the most immediate and available method of reducing the incidence of drug addiction is to prevent addiction-prone individuals from gaining access to the drugs. Even though only a limited number of persons fall into this category it stands to reason that the larger the number who are exposed, the larger the number of persons who become addicted. In an effort to effect this reduction in availability we are currently engaged in cooperative activity on three broad enforcement levels: international, national, and local. Internationally, we are attempting, through the United Nations, to limit the production of opium to an amount necessary to satisfy the world's medical needs. In this way we can eliminate the possibility of an overproduction being diverted into illegal channels. Nationally, we are supporting appropriations for increases in enforcement personnel, and through legislation, attempting to remove some of the procedural obstacles which make convictions more difficult. These two areas of enforcement are our first line of defense against drug addiction, for to the extent that the production and smuggling of illicit drugs are prevented, to that extent our local problem is reduced.

Locally, we feel quite capable of performing the enforcement duties assigned to us. At present we have the largest narcotic bureau of any city in the world, composed of 175 men and women whose primary efforts are directed towards the elimination of narcotic distributors. In addition, as a result of a stepped-up program of education in the department, every member is actively engaged in the effort to eradicate the sources of narcotics in the city. Because of this accelerated enforcement program, the number of arrests for narcotic violations has steadily increased since 1950 to a point where in 1958 over 7,000 arrests were made for violations of the narcotic laws.

Coincident with the increase in arrest activity, there has been a gradual, but noticeable decrease in the number of new addicts coming to our attention in each calendar year. This decrease has also been noted in other cities having large addict populations, but the significant fact is that the greatest decrease has been noted in those cities having the strictest narcotic laws. In this regard, His Holiness, the late Pope Pius XII, speaking before an international group of physicians at the Vatican on February 24, 1957, warned against addiction to narcotics and the then newly-developed tranquilizers, and stated that severe legislation is needed to curb their improper sale and administration. He further stated: "Facts show that the abuse of drugs leads to complete neglect of the most fundamental demands of personal and family life" (Pius XII, 1957, p. 272).

THE ADDICT HIMSELF

Our second, but no less important, attack on addiction has been directed at the addict himself. After questioning thousands of addicts we have found that, contrary to common belief, addiction is not spread by large-scale peddlers for the profit motive but by the proselytizing of the addict himself. Since World War II, the demand for narcotics has been such that it has been unnecessary for peddlers to conduct marketing campaigns to dispose of their wares. At the same time, however, there has been an increase in the experimental type of addiction found among teenagers and adolescents in whom the need for rationalizing their own habits and the conformity pressures operating within adolescent peer groups has induced initiated individuals to convert their fellows. In addition, because the adolescent addict has fewer means of supporting his habit and less contact with other addicts than his adult counterpart, he is more inclined toward drug peddling to other adolescents to finance his addiction. We have seen this pattern of addict turned peddler repeated almost without exception, with the result that a good portion of our teenage population has already dedicated itself to a life of crime and physical degradation.

Interestingly enough the addict denies that addiction is injurious either to himself or to society. Rather, he belligerently asserts that an individual's vices are his own affair. He sees no reason why he should be deprived of his drug pleasures, and even maintains that if he were given a steady supply of drugs he would be able to hold down a job, and even work more effectively. He claims that re-

strictive narcotic laws have caused rather than reduced addiction, and finally states that he perpetuates his own habit just to remain normal.

FACTS IN THE CASE

What are the facts in the case? We have found, and informed medical sources agree, that when an addict has an ample supply of drugs he becomes lethargic, slovenly, undependable, and devoid of ambition. He loses all desire for socially productive work and exhibits little interest in food, companionship, family ties, or recreation. The so-called push which he attributes to the use of drugs becomes evident only when he becomes concerned about the source of his next dose. Actually his sphere of interests become more and more constricted until most of the time he is preoccupied with "enjoying" the effect of the last shot or getting ready for the next. As a result he becomes a burden to his family, his friends, and to society in general.

We realize that addiction requires medical treatment before a cure can be effected, but we do not feel that the addict should be thought of only as a sick person. His sickness was not contracted unintentionally but by design. Undoubtedly he knew that possession of drugs was illegal and realized the demoralizing and debilitating effect that their use could have on the human body. Then, disregarding the obvious dangers, he started to use drugs in direct opposition to the norms of society, displaying criminal as well as medical symptoms. It is likely, too, that before using drugs he also engaged in other types of wrongful activity. If the average citizen decided to acquire narcotic drugs, unless he were a physician or a nurse, or in some way in contact with a legal supply, he would not know where to turn for an illegal source. Even learning the source, drug peddlers, because of their fear of apprehension, will not sell to just any person who happens by. Consequently, before a person is able to get narcotics to use he must be accepted by at least those on the fringe of the criminal element. Gaining this acceptance presupposes a previous pattern of antisocial, if not illegal, behavior. The rate of relapse would also tend to disprove the purely medical theory, for on the occasions when, through confinement, he has been withdrawn from drugs and cured of his disease the addict loses no time in returning to drug usage to satisfy his hedonistic desires.

Of course many people feel that addiction is criminal only because society has seen fit to legislate against it, so that by abolishing the

law we could eliminate the crime. This theory is no more sound when applied to addiction than it would be if applied to a crime such as robbery. It is obvious that both of these types of behavior, even though they were not illegal, would still be offensive to the great majority of the public, which would react by lynch law or some other type of punitive activity. Rather than legalize addiction, since continued use of drugs may readily impair physical and mental health and result in widespread social disorganization, every citizen has not only a right but a duty to suppress it.

THE BRITISH CONTROL PLAN

In the past few years there has been a growing agitation by many well-meaning but misinformed individuals for the United States to adopt the so-called "British Plan" of handling drug addicts. As a result, shortly after taking office Governor Rockefeller directed Dr. Granville Larimore, Deputy Commissioner of the State Department of Health and Dr. Henry Brill, Assistant Commissioner of the State Department of Mental Hygiene, to make an "on-the-site" study of the British narcotic system. This study was made during the months of September and October, 1958. An interesting sidelight of the study, as reported by the doctors, is that they were the first persons from the United States to confer with those people who are concerned with the administration of narcotic control in England. The investigating doctors reported that they found this rather startling since "There surely has been no dearth of material in both the lay and medical press in this country about the workings of the British system" (Larimore and Brill, 1959, p. 4). After completing their study a report was submitted to the Governor, and I should like to quote some of the conclusions that were reached. They concluded, in part, as follows:

> England has a relatively minor narcotic addiction problem at the present time and this problem is one of "medical" rather than "criminal" addiction (p. 23).
>
> The British narcotic control system which appears vastly different than that of the United States on superficial inspection is found not so dissimilar upon a more careful study of its administrative operation (p. 24).
>
> The theoretical freedom that the British physicians have under the law to prescribe narcotics, while not widely taken advantage of, is still not believed applicable for adoption in the United States. The operation of the National Health Service of England which practically

prevents patients from going from one physician to another, effectively deters addicts from obtaining drugs from more than one physician at a time. The absence of such a deterrent in the United States is in itself a compelling reason against the adoption of such a policy (p. 24).

The British experience with maintenance of addicts on stabilized doses of narcotic drugs is not adequate enough nor are its results sufficiently applicable to the United States to warrant the adoption of such a procedure in this country without further study under controlled conditions (p. 24).

There appears to be no practical method of preventing the occurrence of drug addiction given a susceptible individual, an available drug supply, and an environment conducive to the fostering of addiction. For example, the British have what appeared to us to be a potentially serious situation from a narcotic standpoint in the Notting Hill section of London. Yet at the present time there are no practical preventive measures that might be employed to forestall the development of widespread addiction in that area, other than strict law enforcement to minimize the risk of the introduction of the drugs on a large scale (pp. 25-26).

In addition to these conclusions, the report indicates that one of the main reasons for the low addiction rate in England is the abhorrence that the British people have of addiction, which apparently extends to all levels of society from the upper class down to the lowest criminal element. They found that, even in the criminal classes the addict is considered at the lowest level below the meanest pimp or pickpocket. Contrast this attitude with that of an expanding group of vociferous Americans who are campaigning for drug clinics to literally sustain addiction and give it an aura of respectability. I feel safe in assuming that at the present time there are many people seeking some sort of "escape" from their problems who are deterred from the use of drugs solely by having to consort with criminals and shady characters to get them. To remove this deterrent and make addiction an accepted condition, to be freely discussed and acquired, would undoubtedly cause many people to become addicted simply by contact and example. Rather than this, since the technique of despising and ostracizing the addict has resulted in a lack of susceptible individuals in Britain, perhaps we might adopt that part of their "system" in an effort to develop environment in this country that would inhibit rather than propagate addiction.

GENERAL RECOMMENDATION

Though there is no panacea that will immediately dissipate the narcotic problem, we feel that the best solution lies in a combination

of the following three approaches: (1) Close cooperation between narcotic enforcement agencies and medical authorities; (2) a law to clear the streets of criminal addicts and drug peddlers so as to stop further contamination of the general public; and (3) institutional treatment of addiction by medical authorities, following compulsory commitment of addicts. Since our philosophy of government permits society to invade the domain of personal rights to protect the general welfare, we should continue to legislate against possession of the drugs necessary to addiction, while at the same time vigorously opposing any legalization or ambulatory treatment procedures which would tend to perpetuate addiction and reduce the human will and intellect to a condition of abject slavery to a repugnant habit. In this way, justice will be tempered with mercy but not to the extent of breaking down the moral fabric of the whole community.

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The Clergyman's Viewpoint

NORMAN C. EDDY

Rev. Norman C. Eddy is a member of the group ministry, consisting of twelve ministers working together in the East Harlem Protestant Parish. Within the parish and under parish auspices are two parish churches, a clinic, and a narcotics headquarters. Mr. Eddy is Director of the Narcotics Committee of the East Harlem Protestant Parish which is a unique and noteworthy effort to deal with the narcotics problem at the parish level. Mr. Eddy received his A.B. degree from Yale University in 1942, and his B.D. degree from the Union Theological Seminary in 1951.

The complexity and the controversial nature of the problem of narcotics addiction have been clearly demonstrated by the papers presented at this Institute. It is understandable, in the face of these difficulties, that so few individuals and so few of the professions should care to be involved in attempts to help addicted persons. Perforce lawyers and judges have had to deal with the cases of addiction which clutter our courts. The personnel of law enforcement agencies and correctional institutions cannot escape the responsibility put upon them. Social workers deal frequently with the tragedies caused by addiction. The doctors and the clergy, however, have stayed as far away from addiction and addicted individuals as they could get, for a variety of reasons. Yet until the medical profession and the Church begin to assume responsibility for addicted persons, there can be no hope for an all-out, co-ordinated attack on this tragic,

baffling problem. Without intelligent, informed planning by all professions and groups who have a responsibility for addicted persons, there can be no hope of progress.

It is a unique privilege and a real sign of hope for me to be invited to speak as a clergyman to clergymen in an Institute where most aspects of addiction are being discussed by experts. With their presentations as a framework and a counterbalance to what I have to say, I feel free to set forth the opinions and suggestions which have grown out of the nine years of work of the East Harlem Protestant Parish and its Narcotics Committee with addicted men, women, and youth.

THE PROBLEM PRESENTED BY THE ADDICT

We, the clergy, have an inescapable responsibility for the care of the souls of people who have sold their lives into slavery to a mild-looking white powder called heroin. Its hold over individuals has all the power of the devil. Many people can be released from this bondage only by the power of God. Yet we, the clergy, have not learned how to reach out to the addicted person, even though we may be aware of a general sense of responsibility for those who are so obviously lost.

The clergyman who does have a conscientious desire to reach out to these troubled people has two immediate problems, the addict and himself. Clergymen know little or nothing of the problem. If they have ever seen an addict, it has most likely been in the form of a pathetic individual with a well-tailored story who is looking for money. At the same time, if his church is in a neighborhood where there is a high incidence of addiction, the clergyman can be quite certain that on Sundays he looks out on men and women in his congregation who have the problem in their immediate families, but who are too proud and too ashamed to bring their anguish to him. His first step is to educate himself so that he knows how to reach out to those in need.

At the same time, the addict himself is not going to make it easy for any clergyman who is genuinely interested in helping him. It is embarrassing to discover how many addicts are former altar boys and how many are the sons of ministers. Whatever his religious background, however, the addict is not going to turn to the Church. When I suggested this as a possibility to friends of mine now at Rikers Island Penitentiary, they laughed . . . without bitterness. They simply

laughed. As one of them put it, "They would kick us out." On the one hand the addict knows that no one in the churches understands him or his problem. On the other, he bears a burden of guilt for his addiction which he will scarcely admit to himself, and an open sense of shame for the many illegal acts he has been forced to commit in order to support his habit. Because he knows that the peculiar nature of his guilt feelings will not be understood in Church, he turns away from it.

In spite of this estrangement between the Church and the addict, most addicted people present a fascinating challenge to anyone who is interested in ultimate religious questions. In our neighborhood in East Harlem, we have seen a great variety of individuals who have become addicted. There is no simple stereotype. All are unique personalities. Many are far above average in intelligence. Some are extremely dull-witted. Some have worked all their lives and have supported their habits with their earnings. Some were leaders of fighting gangs before they became addicted. There are artists, musicians, and potential social workers among them. It is necessary to cut through the stereotype of the addict by becoming personal friends with the many people who are addicted.

THE ADDICT AS SEEN BY THE CLERGYMAN

Having come to know about 150 well, and 600 casually, our Parish Narcotics Committee has broken through the stereotype, but has some generalizations of its own. Addicts are people without a purpose. Some are equipped with excellent minds and are finding no answers to their questions about the causes of evil, the existence of God, the reason for suffering, or the nature of sex. A group in our Committee has adopted the 88th Psalm as their own, for in this lament of total despair, they have found the perfect description and expression of their own loneliness and suffering. To this sense of purposelessness, the Church in general has provided no solution.

An observation to which I have found no exception is that addicts and former addicts are impatient people. Put in another way, they cannot stand mental, emotional, physical, or spiritual pain. Whether this is a result of the permanent effect of the heroin on the nervous system and the balance of body chemicals, or whether people with a low threshold for pain tend to be those who become addicted I do not know. But narcotics have traditionally been pain-killers, and heroin appears to be the pain-killer par excellence. In the face of this

reality, what has the Church to say about the nature of pain and the ways in which it is to be overcome or endured? It has much to say, but can it speak to the addict so powerfully that he will find the love of God to be stronger than the easing of pain provided by heroin?

A third consideration of concern for us as clergymen is the nature of the guilt feelings borne by the average addict. These are complex, and must be dealt with sensitively. It is safe to say that, these days, most addicts know that they are doing wrong when they first start taking narcotics. For this they bear an understandable sense of guilt which some may not admit even to themselves. But once a person has become physically and psychologically addicted, he is sick, and he must be treated as a sick person. A person who gets a venereal disease may have committed an immoral act in doing so, but the disease itself must be treated medically. Addiction, however, is in part a disease of the will and must be treated psychiatrically and spiritually. To confuse the guilt feelings of the addict further, however, he has almost no recourse except to crime in order to support his sickness here in New York City. The adult addict is burdened with shame because he has had to steal or to sell narcotics, and because he has had to make his family suffer. At the same time, society has to absolve him of much of his guilt because it gives him absolutely no opportunity to cure himself through a hospital or a private doctor. The clergyman attempting to deal with this complicated mixture of real and unreal guilt feelings must go very slowly in his pastoral counseling. He is likely to find as he gets to know the addict that he is a person with very definite ethical standards, some of which he has maintained even in the face of addiction, and others of which he feels desperately guilty about having broken.

The most complicated, but perhaps most important, area of the addict's life for the clergyman is his religious views and experiences. Initial expression of indifference to religion usually means nothing. Under the pillows of boys at Riverside are many religious poems, poured out in bad English but in anguish of soul. Many find garbled religious messages in their dreams. Many reject superficially the religious training of their youth, but in fact cling to their twisted understanding of it as their only hope in a life of confusion and despair.

THE RESPONSIBILITY OF THE CLERGYMAN

The Church cannot escape its responsibility in the areas suggested here. It must always be in the forefront in breaking down stereotypes,

viewing each person as a unique child of God. To the purposeless souls of this world wandering aimlessly through life, it must reach out with the Christian message of hope and salvation. For suffering humanity the world over, the Church must give surcease where possible, and the eternal comfort and strength of God where pain must be endured. The addict, with his peculiar sensitivity, cries out for this help, but there are few to hear his cries. While in the area of guilt feelings the Church is in danger of confounding the real with the pseudo, or of refusing to give psychiatry its due, the power of God alone, as mediated by the Church, can purge the many addicts of their guilt. Finally, apart from the broken religious traditions, the visions, the dreams, the poetic religious yearnings shared by so many addicts, the Church alone can build a new life dedicated to the service of God rather than to enslavement to heroin.

How is the clergyman to equip himself to minister to the addict if he knows that addiction is prevalent in his neighborhood? He must educate himself. The best single, comprehensive gathering of writings on narcotics for the intelligent reader is contained in the 1957 winter issue of *Law and Contemporary Problems,* the Journal of the Duke University Law School, the entire issue of which is devoted to the question of narcotics. The Community Council of Greater New York can give information about films on addiction, sources of well-informed speakers, and the titles of pertinent books. Members of Narcotics Anonymous, modeled after A.A., are very eager to talk with clergymen about their first-hand experiences with the problem.* The Neighborhood Council on Narcotics Addiction can advise on setting up community programs.†

Once the clergyman has done a little self-preparation, he may want to form a small narcotics committee from among his parishioners, or he may want to do what an increasing number of churches are doing—sponsor a movie or a forum on addiction. When he has made his own interest clear, he will easily find ways of discovering the nature and extent of the problem in the neighborhood. He will soon be using the limited resources for referral and for cooperation in this complex problem, for slowly and shyly people will begin to seek him out and to ask his help in solving problems which are quite beyond solution. At this point, the pastor's knowledge of normal

* Narcotics Anonymous meets only on Wednesday nights at the McBurney YMCA, 215 West 23rd Street, New York 11, N. Y.

† The Neighborhood Council on Addiction is located at 306 East 103rd Street, New York 29, N. Y.

pastoral counseling techniques will begin to stand him in good stead. Slowly he will have to evolve his own view of addiction and to develop his own sensitivity to the plight and personality of the addicted man or woman who comes to him for help.

In summary, it must be repeated that the clergy have neglected their ministry to the addict. It is up to the Church to make the first move. While there are signs of hope in the whole field of addiction, largely there is despair. Knowing the need and the suffering and the anguished yearning of the addict, the Church above all cannot stand by, whether or not there are signs of change and progress. For whatever the other professionals and fields of human endeavor may say about the problem, addiction to heroin is a symptom of a deep-rooted spiritual sickness, and a diabolical answer to the spiritual quest of the man without faith in God.

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General Aspects of Treatment

HERBERT BERGER

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Those of you who had the opportunity to hear the distinguished experts on narcotic addiction during yesterday's session were impressed, I am sure, with an important facet of this problem, namely, that the

determining factor in drug addiction is not the narcotics, heroin, morphine, or demerol, but the addict himself. This elementary fact seems to have escaped our legislators who continue to introduce legislation directed against the importation, manufacture, transportation, and sale of drugs instead of initiating efforts *for* the addict.

THE REASON FOR NARCOTIC ADDICTION

Our research must be brought to focus on the individual who feels constrained to turn to drugs, to understand his motivation, his unwillingness to face reality, his desire to remain in his narcotic-induced dream world even though he knows full well that it will cause his eventual disintegration. From the beginning of time man has found it necessary to escape from reality and from the vicissitudes of his surroundings. Since man's environment is composed of only three elements, ourselves, other people, and various inanimate objects, it seems strange that he has been unable to cope with it. There is little doubt that the need for escape and surcease from our difficulties is a normal, human attribute. Certainly a large segment of our population, and of every culture studied in the history of the world, has practiced some such form of release.

If our surroundings are intolerable we can alter them in only three ways. We can change our emotional and physical climate, we can escape from our environment, or we can change ourselves. The first two of these methods have always been difficult and often impossible. The man who has lost a leg cannot will it back, and those who ran away find that their problems have a way of pursuing and eventually overtaking them.

Man, therefore, must perforce change himself. This he does through education, intelligence, forbearance, religion, a spirit of compromise, and in all too many instances, through the medium of chemistry. Fermentation has been known since the earliest times. Its product, alcohol, has been used by us in an attempt to make life tolerable and to reduce our distress at its vicissitudes. In like manner various plants have come into use, the ingestion or injection of which serve a similar purpose. These include betel nuts, opium, cocaine, fly agaric, peyote and many others.

Before we trifle with this universally used mechanism of adjustment, what have we to offer in its stead? If sobriety or abstinence from drugs is our goal, then we are as doomed to failure as if we

were to treat a high fever by the immersion of the patient in ice water.

While temperance is a more desirable state for society than drunkenness, we must ask: How does the patient feel about it? His liver may thrive, but will his personality and his joy in life be impaired?

Success in the management of the addictive diseases can only be achieved when the "why" of narcotic addiction is understood. This is a fundamental prerequisite if man is ever to shed his dependence on chemicals, be they alcohol, narcotics, barbiturates, tranquilizers, or stimulants.

Yet everything about the underlying disease that erupts as alcoholism or narcotic addiction seems to militate against the acquisition of this basic knowledge. The patient, family, and community demand that we treat the narcotic addict. Our humanitarianism causes us to acquiesce. The few people interested in these diseases are importuned to do something so that there is practically no one left to investigate, to learn "why." But investigate we must because new addicts are formed faster than old ones die or are clinically cured.

To help us begin to understand these problems Fordham University has brought you these very able people. These experts in their respective fields will bring to you some of the more recent additions to our knowledge of the nature of addiction and will, I expect, emphasize the person rather than the chemical.

THE APPROACH TO TREATMENT

Perhaps now we can begin to approach the problem of treatment. The narcotic addict is sick, distraught, nervous. He has sought to alleviate his symptoms by a chemical. His error is twofold. First, he turned to an amateur for his therapy, himself, when he needed the best brains in medicine. Make no mistake, despite the tremendous publicity given to the skilled artisan, the surgeon, or that deft thinker, the pharmacological chemist, the most difficult task in all medicine is the management of what the public euphemistically calls, the *just* nervous patient. I'd rather see anybody with just two broken legs. They're a great deal easier to cure.

His second error is that he has always treated his symptoms and not his disease. This is like taking a nostrum from the corner pharmacy to relieve the headache caused by a brain tumor. The headache may go, but the tumor keeps growing. So the narcotic addict relieves

his present symptoms with his drug as he retreats ever further from reality. He is the great procrastinator.

Small wonder that the medical profession has had so little success in treating him. On the one hand the laws of our country have isolated the addict from his physician so that we have had little opportunity to develop skills in this area. On the other, the addict presents an almost congenital inability to accept the normal frustrations of life. He literally has to be made over if he is to live without drugs. This involves as much a *spiritual* rebirth as a mental or physical one. It is for this reason that we welcome the clergy with so much enthusiasm into this struggle. The happy marriage of both these disciplines has spawned the greatest success, as evidenced by Alcoholics Anonymous in alcohol addiction, and in Rev. Norman Eddy's East Harlem Protestant Parish Narcotic Clinic in the field of narcotics.

The brotherhood of man in the marriage of science and religion can best be emphasized by the example of a Jewish physician praising the dedicated work of a Protestant minister to a group of Catholic priests. These common aims break down divisive forces between us so that we can work together for the common good of our brothers before God, our Master.

TREATMENT POSSIBILITIES

How can we begin to cope with these fantastically difficult problems? Subjected to careful analysis, there would seem to be only three possible approaches:

1. *Destroy them.* The death penalty for narcotic addicts isn't new. It was tried by Chiang Kai-shek in China only 20 years ago. It, too, drives the addict underground and is, of course, an admission of failure. Prior to 1956 I felt certain that a civilized country like the United States was not likely to enact such a law. But the Boggs Act passed by our Congress comes dangerously close to it in recommending the death penalty under certain circumstances, but not mandating it.

2. *Incarcerate them for life.* This has been suggested by the district attorneys of two counties in New York State. I am more than happy that Messrs. Hogan and Silver have interested themselves in this perplexing problem and I hope you will consider their suggestions. They work in areas full of addiction and have considerable experience with it. My opposition to this remedy in no way lessens

my respect for the proponents of this measure. This technique, too, is an admission of defeat. The cost of incarcerating our addicts, *if we could find them,* would be enormous. Remember our addicts are younger people, most of them in their teens, and they have a normal life expectancy. Society would be deprived of the materials they might produce. Their families would probably be placed on public charity. Nor have we the institutions available. But these are minor considerations. The major one is that we would not find them, and this is an admission of defeat.

3. *Treat them as sick people.* This is the only course left, and I earnestly commend it to you. The plan is as simple as it is direct, and involves only two steps:

a) Recognize the addict for what he is, a mentally sick person whose prime symptom of illness is addiction.

b) Bring to bear on this unfortunate psychopath the whole weight of our extensive knowledge in medicine, sociology, psychiatry, religion, and humanity so that he may again be made well, and rehabilitated so that he can live without narcotics if this can possibly be done. If this is not possible with our present state of knowledge, then let us carry him on narcotics under control until we learn enough about this subject to eventually effect a permanent cure.

ANTICIPATED OUTCOMES OF THIS PROGRAM

What can we expect from this program? There are several possible outcomes:

1. To appreciate the magnitude of the problem.

2. To stop crimes committed by addicts in order to obtain the price of drugs.

3. To stop the introduction of addiction to new people by the present users who are trying to guarantee their own sources of supply.

4. To prevent death and disaster to these addicted individuals who inject impure, dirty, infected materials into themselves. Many lose their lives from overdosage, or from "hot shots" which contain poison. This is the way the underworld disposes of a dangerous addict who has no money to purchase drugs, or who informs on the higher-ups.

5. To empty our jails of these non-criminals or those persons who have become criminals only through our own inept legislation.

6. To give us the opportunity to study addiction so that we may eventually discover a real cure for this disease.

REQUIRED SAFEGUARDS

Naturally such a program will require careful safeguards! Among these would be the following:

1. It will demand the service of clinics in our larger cities and of individual physicians in smaller localities.
2. Narcotics should be administered only at the clinic. The addict should never be given a supply of medications.
3. The addict must be fingerprinted and properly identified, registered, and photographed. Only those who are actually addicts can be treated. These can be readily recognized either by incarcerating them and withdrawing them from the narcotics after strict seclusion, or by the administration of narcotic antagonists such as Nalline.
4. Hospitalize those patients whom the medical personnel at the clinics feel can best be served by in-patient techniques. These should be individuals who request hospitalization after being so advised by the clinic physicians. They should not be forcibly incarcerated unless their physical or mental condition is so critical as to make them a menace to society.

PRACTICALITY OF THE PROGRAM

Are these suggestions visionary? One need only investigate countries that have adopted a medical and humane approach. The United Kingdom has 279 known drug addicts and probably very few unknown ones. There is no crime and no proselytizing there. Physicians treat addicts and write prescriptions which are filled by pharmacists. The term "criminal addict" is unknown in Britain.

Recently our Commissioner of Narcotics tried to make the British government ban the importation and manufacture of heroin since it is signatory to one of the United Nation's pacts outlawing the drug. When I appeared in London to testify against this step, Parliament was quick to see that just such a step by our government produced the enormous problem the United States now has. The ban on heroin was consequently rejected.

While we have an enormous responsibility to discharge toward narcotic addicts, it is relevant to consider that they are measured in hundreds of thousands, while the rest of us are counted in millions.

This approach we have explored today would protect 180 million citizens against the depredations into which our laws force these few.

If we have been mistaken in our approach to this problem, need we feel ashamed? Oliver Wendell Holmes, at a Harvard Law School commencement, said:

> An ideal system of law should draw its postulates from science. As it is now, we rely on tradition, on vague sentiment, on the fact that we never thought of any other way of doing things, as our only warrant for rules which we can enforce with as much confidence as if they embodied revealed wisdom. Who can give any definite reason for believing that half of the criminal law does not do more harm than good?

Perhaps this discussion has suggested to you that the existence of an enormously growing narcotic problem in the United States now demands a re-evaluation of our methods. Even if the medical, humane attack were to fail there will no longer be need for the addict to proselytize in order to guarantee his own source of supply. By normal attrition he, too, will reach the end of his days and the problem may well have solved itself. But this is contrary to all we have learned about research. When the great weight of scientific thought, supported by our great foundations and universities, is brought to bear on this problem it, too, God willing, will yield.

Hospital Treatment

RAFAEL R. GAMSO

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Hospital treatment is one of the many services which addicts need. They have periods of acute physical illness due to overdosage, withdrawal, or medical complications, as well as psychiatric disabilities which can be best studied and treated in a hospital with its full staff of medical, psychiatric, and ancillary personnel. During periods of hospitalization addicts are protected from the troubles and turmoils of the community with which they are in conflict, and plans can be made for continued care and assistance following hospitalization. In addiction, as in other complex conditions, the hospital is the center for treatment, care, and study, concerning itself with public health as well as community aspects and the continuous care of the individual until he has achieved maximum rehabilitation. In some cases the hospital must determine limitations which cannot be over-

come, and, having delineated the extent of the persistent disability, formulate plans for the care of the patient who has residual symptoms which cannot be corrected. Despite the fact that the medical profession has accepted the premise that drug addiction is an illness, and that drug addicts are sick persons, there are few physicians who will work with addicts or hospitals which will provide the medical care which they need.

I know that you are familiar with the federal hospitals at Lexington and Fort Worth. The staffs at Lexington in the research unit (Isbell, 1955, and Wikler, 1958) and the hospital section (Lowry, 1956) have made great contributions to our understanding of addiction and its treatment.

OPENING OF RIVERSIDE HOSPITAL

Other hospitals may, from time to time, accept patients for detoxification or other treatment. California had a special hospital for drug addicts from 1928 to 1941. In New York, Riverside Hospital was established July 1, 1952, as a result of public demand that something be done to help young drug addicts. Prior to its opening, conferences were held under the auspices of the New York Academy of Medicine (1953). The opinions and recommendations of the conference members, and reports of the experience obtained in the treatment of addicts at Lexington, Fort Worth, and Bellevue, helped in the development of plans for Riverside Hospital and the formulation of a Public Health Law (1958, pp. 20-22), whereby patients could be put under the jurisdiction of the hospital. Prior to the opening of Riverside, young drug addicts were received in the adolescent wards of Bellevue and Kings County Hospitals for detoxification and study. The Bellevue staff (Zimmering, *et al.,* 1951) reported that the young drug addicts there were cooperative, non-aggressive, passive individuals.

Riverside Hospital is located on North Brother Island and is reached by ferry from the foot of East 134th Street, in the Bronx. Prior to World War II, it had been a tuberculosis hospital. The Island is 13 acres in area. The main building has four wards for 110 male patients, administrative, nursing, and social service offices, as well as offices for the psychiatric staff. The psychologists and the vocational counselors are housed in buildings, each of which has additional uses. Female patients have thirty beds in one wing of a U-shaped building, the other two sections being used to provide quarters for

nursing personnel and offices for the vocational counselors. The church building has Catholic and Protestant chapels. There are also a recreation building, a school building, a power plant, storehouse, maintenance shops, and several deteriorated, unused buildings.

When the hospital was opened, it was the belief of the staff that the patients entering voluntarily, having found themselves in need of treatment and desirous of assistance, would be cooperative, would welcome humane medical withdrawal, and participate with interest in their psychiatric evaluation and treatment. It was expected that they would attend the program designed for them, namely, therapy, school, constructive leisure-time activities, and supervised living with freedom from restraint in a healthy environment. From the outset it was evident, as reported in Riverside Hospital's first annual report (Riverside, 1952), and later by members of the hospital staff (Gamso & Mason, 1959), that patients enter primarily because of pressure by police, courts, family or others, or because they were unable to support their habit. They came in, not with a desire to permanently stop drug use, but rather to have a temporary respite and/or a reduction to a lower dosage. They were uncooperative, did not follow their programs, and were very disturbing in the hospital setting.

STRUCTURED PROGRAM NEEDED

It became necessary to develop a structured program. Patients were required to follow programs which were deemed suitable for them. Staff had to be firm and insist that they get up in the morning; that they report for breakfast on time; that they have their rooms cleaned and go to their assignments by 9:00 A.M.; that they report to their therapist; and that they conduct themselves in an appropriate manner. In the beginning, many of the professional staff felt that this could not be required of our patients; that they were so disorganized that we must expect their behavior to be disorganized and purposeless until psychotherapy had reached the point where they could assume responsibility on their own volition. Nevertheless, it gradually became evident that administrative procedures and pressures could succeed in bringing order out of chaos. After a transition period, patients began to come to their treatment sessions regularly, and to attend the school and other programs in accordance with their assignments.

It must be noted, however, that even today, seven years after the hospital was opened, it is still necessary to provide close supervision

and insist that patients participate in their programs. On their own they tend to persist in behavior which they had followed in the community, namely, sleeping all day, loafing around in the evening and staying up all night; their only interest being the securing of drugs. It is obvious, therefore, that management problems are of great importance. Patients will make efforts to bring drugs into the hospital or have drugs supplied to them. They will attempt to break into the pharmacy or other places where medications of any type, narcotics, sedatives, stimulants, intoxicants, or others, might be stored. There are even substances, such as nutmeg in the kitchen, which they will obtain, if possible, to mix as a drink since apparently these substances give them a feeling which they desire.

HOSPITAL TREATMENT

Hospital treatment, however, is not merely control over adverse behavior, or attempts to maintain security. When he comes in the patient is either acutely ill with withdrawal symptoms or may develop such symptoms later if he has taken a shot shortly before admission. It is important, therefore, to provide medications in the form of Methadon for those patients who require withdrawal from narcotic drugs. Withdrawal is usually completed within three or four days. About 20 percent of the patients have been taking large amounts of barbiturates and may need withdrawal from them over a period of several weeks. Cocaine is also used by some patients, but this does not require medication for withdrawal.

Following the withdrawal from heroin, a complete evaluation of the patient is conducted, consisting of social history, psychological studies, psychiatric interview, aptitude testing, and observation by a staff of nurses, recreation workers, schoolteachers, and an occupational therapist. Three to four weeks after admission a diagnostic conference is held. All the persons who studied the patient present their findings. A determination is made as to whether the patient is suitable for care in the hospital at that time. Among the factors considered are whether he has a positive attitude or whether he is deeply antagonistic to being retained in the hospital; whether there is a psychiatrist, psychologist, or psychiatric social worker who has time available for therapy or supervision; and whether he has the potential for receiving therapy, which means that he is not overtly psychotic, that he is not mentally defective, and that he is not too deeply involved in antisocial behavior as to be unmanageable in Riverside Hospital.

All these criteria are interpreted rather liberally so that many patients are kept in the hospital who might, on stricter evaluation, be eliminated from prolonged in-patient care. Even so, less than half the patients are retained beyond the detoxification and diagnostic period on first admission. Those who are retained are transferred from the study ward to a residence ward and kept for a minimum of six months on first admission. Those who are separated from in-patient care are assigned to the Aftercare Clinic to attend once weekly and be seen by a member of the professional team who studied the individual case. Patients retained in the hospital will have a psychiatrist, psychologist, or psychiatric social worker assigned as therapist, and will be required to attend the school or participate in the work program. The recreation department maintains a variety of programs daily after school closes, and on Saturdays, Sundays, and holidays.

PERSONALITY PROBLEMS OF THE ADDICT

In accordance with the New York State Public Health Law (Public Health Law, 1958), patients under 21 are admitted and put under the hospital's care, treatment, and supervision for a period not to exceed three years. This includes both in-patient and out-patient care and permits the hospital to provide care in the place and manner which seems most suitable at the time. A study in 1956 on the "Post-Hospitalization Adjustment" of 30 adolescent opiate addicts treated in 1955 (Gerard, *et al.,* 1956) revealed that about one in three showed some improvement at the end of the year. Further studies have shown that the number of persons who remain permanently abstinent from drug use is extremely small. We must bear in mind that most of the patients received at the hospital have had many difficulties in life and have made poor adjustments prior to their hospital admission; that 15 percent have relatives who take narcotics; that about 10 percent started using drugs before they were 14 years of age, the average age of beginning use being 15.7 years; that 19 percent spent between one and ten months in jail or hospitals in the year preceding their first entrance into Riverside Hospital; and that 73 percent have been arrested one to seven times before hospitalization. Their average age on admission is 18.

Experience with other individuals who have shown such deviant behavior, and who have the personality problems presented by our patients, has shown that it requires several years of treatment be-

fore any lasting change can be effected in a substantial number of them. These then are ineffective individuals (Gold, 1958) whose use of narcotic drugs is an additional manifestation of their disturbance. It is obvious, therefore, that they will require not only hospitalization but also the attention of well-qualified, experienced staff, as well as prolonged, intensive care since not only do they have a history of antisocial behavior but they have found a chemical which gives them pleasure, dissolves their problems, and separates them from care and responsibility.

In-patient treatment in a hospital is only one aspect of the care which they require. Often, while in the hospital and under close supervision, they adjust well. They are able to follow programs. In many cases they perform remarkably well in art, ceramics, woodwork, music, and other areas of the school program. They may display outstanding athletic skill in the recreation program, and socialize reasonably well with patients and staff. However, when they leave the hospital and are again confronted with the necessity of maintaining themselves, they withdraw from their surroundings and are no longer able to perform constructively or take a responsible part in the community. It is obvious, therefore, that hospital care must be supplemented with an adequate and diversified follow-up program, staffed by well-qualified and experienced professional personnel.

AFTER-HOSPITAL CARE

Riverside Hospital maintains jurisdiction over patients after they leave the in-patient services and requires their attendance in the Aftercare Clinic on a weekly basis. This is not enough. In 11 percent of the cases they return to drugs immediately. Yet they themselves refuse to believe that they are in need of help. It is desirable to have staff to visit homes before patients leave the hospital to see that the arrangements which are planned can be put into effect. It is especially necessary to make home visits when patients are making poor adjustments. Field workers should be available to visit prisons to continue therapy on an individual or group basis and arrange for patients' attendance at the Clinic when released from jail. In most cases, when they leave the place in which they are confined, they will still be wards of the hospital. Staff has not been available for these field services. A complete program would include the participation of other agencies so that patients' needs for housing, employment, and other services are met.

If the patient does not appear at the Clinic, he is contacted by telephone or letter and notified of an appointment for the following week. Failure to keep that appointment results in a series of administrative actions, leading, finally, to the filing of a Wayward Minor Petition by the hospital with the appropriate court so that the patient may be brought back to the court for determination by the presiding magistrate as to whether the patient should be required to return to Riverside Hospital or be sent to a training school or correctional institution.

It has been observed (Mason, 1957) that with prolonged care even resistant patients develop a relationship with a staff member and that patients then begin to recognize that they have difficulties and that they need help. They begin to realize that the staff is willing to help them and that the hospital can be of value to them. They find that staff members understand their needs and their problems and can help them work them through in a more constructive manner than the use of narcotic drugs. It is entirely possible, of course, that in some cases the relationship develops only with staff members and with the hospital; that the patient has not developed the ability to form relationships with other persons, and that in the community he can feel at ease only in the presence of other addicts; and that the only place where he is accepted is in the company of drug users and thus he returns to drug use with them.

NEED OF SUPPORT FROM OTHER COMMUNITY AGENCIES

We are firmly convinced that drug addiction must receive the full interest of all agencies in the community. The addict must have the advice, guidance, and support of the hospital, his community, and, of course, his family. His association with the hospital must be friendly but firm. It is our increasing conviction that the hospital must insist that, when a patient returns to drug use, he must return to the hospital for detoxification and in some cases for prolonged therapy. Prolonged hospitalization is not desirable in all cases since some individuals can only benefit from detoxification. Until they develop motivation for psychotherapy, it might be destructive to them and others, rather than helpful, to retain them forcibly in the hospital.

In the work at the hospital, the clergy play an active role (Edens, 1957). All patients are seen by the clergymen of their respective faiths, who attempt to awaken within them an appreciation of the interest which their religion has in them. An attempt is made to get them to realize that they are not going to be judged or held in con-

tempt for their past behavior, but rather that the religion to which they belong has understanding and that the desire of the clergy is to develop in them a spirit of participation and of cooperativeness. The clergy do not seek to direct their lives but rather to help them enrich their lives. Rarely does the patient come to religious services except when there are particular things to be gained. When patients are confined to closed wards, they request permission to attend services. When they are moved off the closed wards, they are very unlikely to do so. In addition to religious services, the chaplains at the hospital have made themselves available, meeting the patients in wards and recreation areas, where the patients are at ease and where they get into discussions, which then may result in better understanding by the patients with regard to religious matters. The hospital has been used as a training center in pastoral care by the Council for Clinical Training and by the Religion and Psychiatry Department of the Union Theological Seminary.

The community is also represented in the hospital through a Lay Advisory Board, which meets with the Medical Superintendent, and through volunteers who perform numerous services (Buckley and Tendler, 1958).

TRAINING AND RESEARCH FUNCTION OF THE HOSPITAL

In addition to its primary function of service to patients, providing detoxification, evaluation, and long-term psychiatric and rehabilitative treatment, the hospital serves other fundamental and necessary functions. It is a place where staff can further improve their understanding and knowledge of drug addiction, where physicians, psychologists, social workers, nurses, teachers, lawyers, public officials, clergymen, and other professional personnel have the opportunity to visit, observe the program, see patients, and learn at first hand the problems of drug addiction.

Many additional things can be done, including laboratory studies of many types, increased studies of psychodynamics, of the effects of various drugs upon mood and behavior, as well as expansion of treatment and development and testing of modified techniques of hospital and out-patient care. In all these things, progress is being made. However, it is obvious that, if the treatment of drug addiction is to become more effective, more professional personnel must concern themselves with the problem. Addiction should be studied in its broadest sense. This would include alcoholism, barbiturate addiction, use of stimu-

lants such as the amphetamines, as well as narcotics. Studies can best be done in a specialized hospital which has adequate staff and facilities for clinical service and research. Training and research fellowships are needed.

CONCLUSION

In conclusion, I should like to state that specific treatment can be provided for the alleviation of withdrawal symptoms and for such medical complications as malnutrition, hepatitis, skin and other infections, including malaria, subacute bacterial endocarditis, tetanus, etc. There are psychiatric, biologic, cultural, sociologic, economic, religious, and ethnic factors which can be best studied in a hospital. Their modification can be best initiated in a hospital. Prolonged treatment is necessary to effect any significant change and should be conducted by a well-qualified therapist. Alternating periods of in-patient and out-patient care may be necessary. The cooperation and participation of other agencies must be solicited. Finally, life experiences must be used to reinforce therapeutic efforts.

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Agency Treatment

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This report differs somewhat from customary discussions of drug addiction in that it has rather more optimistic things to say than are usually heard about the possibility of agency work with addicts. It should be stressed at the outset that I have tried to steer a middle course between the Scylla of prevailing pessimism and the Charybdis of "overselling" any progress we have made, which would be equally inaccurate and misleading. The truth, as always, lies somewhere between these two poles. Drug addiction is an exceedingly complicated and stubborn problem which, nevertheless, can be made to yield its secrets. This would require concerted efforts on the part of community agencies, the clergy, and professional disciplines to: (1) initiate a range of rehabilitative services and varied approaches; (2) develop a more enlightened public understanding through wide-

spread education; (3) initiate a searching appraisal of those stereotyped attitudes among professional as well as lay persons which have thus far confused the issues; (4) redefine addiction in medical rather than legal terms. As in other fields, the provision of adequate research facilities and realistic financing by the community would appear to be the *sine qua non* of progress.

I should like to indicate that the views presented here are my own and do not necessarily reflect those of the United States Public Health Service; and that the statements made here are an outgrowth of experience: (1) with the Follow-Up Study conducted by the Public Health Service from 1952-1956 (Brill, 1954) and now being continued for a second five years; (2) with the Demonstration Center program initiated by the Community Services Branch of the National Institutes of Mental Health in 1957; (3) as a consultant with the Nyswander Project (Nyswander *et al.*, 1958) established in 1956 to investigate the possibility of outpatient treatment of addicts.

FOLLOW-UP STUDY

The Follow-Up Study was a project begun in 1952 to investigate the feasibility of reaching patients discharged from the Lexington Public Health Service hospital for addicts over a five-year period, and to study their patterns of relapse and general adjustment in the community. Although the report of this study has not yet been released, it may be said at this time that the findings were in one respect negative, in that the great majority of patients were found to relapse quickly following their return to New York City. While the reasons for these relapses are still largely a matter for conjecture, we feel that continued investigation is warranted in order to explore further such questions as the proper uses of hospital in-patient treatment, and appropriate techniques for holding patients, so that the majority do not leave before thirty days, as is the case at Lexington. It is our belief, also, that the absence of local aftercare facilities and the reluctance of community agencies to extend their services to addicts have played a significant role, though the extent of this requires further study. What emerges clearly is the fact that the basic problems of the patient are not resolved at any point during this process so that relapse becomes inevitable in most cases.

We did learn a number of surprising things about addicts, which I should like to recapitulate briefly here:

1. It proved possible to locate and reach almost all dischargees—

a surprising and unexpected finding in view of the difficulties other public health investigators have experienced with TB and VD patients, generally considered a more accessible population.

2. Patients, for the most part, related trustingly to us once we had overcome their initial doubts and mistrust; and they could offer information about themselves in surprisingly honest fashion without the need for our seeking additional proof of veracity through such devices as urinalysis, asking them to expose their arms, etc.

3. Some patients were aware of the need for rehabilitative services and could have responded to more intensive help. Our program did not provide for the offering of more than very limited assistance during this time since it was our primary goal to evaluate the adjustment of patients following discharge from Lexington without the provision of additional aftercare services. We needed to steer a middle course by offering carefully circumscribed services sufficient to hold them while yet avoiding "diluting" the study by adding extended assistance.

4. We discovered that all patients cannot be lumped together under the label "addict," since very diverse individuals with varying strengths, weaknesses, and degrees of pathology are included.

5. A number of stereotypes with which we began needed to be revised. Among them were the following:

All addicts are criminals. The majority of our patients had not engaged in crime before use, so far as could be ascertained through their social history and our own contacts with them. We might note, parenthetically, that labelling addicts "criminals" is a clear case of circular reasoning in that society has defined addiction, which is an illness, as a crime and then "hangs" addicts for it. The fact is, that even when patients are forced into criminality following addiction (because this is the only way the majority can support their habit), the crimes tend not to be violent, assaultive, or directed against people, but are of a relatively more innocuous type involving theft of property, as in shoplifting. Cases of assaultive and armed robbery have been rare in our experience.

6. This leads us to the stereotype of the *drug fiend* or *drug maniac*—a myth exposed 30 years ago, which has nevertheless been very slow in dying. In reality, most addicts are fearful of their aggressive and sexual drives and use drugs to sedate and kill these impulses. The aggression is rather turned on themselves as manifested in their chronic depression or dysphoria, which they unconsciously try to alleviate through use of drugs. It is also evidenced in their self-

defeating behavior, by which they attempt to punish themselves to allay feelings of guilt and the demands of a lacerating superego.

7. *All addicts are hopeless* otherwise known as *Once an addict always an addict.* While this may be true of some addicts, we certainly do not feel that it applies to all. A number of patients were able to abstain from drugs during the five years of our first Follow-Up Study, supported by the knowledge we would be available at times of crisis. The Nyswander Project for ambulatory treatment of drug addicts had further encouraging findings to report in that approximately one-third of the patients evidencing desire for treatment have remained in therapy for periods up to three and one-half years, have remained abstinent, paid their fees regularly, and did not differ markedly from other patients seen by the therapists (Nyswander *et al.*, 1958, pp. 718 ff.). Perhaps the most serious impediment to helping addicts has been the fatalistic attitude of treatment personnel, which is bound to kill whatever hope the patient had initially in seeking help with his problems. What is pointed up is the need for small experimental research units designed to investigate all possible aspects of the narcotics addiction problem in the hope of finding the answers we do not know today.

REFERRAL PROGRAM OF DEMONSTRATION CENTER

Upon conclusion of the first phase of this study, the Community Services Branch of the National Institutes of Mental Health established the Referral Program of the Demonstration Center in 1957. Briefly, this program is attempting to evaluate the premise that more patients could be helped if local community agencies extended rehabilitative services to them. The Center, not a clinic itself, is undertaking to refer carefully selected patients to appropriate agencies in the hope these agencies will learn to see addicts as human beings with a problem, who can benefit from their services and from treatment in medical and social settings rather than being shunted about futilely from jail to jail in an endless cycle of relapse and incarceration.

Our experiences in agencies in the new Referral Program have proved encouraging beyond expectation. For example, most employment agencies for years refused to extend service to addicts over 21 in the belief that only those under 21 are "workable," a highly questionable assumption since our work points to the likelihood that the reverse is true, and that those over 21 offer better potential for

rehabilitation. For many years now, municipal and voluntary hospitals and mental hygiene clinics have closed their doors to addicts, while most social agencies felt reluctant to accept them when more workable clients were waiting for help.

When we first began making the rounds of community agencies in 1957 to learn whether they would accept referral of selected patients from our Center, we were greatly surprised at the universal agreement on the part of diverse agencies to cooperate. Among those participating are several employment agencies, such as the New York State Employment Service, which agreed to modify its earlier restriction on patients over 21 and make its special placement counselors available to our patients, the Federation Employment Service, Vocational Foundation, Inc. and others. The Department of Welfare set up a liaison person at their Central Office to expedite emergency assistance to Lexington dischargees; the Division of Vocational Rehabilitation accepted our patients for vocational counseling and training; and the Department of Hospitals agreed to admit a limited number of our patients for in-and-out patient treatment, "local hospital conditions permitting." At present, all municipal mental hygiene clinics and a large number of voluntary clinics are prepared to receive selected patients referred from the Center.

In attempting to evaluate the reasons for this preliminary "success"—a success in understanding, we must emphasize, which requires further implementation in practice—we would emphasize the following factors. First, the Demonstration Center offered all possible assurances to agencies to allay their anxiety about working with addicts in the hope that further experience would enable them to accept these patients more freely in the future.

Among the assurances offered were:

(a) Patients would be carefully screened both at Lexington and our Center before referral in the hope of finding and testing out the so-called "best" patients—though our present state of knowledge makes any effort to define criteria of predictability hazardous.

(b) Along with the careful selection of patients, we indicated we would refer only totally abstinent patients in view of agency fears about working with patients who had relapsed to drugs, even where they had taken only one or two shots. It is our feeling that agencies will need to learn to evaluate relapse more dynamically, regarding taking a shot as comparable to an individual's taking a drink to bolster his courage before coming to an agency; or else regarding use during

treatment as a temporary regression similar to other instances of acting out, which can be utilized to enhance the patient's understanding of his behavior and his relationship with the therapist.

(c) Another precaution offered was that only a very small number of patients would be referred.

(d) Finally, we promised that we would be continuously available to the agency for information and consultation.

In addition to the reasons cited, we feel that these agencies' good conscience and desire to help in spite of skepticism and previous negative experiences with this group played an important role. Agencies are increasingly tending to see drug addiction as part of the community's concern with multi-problem, hard-to-reach families whose existence cannot be ignored.

In our work since then, we have been further encouraged by the discovery that we could establish sustained relationships with patients, and also make referrals to agencies that would "stick," given adequate skill, preparation, and care. Our staff members, coming as they did from a variety of agencies dealing with more traditional client groups, began employment at the Center with some skepticism and unwitting negativism about the possibility of helping these patients. In spite of themselves they have been encouraged by their growing ability to reach and to hold patients, help them abstain from use, and make initial efforts to improve their life situations. There has been a growing feeling that addicts can be helped provided caseworkers make the required effort to understand their special characteristics and are willing to use their skills creatively and flexibly to meet the special needs of addicts.

UNDERSTANDING THE ADDICT

Workers have recognized that there are important differences among addicts in such basic aspects as motivation, which must often be stimulated in various ways before patients feel impelled to alter their way of living. They may also have a poorer awareness of time, or else they are so caught up in their customary patterns of compulsive activity, that it becomes difficult to structure regular interviews. If they come hours late, they may evidence no guilt or apparent concern; or expect the caseworker in her role of the all-understanding parent to overlook and forgive the poor behavior.

At other times, there may be excessive guilt and lacerating self-

condemnation for their inability to maintain appointments and schedules. More so, perhaps, than other patients, this group has suffered from the lack of any really meaningful relationships throughout life and they will tell the worker this is the first opportunity they have had to communicate their real feelings and aspirations. The individual face-to-face relationship therefore offers the best means currently known for helping certain addicts. That it cannot provide the answer for all, and that other approaches must be found for other "categories" of addicts, appears equally clear so far as can be judged from our Center experience.

Reports from agencies to which our patients have been referred testify to their appeal, as in the case of one employment agency where the placement counselors, at first resistive and fearful, found themselves becoming more and more drawn to this essentially attractive and unhostile group, bending over backwards to help place them. Employers, too, tended to find them equally appealing, though troubled by the fact that patients could not maintain employment over long periods of time, a situation which underlines the need for a concomitant sustaining casework relationship.

At the risk of being repetitive, we must again mention that these statements are in no way meant to belie the difficulties inherent in working with addicts. Experience has shown them to be a predominantly passive, dependent, poorly motivated group with weak egos and superego "lacunae"; for the most part impulsive and intolerant of frustration so that efforts to reach them frequently resemble a race against time and the needle. As we work with them, a number of stubborn patterns soon become readily discernible in varying degrees —self-defeating trends, magic thinking, unreal aspirations, poor controls and a deficient reality sense, along with numerous blockings in the areas of work, love, and interpersonal relationships.

Fenichel has emphasized the importance of drugs in elevating self-esteem (Fenichel, 1945, p. 377); while Lewin points to addiction as a "manic-depressive" equivalent (Lewin, 1950, p. 40) because of its cycle of elation through use, alternating with depression while abstaining from drugs. Szasz has clarified the "counterphobic mechanism" in drug addiction as in all addictions, stressing its use not only to generate feelings of elation, but also as a device on the part of the patient to test his strength in relation to drugs—a substance he essentially fears (Szasz, 1958).

Our own experience has taught us that patients will also use drugs

to bolster their strength in order to ease the strains of living and help them cope with people and situations; and that diagnosis here, as in other illnesses, cannot be equated with prognosis since some patients labelled schizophrenic may make better progress than a chronic neurotic; similarly, an old-timer with a long-standing history of addiction may respond to help and find the resources within himself to abstain from use, to our surprise and his. Perhaps another point to be mentioned in this connection is the necessity for revising our thinking of addiction as a chronic illness, comparable to TB or diabetes, so that we will not be discouraged by the small figures of cure, but see every improvement as real headway in a severe, multifaceted illness.

While our findings are preliminary, based as they are on only a small number of patients, the fact that our workers have related to some extent has given them strong impetus to continue trying, with increased confidence in their growing experience and skill and a belief that they can manage even better with succeeding patients. And as our own Center proceeds, so we hope will other agencies—experiencing firsthand the possibility of working with this group as with other clients, and accepting responsibility for helping them rather than permitting them to be handled punitively for an illness not of their making.

BROADER CONSIDERATIONS OF TREATMENT

In considering approaches and broader solutions, it must be stressed, finally, that there are no easy answers to the problem of addiction. As Dr. Cooper, Director of Health for the Community Council, said half-facetiously, "We are starting from scratch and everything we do is therefore bound to be an improvement." No one knows all the answers today. We need to experiment with many kinds of services in the community and employ far-ranging research to find ways to reach addicts and evaluate the pros and cons of various plans, each of which entails extensive ramifications and unknowns.

As one example, many workers in the field have suggested setting up half-way houses as an intermediary step between hospital and community. If we establish such facilities, we are confronted with the disadvantage of housing addicts in a common setting where, as a group of impulsives, they may seduce each other to use. Would it

be better to have a mixed group of patients? And can we afford to overlook one of the crucial problems of addicts—that they have never resolved ambivalent feelings towards their families and are not equipped to live alone, for the most part preferring the disturbed home with all its tensions to living away? Half-way house personnel must necessarily include highly skilled professionals, which involves the question of financing. Who should "foot the bill" for such a complex of services? Should we also try night and day centers? We see how complicated any specific proposal can become.

Another question with various pros and cons relates to the problem of voluntary versus mandatory treatment. In view of the known difficulty in holding patients to treatment, mandatory commitment has a certain appeal, but may also offer definite impediments to therapy. It is our belief that a trained staff can hold patients under either system, though our Center utilizes the voluntary approach. If the mandatory approach is used, we hope it could be under mental health statutes and not through criminal procedures which perpetuate the stigmatizing of patients.

Another question frequently debated is the following: Shall we use existing agencies, or is there a need for specialized facilities experienced in work with addicts and known to them so that they feel welcome and understood immediately upon coming in? We are inclined to believe there is a need for all kinds of services; and, in view of the paucity of existing facilities and pervasive lack of knowledge among professional as well as lay people, continuous exploration is needed. There is something to be said, on the one hand, for having wards set up in municipal hospitals in each borough in line with the recent addition of psychiatric wings to general medical hospitals, which is serving excellently to remove the stigma from mental illness, and could be duplicated with drug addiction. But specialized agencies with specific know-how and experience obviously have a role to play at present as our Demonstration Center experience has shown.

Too often, finally, the addict is seen as standing alone, a puzzling attitude in view of the well-established attachment of the addict to his mother in a symbiotic relationship which the mother uses to discharge her own destructive or seductive impulses. The need to work with the entire family would be in line with the growing emphasis on family diagnosis and counseling if we are to understand the real origins of the illness and the means for effecting a cure (the recent

book on this subject by Ackerman, 1958). The question of what constitutes a cure and what are suitable goals in treatment entails a further area of discussion we shall not attempt to enter into here.

Should the clinic plan be tried on a restricted basis as part of a general research program? Can we experiment in testing the effectiveness of various helping techniques—individual versus group therapy; or service on various levels—from employment referral, to vocational counseling, to family casework, and psychiatric treatment? It is hoped that the work community agencies are doing in conjunction with our Center may help provide answers to some of these questions. Meanwhile, we see as one of the most pressing requirements the need for community agencies and the professional disciplines to do some sincere soul-searching in order to free themselves of conventional thinking in relation to addicts, and learn to investigate the feasibility of helping this group. If nothing else can be accomplished than removing the addiction problem from the grip of the law and placing it in the hands of community agencies and medical facilities, a tremendous step forward will have been taken in relation to this most troublesome of social problems.

SUMMARY OF PRELIMINARY FINDINGS OF THE N.Y. DEM. CENTER

Among the Center's findings was the understanding first that (a) there is a need for setting up limited goals which would be more realistic and within the province of these patients. It is important to view addiction as a chronic illness so that any periodic abstinence even for a few weeks or a few months—would be considered a boon to patient, family and community. Total extended abstinence might be a goal beyond realization for most addicts. (b) There is need to be unusually active in relation to addicts, to reach out to these extraordinarily passive-dependent individuals. Efforts must be made to cut through the repetitiousness and "obsessional" preoccupation of addicts with drugs and drug use in the hope eventually of penetrating into more meaningful areas involving communication and expression of feeling. (c) The casework relationship with the narcotic addict is less intense than the usual treatment relationship at the outset; it is not always appropriate, even if possible, for the worker to attempt to "open up" areas of feeling. Rather, the patient may first need to view the worker as a strong helping figure. The relationship should thus be predominantly supportive with the worker assuming an active, directive role. Such a relationship can sustain the client and permit the

worker to provide concrete services with emphasis on the here-and-now, without the patient's becoming involved in exploration of feeling and the development of self-awareness at a deeper level of counseling. (d) Relationships established with patients, though different from the traditional relationships, nevertheless lead them to return repeatedly in each recurring crisis situation in spite of a number of breaks in contact. Relationships needed to be characterized by a good deal of permissiveness in relation to appointments and the manipulative demands of patients. (e) Workers must therefore stop adhering too closely to the idea of regular weekly office interviews. Instead, they would offer casework service on a sporadic, or crisis basis as the patient required, using the crisis to build a relationship, hoping to increase the interval of contact each time the patient returned and help the patient maintain his adjustment for longer periods. It was noted that, even in brief contacts, some seed had been sown; so that the patient later felt impelled to return to the same worker for help in his newest crisis. (f) A long period of preparatory casework ("pre-treatment") is required with patients before they can be considered to be participating genuinely in treatment.

Further Findings—Among some of the later project findings was the fact that, (a) although patients tended to drop out after one or two visits, they frequently returned after an absence of several months or more. Question was then raised whether it might not be possible to hold them for longer periods each time they returned, and help them abstain from using drugs for increasing lengths of time. Subsequently, statistics confirmed the fact that, in initial contacts, workers were holding many patients for many more interviews as against the previous one or two. Workers were also pleased that their diagnostic skill had improved and they could better estimate whether they were reaching a patient and holding him for sustained service. It was clear however that, in most cases, if we established abstinence from drugs as our primary goal it would not be achieved in a straight line. If it happened at all, it would occur through a series of stops and starts, with allowance made for an indefinite number of relapses, slips and other acting-out behavior. Experience taught us that patients often fall back on drugs in an unconscious effort to achieve some balance in their lives, and to bolster their strength in meeting the strains of living and coping with people and social problems. As in other illnesses, diagnosis does not always give a clear indication of prognosis. Even very sick patients, or old-timers with a long-standing history of

addiction may, on occasion, respond to help and find the resources within themselves to abstain from use of drugs—to our and their surprise. (b) We noted that addicts are frequently members of families which may require as much help as the patient himself. Direct work with the addict's family is a sine qua non in any efforts to rehabilitate him. Too often the addict is viewed as a single, unattached individual without reference to his family group. (c) Workers charged with responsibility for rehabilitating addicts and their families need to increase their understanding of the diverse factors contributing to their addiction, including the socio-cultural characteristics of urban lower-class society and the addiction subculture. (d) We need to understand narcotic addiction as a complex, multi-faceted problem which has not responded to traditional rehabilitative approaches. There is a need for small experimental research projects geared to answer a number of outstanding questions before we can hope to "rehabilitate" the narcotic addict.

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Legal Aspects

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In the 1870's in New York City the majority of criminal arrests were of persons allegedly drunk in public places—mostly the hapless immigrants living in utter degradation. In an annual report in 1877, the then President of the Board of Police Justices, referring to this condition, remarked that the source of all crime was alcohol. Were one to view the Felony Court in New York City or the criminal courts of many of our larger cities today, he would be inclined to say that the

source of all crime is not alcohol but narcotics. He would see one charge after another of possession or sale of narcotics, and were he informed as to the background of those charged with shoplifting, petty larceny, and prostitution, he would know that in case after case the defendant was a dope addict.

The President of the Board of Police Justices in 1877 was of course making a most superficial analysis of his problem. It is submitted that the emphasis on drug addiction with reference to the current judicial drama is equally superficial. In each instance, whether it is excessive drinking or the use of drugs, alcohol or dope is characteristic of the individuals before the court. Perhaps drunkenness and addiction are symptomatic of the problem before the court, but they are not the problem. In each instance we are dealing with individuals who are socially and emotionally inadequate—individuals who are seeking an adjustment through the use of either alcohol or dope to a society that to them is bewildering. In any event, we are not apt to solve the problem by confining our reflections merely to their antisocial use of the drug, be it alcohol or morphine.

LEGAL APPROACH TO ADDICTION

The unscientific approach of society to the problem of excessive drinking is an age-old one. Our present policy toward drug addiction is relatively new. Up to 1914 in the United States there was virtually no legislation on the subject. At that time, however, various individuals and groups were becoming increasingly alarmed about the addiction to narcotic drugs. They felt that something should be done about it, and that something they felt should be to pass a law. The law which they inspired is the Harrison Act, which to this day forms the cornerstone of American legislation with respect to narcotic drugs. Properly interpreted, the Harrison Act is sane and intelligent legislation. It is not a criminal statute. It is more in the nature of a regulatory statute. Using the taxing power, Congress sought in the Harrison Act to regulate and control the distribution of drugs. Those who, like myself, are rather critical of society's attempts to solve everything by passing a criminal statute, do not in the main have any serious quarrel with regulation. In many instances where a penal statute is not morally justified, nonetheless there is warrant for and it is wise to pass statutes that regulate conduct. This is certainly true in the field of narcotics.

Nonetheless, I am sharply critical of American policy toward drug

addiction. One may well inquire, if the Harrison Act is the cornerstone of existing legislation and it is not prohibitory but rather regulatory, why then is there a quarrel? The answer is simple. Whereas the Harrison Act is in fact regulatory in nature, the United States government interprets it as criminal and prohibitory in nature. Frequently, and certainly in this instance, bureaucratic policy can be of more significance than the actual legislation on which the policy pretends to be based.

The Harrison Act was, as above stated, passed in 1914. World War I almost immediately ensued, and the law remained largely dormant until after World War I. At this period considerable public opinion began to develop regarding addiction. By 1920, in many quarters at least, it verged on the point of hysteria. There were various exaggerated and disturbing reports. A committee of the Treasury Department itself reported that throughout the United States there were a million addicts. It is doubtful that anyone really knew how many addicts there were at that time. Certainly we do not know today, but it is generally agreed that the figure quoted was preposterous. Nonetheless, this report and other statements intensified the hysteria that was developing.

Inevitably the hysteria spread. The medical profession was not immune. The leading members of the American Medical Association became particularly concerned regarding the relatively few individuals in their profession who were exploiting the situation. In the nature of things, there were a few people in the medical profession who were virtually abandoning the practice of medicine, and exploiting their license to practice, becoming criminal entrepreneurs. This was unfortunate but a not uncommon human phenomenon. It was not viewed, however, as such by the organized profession but rather as something that might seriously discredit the entire profession. It called, in their opinion, for no ordinary measures. The officers of the American Medical Association were prepared to go to any lengths to remove the blot on the integrity of the profession. They urged vigorous action on the part of the authorities. They urged the Treasury Department to seek an interpretation of the Harrison Act that proscribed doctors from administering drugs in the course of therapy. They found willing allies in those charged with the enforcement of the Harrison Act.

Buttressed by inflamed public opinion, these men and the government lawyers sought rulings that would ban the medical profession from having anything to do with drug addicts. Thanks to public

opinion, they were successful not only in the trial courts but even in the appellate courts. In three successive decisions, the Supreme Court of the United States—even though it was only by a divided vote—gave considerable support to their position. Inevitably, however, public opinion subsided in the course of time, and eventually another decision involving the criminal conviction of Dr. Charles O. Linder came before the Supreme Court of the United States in 1925. By this time the Supreme Court, having regained its balance, had begun to realize that it was veering in the wrong direction and expressly stated that the prior rulings were to be confined to the facts then before the court—a judicial way of overruling them—and unanimously reversed the conviction of Dr. Linder. It said:

> It (the Harrison Act) says nothing of addicts and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for medical treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purpose solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction.

GOVERNMENT POLICY TOWARD ADDICTION

One may well ask, what then is the difficulty since the court straightened out the matter? The difficulty lies in the fact that the court initially gave considerable support to the policy of the Treasury Department, and that by 1925 this Department had literally terrorized the doctors away from the treatment of addicts. When Dr. Linder's case came before the Supreme Court in 1925, any doctor worthy of his name had ceased to minister to those addicted to drugs. One lonely decision of the Supreme Court was of little comfort to them when the Treasury Department proceeded to ignore the Linder ruling and continued to assert policy in accordance with the prior rulings. Indeed, the Treasury Department asserts that policy to this very day.

A lawyer may well advise a doctor that the law of the land sanctions the use of his medical discretion in dealing with an addict and indeed does not proscribe him from administering drugs if in his medical opinion that is the intelligent course of therapy. Whether it be the opinion of a single lawyer, however, or indeed the opinion of the entire legal profession, this avails a doctor little in the face of the attitude of the Treasury Department. With this outspoken policy, a

transgression of the policy confronts the doctor with the possibility of indictment with all of the humiliation and expense inherent in criminal litigation, and of course the possibility of limited or prolonged incarceration. No self-respecting doctor is inclined to be martyr enough to undertake all this aggravation for the cause of the drug addict. And so, regardless of what the law of the land may be, the policy of the United States government continues to effectively proscribe doctors from practicing their profession when it comes to drug addiction.

THE PATHOLOGY OF DRUG ADDICTION

Why is this so serious a matter? Drug addiction is a pathological problem. The addict not only uses drugs to excess but he has a pathological craving for these drugs which in large measure or entirely transcends his free will. Only with the grace of God and the help of his fellow man can most addicts resist the use of narcotics. The addict is going to get his drugs regardless of the barriers.

Not only is addiction pathological in nature, but it is symptomatic of a much more deep-seated and complex pathology. It is a reflection of the fact that the individual is emotionally and socially disturbed from a fundamental standpoint. Not only does each addict differ widely from the next addict from the standpoint of his use of drugs, but he differs more widely with respect to the underlying pathology which makes him addiction prone. In the nature of things, the medical practitioner should be addressing himself primarily not to the pathological addiction but rather to the underlying cause.

Were an addict to visit a doctor, the doctor's first problem would be to determine why there is addiction. If the addict is in a condition in which he is craving drugs or going through withdrawal symptoms, he is not in a condition in which the doctor can establish rapport. The doctor can hardly at that time begin to establish a relationship of confidence that would enable him to probe and determine what disturbs his patient. It may well be that, before he is to begin his therapy, he will have to create a greater degree of tranquility. It may well be that he must administer to the patient limited quantities of a narcotic drug. In any event, whether this procedure is indicated or not is a medical question and not a question either for the lawyer or for organized society. There are those among us—the medical doctors—who through schooling and experience are more

qualified to make use of the medical and related sciences. They are licensed to do so, and this license should not be so limited.

Again, why is this so serious a matter? Prior to 1920, were an addict to knock on the doctor's door, the doctor would have felt perfectly free to approach his various problems. Since that time, however, it has become increasingly the attitude of the federal government that the doctor will deal with the addict at his peril, particularly if his medical judgment indicates to any degree that there should be either temporary or prolonged administration of drugs. The medical profession has withdrawn from administering to the addict. No longer can an addict present his complex enigma to the medical practitioner. He has learned that the medical door is closed to him. He must seek his solace and comfort elsewhere.

THE NARCOTICS RACKETEER

This situation began to confront the addict in the 1920's. This was a time when the criminal element had begun to find tremendous financial gains from our hypocrisy in a related field, namely, the sale of liquor. Organized crime, which had begun to prosper under prohibition, was in existence to take advantage of our hypocrisy with regard to drugs. Its members soon perceived that, despite the risk inherent in smuggling, their reward would be considerable. We were providing them with a hard core of addicts, be it the one million referred to by the committee of the Treasury Department or a much lesser number, people who simply had to have their drugs from one source or another. We had stopped the legal source. Were organized crime to engage in smuggling, it was certain that these people would buy their drugs. Worse than this, they were soon to find that these pathetic addicts in many instances would have no recourse but to distribute the drugs for them in order to meet the new black market prices. In order to sustain himself, an addict was soon to find that he had no recourse but to become a pusher. The real narcotics racketeer found that he subjected himself to relatively small risk of detection and that the kind of activity that would result in arrest would in the main be performed by the addict pushers and small fry. Thus we have the drama in a city like New York of increasing arrests annually to a point where arrests last year for possession and sale amounted to some seven thousand, virtually all of the defendants being people who are slaves to drug addiction.

COMMUNITY HELP FOR THE ADDICT

What escape is there today for the drug addict? Assuming he has a degree of free will, assuming that he has the motivation and the desire to seek a cure, where is he to go? Can he be cured? Are there institutions that will provide help? There are few medical problems about which there is less human knowledge. None of those who are really competent in the medical and related sciences profess to have any cure. Indeed they admit to ignorance on some of the most elementary facts of addiction. They have not had experience with the drug addict, in measure because of federal policy. There is, for example, a growing impression that a substantial percentage of drug addicts mature out of addiction without help in a period of ten or so years. But the curious fact is that whether or not this is so is not known. We have a mere theory or hypothesis but we have no scientific data. Indeed, we have not had clinical or other experience on elementary aspects of the problem. Nor, indeed, do we have the facilities to help. In the main, we have the federal institutions at Lexington, Kentucky, at Fort Worth, Texas, and the New York City institution at North Brother Island. The federal institutions make no claim to any substantial cures. They say rather that, since they do not have the means to conduct a follow-up, they do not know whether anyone is really cured or not. There are isolated reports of addicts who have been treated at these institutions and who no longer use drugs. The reason, however, is unknown, and the number of these reports is relatively insignificant. Moreover, it is a fact that over two-thirds of those who go to Lexington, Kentucky, the principal federal institution, voluntarily leave there in less than 30 days. Most of the remainder leave in a relatively short time thereafter. Whether this is a reflection on the institution or not, it is manifest that the institution can accomplish little or nothing in that period of time.

The institution at North Brother Island conducted by the City of New York is confined to those under 21 years of age. It has been, from the outset, of an experimental nature. It has never been claimed that it has been successful, and it is presently scheduled to be abandoned. It is suspected that one reason for its scheduled discontinuance is that it is even more difficult to help the young addict than the adult addict. A process of maturation, of course, cannot have set in, nor does the addict have the motivation that he might later have.

THE PROBLEM OF HELPING THE ADDICT

I am reminded of a long distance telephone call that I received several years ago from a priest who is attending this conference. He was telephoning to confirm certain impressions that he already had. This priest has long been interested in problems of addiction so that he had a considerable degree of competency to make his own determination, but he sought the opinion of another person. He related that he had been assigned to parish work in New York City many years before and had known a family that included several young boys. One of them had just telephoned him from New York City telling how one of his brothers, then aged 22, had been acting strangely. The family had increasing misgivings and were now convinced that he was addicted to drugs. They wanted advice and help.

The priest's immediate reaction was somewhat negative. We discussed the availability of Lexington, Kentucky. We dismissed this possibility, first because it is a voluntary institution and the young man had not even yet acknowledged that he was an addict, and we had no reason to believe that he could be persuaded to go to the institution. Moreover, neither one of us had any confidence that the institution would help in solving his problem. North Brother Island was unavailable because of the young man's age. Manifestly, the priest could not urge the parents to have the young man see his physician. The doctor, because of lack of experience, would be ignorant of the problem, and moreover he would be reluctant even to see the young man. The priest mentioned the police but himself volunteered that the only efficacy of having the matter referred to the police would be to make the young man a stool pigeon to participate in a questionable enforcement program that might be intensifying rather than solving the problem. The priest received from me confirmation of his own analysis but no additional guidance. Were I to receive a telephone call of this nature today from any one of you, the conversation would not be different from that of several years ago.

St. Thomas Aquinas taught us that human law must be based on the moral law, but that it is not the function of human law to put its sanction behind all of the moral law. He taught, rather, that the function of the human law was very limited, that it was to implement the moral law only in that relatively narrow sphere of activity where violations of the moral law have a substantial impact on the common

good. It is not the function of the human law to make saints out of men. Sanctity is much more an individual affair. Human law is rather designed to create a situation where the individual himself is free to use his own best efforts to attain his individual sanctity.

Recently the Most Reverend William Godfrey, Archbishop of Westminster, England, was called upon to comment on the Wolfenden Report on homosexuality. He made a statement which I am taking the liberty of quoting at length because of his relatively brief and fine exposition of Catholic doctrine in a related field:

> In view of the inquiries which have reached the Archbishop's House following the publication of the report of the Home Office Departmental Committee on Prostitution and Homosexuality, the Archbishop of Westminster has laid down the Catholic moral teaching and how it applies to the facts discussed in the Report.
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> 1. As regards the moral law, Catholic moral teaching is:
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> (i) Homosexual acts are grievously sinful.
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> (ii) That in view of the public consequences of those acts, e.g., the harm that would result to the common good if homosexual conduct became widespread or an accepted mode of conduct in the public mind, the civil law does not exceed its legitimate scope if it attempts to control them by making them crimes.
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> The teaching authority of the Bishops is primarily concerned with laying down these two principles of *law* which cannot be denied by any Catholic.
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> 2. However, two questions of fact arise:
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> (i) If the law takes cognizance of private acts of homosexuality and makes them crimes, do worse evils follow for the common good?
>
> (ii) Since homosexual acts between consenting males are now crimes in law, would a change in the law harm the common good by seeming to condone homosexual conduct?
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> Ecclesiastical authority could rightly give a decision on this question of fact as well as on the question of the moral law, if the answers to questions of fact were overwhelmingly clear. As, however, various answers are possible in the opinion of prudent men, Catholics are free to make up their own minds on these two questions of fact.*

It is certainly evident that, from an objective standpoint, we may in the field of narcotic addiction have violations of the moral law on

* This statement appeared originally in the London *Catholic Herald* for December 6, 1957. It is quoted by *America* in connection with the article: Connery, J. R. (S.J.) A theologian looks at the Wolfenden report. *America,* 1958, *98,* 485-486.

the part of the addict. Even indeed from a subjective standpoint I am not unaware that the addict may be sinning to a lesser or greater degree. And I am also ready to admit that his addiction can well have an impact on the common good. But as the Cardinal points out, there are certain other questions of fact that must be determined, particularly with respect to problems such as this, where the impact on the common good is relatively little. These questions ask whether human experience indicates that the enforcement program will be effective, and whether the enforcement program does not have a distinct tendency to corrupt the enforcement officers and to create other evils of a positive nature. I submit that the experience of the United States has abundantly demonstrated that a prohibitory approach on this subject will inevitably be largely futile and that it will do much positive harm.

In England a similar error has not been made. There are reputed to be in all of England proper but 300 to 400 known addicts. This doubtless is in part due to a difference in culture, but I believe it is also in good measure due to greater sanity. An addict is perfectly free to go to a medical doctor with his problems. The doctor in turn does not have the long arm of the law clutching at him to determine the nature of his medical approach to his patient's problem. There is not, therefore, a market for the criminal racketeer such as exists in the United States.

I am reminded of the reply of Dr. Herbert Berger, one of the leading medical spokesmen on the subject of narcotics in the United States today, with reference to a problem such as that posed to me by the priest from northern New York. Dr. Berger stated that he had been called upon to deal with problems of this nature on occasions, and from time to time that he had been able to help the addict. He related that, where the ethnic origin was appropriate, he had counseled having the addict emigrate to Italy or to Israel or to England, but Dr. Berger went on to say that, if he were called upon to help the ordinary addict in the artificial culture existing in the United States, he was as baffled as anyone in his audience.

This is a problem of human degradation that cries out for human tolerance and Christlike charity. We must re-assess our approach to this problem.

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