Problems of ADDICTION *and* HABITUATION

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THE PROCEEDINGS OF THE FORTY-SEVENTH ANNUAL MEETING OF THE AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION, HELD IN NEW YORK CITY, FEBRUARY 1957.

GRUNE & STRATTON

NEW YORK • LONDON • 1958

Library of Congress catalog card number: 58-11835

Printed and bound in the United States (A)

PREFACE

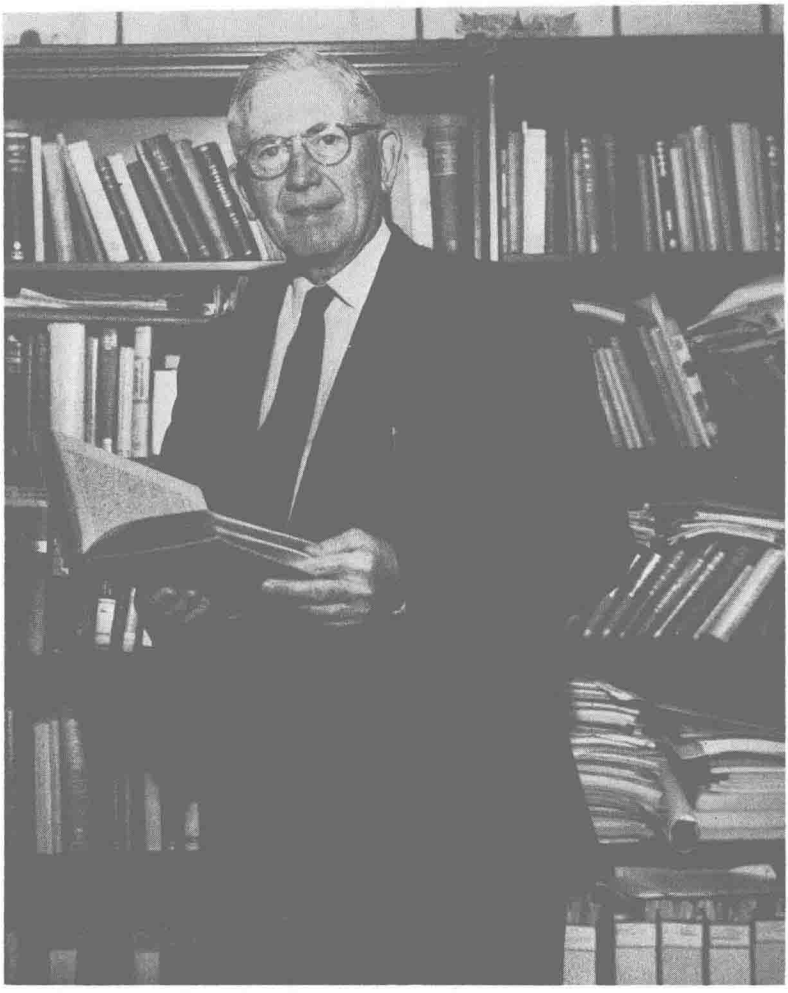
THE PROBLEMS PRESENTED BY ALCOHOLISM AND DRUG ADDICTION are very important in the field of deviant human behavior, both in their extent as well as in their harmful effects. Unfortunately, the actual prevalence is difficult to gauge because of the many social taboos that surround the problem.

The attempts to deal with the problem range from the punitive to the therapeutic, but the problem of finding the most suitable treatment to each specific case has not yet been solved.

This symposium was organized for the purpose of permitting the representatives of the different approaches to meet face to face, so that some of the issues could be clarified by a personal interchange. Addiction was broadly defined to include not only the narcotic drugs but such stimulants as coffee and pica.

As a result of this symposium, it is hoped that a better understanding of the problem can be reached and that research will be stimulated in order to find better therapeutic methods than those which are available today.

THE EDITORS



KARL MURDOCK BOWMAN

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Samuel W. Hamilton Memorial Lecturer, 1957

WRITING A BIOGRAPHY is a precarious business. The greatest men often have the shortest tributes—their real life is in their accomplishments. And yet a brief biography may well be remiss in the omission of much of true importance. On the other hand, prolixity may well obfuscate true values in a deluge of minor and meaningless superficiality. Worse yet, the author of a biography written in a select monograph exclusively for psychopathologists may in his verbal utterances open the door for a searching examination of his own bias, projected thoughts, and pathologic peculiarities. Considering all these hazards, however, an opportunity to write a biography of Dr. Karl Murdock Bowman is worth the risk.

His life history began November 4, 1888, in Topeka, Kansas, the alleged geographical center of the U. S. In 1909 he received an A.B. from Washburn College and then his M.D. degree in 1913 from the University of California Medical School. After interning, both in Los Angeles and in New York (he was apparently a peripatetic student), he began studying his specialty at Bloomingdale Hospital in New York. From 1917 to 1919 he was in the military service overseas, following which he returned to Bloomingdale for a period and then moved to become the Chief Medical Officer of the Boston Psychopathic Hospital in 1921. Migrating again in 1936, he was appointed Director of the Division of Psychiatry at Bellevue Hospital and Professor of Psychiatry at the New York University College of Medicine. His restless feet caught up with him in 1941, and he returned to his old medical school to assume the responsibilities of Professor of Psychiatry at the University of California School of Medicine and Medical Superintendent of The Langley Porter Clinic, San Francisco. In 1956 he retired as Professor Emeritus.

During these many years he achieved a vast array of honors and fellowships starting back in 1920 when he was awarded the Wellcome Silver Medal and Prize by the Association of Military Surgeons of the United States for a study, "The Relation of Defective Mental and Nervous States to Military Efficiency," published in the *Military*

Surgeon. Since then honors and awards have been frequent; they include the degree of Doctor of Science from his alma mater in Topeka, honorary life membership in the Philippine Mental Health Association, and the Selective Service Medal for his work in this field in World War II.

Professional accomplishments include membership on the editorial boards of the *American Journal of Psychiatry, Quarterly Journal of Studies on Alcohol, California Medicine, Quarterly Review of Psychiatry and Neurology,* and *Geriatrics.* His capacities as an editor were obviously gained directly from his great experience as an author, and his list of learned publications numbers 171 separate contributions.

A survey of this massive bibliography reveals the broad capacity, widespread curiosity, and investigative diligence of the man. We find, among many other works, articles dealing with problems of war, special studies on endocrinology in relation to mental disease, evaluations of industrial aspects of psychiatry, detailed researches on alcohol and its problems, clinical appraisals of child psychiatry, studies on marihuana and other drugs, penetrating observations on sexual deviation, appraisals of the role of religion in psychiatry, and reports of psychiatric problems in the Far East.

His colleagues recognized his broad capacities and administrative skills by electing him President of the American Psychiatric Association for two consecutive years, 1944-1946.

His broad vision is apparent in a quotation from "The Trimble Lecture" which he presented before the Medical and Chirurgical Faculty of Maryland in 1941:

> The problem of psychiatry is more than simply preventing or treating mental disease. There is the positive attainment of robust mental health. It is not sufficient that a man is not mentally sick; one wishes him to obtain the optimum degree of mental health. Leaving out definite cases of mental disease, there are still many persons whose efficiency is hampered and whose happiness is thwarted because of their inability to attain a good level of mental hygiene in the community. If we understand how to secure the ideal of mental health for the individual, we shall have a rather good understanding of how to secure a high grade of morale for the community. In fact we may say that what we call the personal problems of the individual for the attainment of good mental health are also the community problems for the attainment of good morale.

This viewpoint that psychiatry is more than just treatment has been uppermost in his thinking throughout the years.

His philosophy, developed through the years, touches almost every field of human thinking, as, for example, in his 1946 Presidential Address to the A.P.A. he strikes boldly at many commonly held misconceptions:

> Unfortunately at the present time the idea is growing that the Government is responsible for everything, and that we have no responsibility either for our own condition or for that of our fellowman. Such a philosophy will inevitably lead to a type of collectivism in which a limited few will dominate the behavior and thinking of the many. This trend is neither new nor progressive. Actually it is a regressive tendency; a return to a more primitive and archaic social organization, which will inevitably lead to the same injustice, tyranny and suffering which have existed recently in Germany and Italy. In spite of this many persons of the so-called intelligentsia wish to develop this type of organization and cannot see what the consequences will be.

Again, his broad and challenging viewpoints are expressed in a paper, "Psychiatry in China," in which he writes,

> I would conclude that no fundamental personality difference exists between the Chinese and other racial groups. The problems of mental health and mental disease are in general the same in China as elsewhere. All types of mental disorders from the milder psychoneuroses to the more serious functional and organic conditions are found. In the absence of any statistical study as to the incidence of mental disease in China, it is impossible to specify the degree to which these conditions are present. It is my impression, however, that they are much more frequent than is generally conceived, and that if careful statistical studies are made it will be shown that the incidence of mental disease in China is not greatly different from its incidence in the United States or the rest of the world.

His writings are always clear and to the point, combining skillful use of data with clarity of thinking and frequent bits of suddenly introjected, subtle humor. For example, in the midst of an excellent discussion on Philippine psychology and culture, he introduces a small paragraph: "The Filipinos use large amounts of garlic in their food, and one sees in the local newspapers advertisements in which the government requests bids to furnish a certain number of tons of garlic to be purchased under United States aid. I would respectfully suggest that Congress cut this item from its aid to the Philippines."

In his private life he has been most happy with his family: his wife, the former Elizabeth Abbott Stearns, and his four children, Richard, Thomas, Murdock, and Walter. These last two have followed in their father's footsteps to medicine. His public life has been equally successful. A paternal counselor to his students, a stimulative worker with

his colleagues, an administrator of great capacity, he has been of proven value to all who have been his associates. May he be granted many more years in his "retirement" (where he works just as hard as ever) to continue his contributions to the advancement of his chosen specialty.

DOUGLAS M. KELLEY, M.D.
(Deceased, January 1, 1958

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1

NARCOTIC ADDICTS: PERSONALITY CHARACTERISTICS AND HOSPITAL TREATMENT

By ROBERT W. RASOR, M.D.*

THE PREMISE with which we start is that narcotic addiction is an illness producing psychological and usually physical dependence on the addicting drug. It is an illness of the total personality of an addicted individual. Although this concept has existed for a considerable period of time, many people still feel that narcotic addicts are "hoodlums" and not different from other individuals displaying antisocial or asocial behavior. However, the concept of drug addiction as an illness is generally accepted by the medical profession.

The U. S. Public Health Service Hospital at Lexington, Kentucky, specializes in the treatment of narcotic drug addiction. It is operated with the same medical philosophy as most mental institutions, although it has some prison-like aspects. About 55 per cent of the patients at any time are Federal prisoners. Only about 12 per cent of the admissions, however, are prisoners, since many patients are admitted on a voluntary basis. Each medical officer in charge has been a psychiatrist and has utilized psychiatric knowledge in the care of all patients who come to the hospital. Many individuals ask why drug addiction is considered a mental disorder, and what, if anything, it has in common with other psychiatric illnesses. People addicted to drugs suffer as do patients with other mental disorders. Those closely related to the addict, such as his loved ones, also suffer. An addict, by accepted definition, is a person who has lost self-control with reference to a drug and uses it to such an extent that he or society suffers, or they both suffer. In this respect he is like other patients with mental illnesses. In addition, he requires someone else to initiate control over narcotics for him until he is able to exercise such control himself.

Those who accept the premise that drug addiction is a mental disorder have studied the disease process in addicted patients. This has

*U. S. Public Health Service Hospital, Fort Worth, Texas.

involved detailed studies of such individuals from many standpoints, including the genetic, physiological, biochemical, psychological, and environmental. This clinical approach has proven quite productive in the study of other disorders. It seems only reasonable that if given a fair trial it would be helpful in understanding the problem of addiction that is so destructive to the individual, and which is also symptomatic of social disorganization when it involves a significant number of people.

The psychiatrist is interested in studying everything that has played a part in the addict's development. He is concerned with the compulsive urge that drives the addict to take the toxic agent, an urge that is felt more strongly than the appetite for food, love, or sex. Drugs themselves do not make a drug addict any more than alcohol makes an alcoholic. It is only when this compulsive urge has developed to such an extent that the individual loses the power to control it, and all his personal resources are directed toward obtaining the drug, that the state of addiction may be said to exist.

The psychiatrist is also vitally concerned with "physical dependence." This refers to the fact that after a period of drug use, abrupt withdrawal of the agent is followed by the development of an "abstinence syndrome" which is associated with measurable physiological changes and which is promptly reduced in intensity by administration of sufficient amounts of the drug in question or of equivalent drugs.[1] Initially after trying the drug, the addict may have the impulse to take it to create the altered psychological state produced by the agent, but after physical dependence develops his urge is reinforced by the desire to avoid the unpleasant physiological effects of the abstinence syndrome. It is only when some of the personal resources and energy of the individual can be redirected toward goals or interests other than narcotics that a process of recovery may be started.

The question always arises as to what type of person is a drug addict. In an effort to place those addicted to drugs in the various diagnostic categories, most of the psychiatric diagnoses have been used.[2] A consistently small group is psychotic. Another small group is classified as neurotic; individuals composing this group have symptoms that are similar to those of almost any group of neurotic patients, with anxiety predominating. The largest group now seen at Lexington is classified under "character disorders"; this includes the asocial, the

immature, the inadequate, the unstable, and the passive-aggressive individuals. At the end of the scale there would be some, although very few, who might be considered "normal."

A rather large number of the white patients seen at the Lexington Hospital allegedly had been started on narcotics by physicians. Rayport[3] found that 27 per cent of the white patients stated that they were first introduced to narcotics by physicians because of their physical complaints during the course of an illness. Only 1.2 per cent of the colored patients gave this history. This rather large group of white patients consists for the most part of older addicts, the average age at the time of admission being 47.4 years. If the illness had been self-limiting, the patient continued to use the drug after the illness had run its course, or if it had been a chronic disease process, the individual continued to use the drug supposedly for the relief of his symptoms. In a controlled, drug-free environment, Rayport[3] found that these patients were successfully freed from their physical dependence, and of those who remained in the hospital for a period of 100 days, 84 per cent felt well while receiving only specific medication and non-addicting analgesics.

A great many patients are given addicting drugs during the course of an illness or as a result of a surgical procedure or a serious injury. Although we do not have statistics as to the number of such patients, it can be safely assumed that the vast majority of them never develop an addiction to drugs. Certainly, most of them have their medication discontinued by their physicians when the symptoms subside and never again resort to the use of addicting drugs.

Psychiatric case studies on the individuals who state that their addiction was initiated by a physician during the course of an illness indicate that such individuals seem to have been predisposed to addiction because of their personality structure. In drugs, they found a satisfaction or a release from tension that nothing else could provide. After experiencing this satisfaction they found it difficult to do without it. Such patients usually have little tolerance for pain or discomfort of any type. They are a very self-centered group of people who become quite upset when their needs are not satisfied immediately. The physician plays a vital role in the onset of this type of addiction. He should be aware of the emotional needs of his patients and not limit himself to the treatment of physical pain or discomfort.

Another large group of addicts, and a group that has increased in recent years, is composed of individuals addicted to heroin. A high percentage of this group is Negro. For the most part, they come from the northern metropolitan areas and account for the increase in the number of younger addicts seen at this hospital and for the wide publicity which has been given to this social problem. There are, no doubt, many factors responsible for the increase of addiction to heroin. First of all, the drug must be available. Secondly, there are usually signs of personality disorganization and social conflict in this group of people who become addicted. Sociological studies by Chein and others[4] indicate that the young addict from metropolitan New York comes from the most socially deprived areas of the city, the areas of greatest congestion and of greatest family disorganization. These are also areas with very high incidence of minority group populations. Sociological factors are of the utmost importance, and we are only beginning to understand some of them. However, even when drugs are available in these environments, Chein found, only a small number use the drug and a still smaller number become addicted.

Why do some individuals develop the compulsive urge for this particular drug? Here again the psychiatrist would say that the individual is predisposed to addiction. For him drugs appear to have a very special significance. They appear to satisfy a very basic need. They provide a type of satisfaction which he has not been able to provide for himself in a more realistic manner. Normally, few means are at our disposal for distorting our perceptions of reality. In our sleep we do so. The psychotic patient demonstrates a distortion of his perception of reality when he takes a flight into fantasy. Another way reality is distorted is by the use of toxic agents such as narcotic drugs and alcohol. Many patients will tell you that life looks much better to them while they use drugs. Disagreeable situations do not seem quite as important. Once this means of altering perception by means of drugs has been experienced, it is difficult for the addiction-prone individual to forego.

Most addicts do not hold themselves in very high esteem. When they are off drugs they feel inferior or inadequate. This is particularly true as it relates to masculinity or femininity. Drugs will enhance their self-esteem; they like themselves much better on drugs and feel that they perform in a more acceptable manner. This is seen in the

musician who may be dissatisfied with the music he is producing when not on drugs, but who may feel when taking them that his music is of much higher quality. These individuals have never reached the level of independence where self-esteem has its foundation in the subject's own achievement. They have a sense of security only when they feel themselves loved, supported, and protected. Such people have few meaningful relationships with loved ones, and once addicted they break these fragile relationships. When such important love relationships are abandoned so readily it is usually because they have never been established in a secure manner originally.

In studies by Drake and Cayton,[5] and Spinley,[6] of family groups in slum areas, it is reported that the family lacks solidarity, consistent affection, and care. Meyers[7] and Chein[4] indicate that a great preponderance of addicts in the large cities are from slum areas and have this form of family life.

Drug addiction is also considered to be a means of discharging unconscious hostility. This may be directed against the self, against loved ones, or against society in general. For the individual, it may represent a form of self-destruction. It may be a form of partial suicide; it may also be a means of punishing others. Time and again this battle goes on within the family, usually between the parents and a child. Drugs are the weapon which the "child" may use to bring suffering to the parent. Quite often addiction seems to be a mechanism for rebellion against society. The addict patient often feels that society is responsible for the position that he is in and he rebels against it. In this regard recent MMPI studies by Hill and others[8] showed that group profiles are very high on the Psychopathic Deviate Scale, indicating, perhaps, the presence of a marked degree of hostility.

Some people seem to become addicted in an attempt to avert a depression. Depressions commonly start following the loss or the threatened loss of a love object. This may be a real loss of a loved one, of prestige, of finances, or of position, or almost anything that threatens the security of the individual. Instead of going into a depression, the person may become addicted if drugs are available. The addict is then able to disregard his loss and, as long as he is able to maintain his addiction, may show no signs of depression. However, if the drug is withdrawn, symptoms of depression may occur. Some observers[9] feel that all forms of addiction are a disguise

for depression. The MMPI studies mentioned also provided test evidence that depression is quite marked in the white addict profiles and somewhat similar in elevation to that found in alcoholics.[8]

Most individuals addicted to drugs are considered very self-centered and narcissistic. They are interested only in the satisfaction of their own primitive needs. This is a very infantile form of behavior. It is acceptable in infancy, but not in an adult. These individuals have not matured in a healthy way. They do not accept mature roles; they make poor husbands, wives, fathers, and mothers; they are poor sexual partners because their sexual development has been retarded. They experiment with many types of sexuality but usually cannot fulfill a mature heterosexual role. They are not interested in giving to anyone. They are interested only in receiving.

Gerard and Kornetsky,[10] who investigated the general social and psychiatric characteristics of male adolescent opiate addicts, believe that all their subjects were seriously maladjusted. Their study was carried out on 32 consecutive voluntary or Federal probationary patients admitted to the U. S. Public Health Service Hospital, Lexington, who had not reached the age of 21. The authors felt that the sample was representative of the young male addicts seen at the hospital and also those seen at the Riverside Hospital in New York.

From their interviews and independently formulated interpretations of projective tests, they found it useful to place the patients into various diagnostic categories. Unfortunately, their diagnoses are not in the usually accepted categories and have little value for comparative purposes. However, after placing these individuals in the various psychiatric categories they felt that all members displayed a common patterned disturbance or a "syndrome" of characteristics consisting of: (1) dysphoria; (2) problems of sexual identification; and (3) disturbance of interpersonal relationships.

In a later study Gerard and Kornetsky[11] undertook to compare the addict subjects previously studied at the Public Health Service Hospital with a control group of adolescents. The control subjects were required to meet the following criteria:

1. Residence in census tracts from which minors had been referred to the Magistrates' Courts for drug-connected charges from January through October, 1949, in the City of New York.
2. Age over 16 and under 21.