

Current Notes

Phases of Alcohol Addiction, by E. M. Jellinek

In 1946 E. M. Jellinek, on the basis of a questionnaire study of members of Alcoholics Anonymous, first formulated his concept of phases in the drinking history of alcoholics. With the original publication¹ of this concept Jellinek outlined a more detailed questionnaire, which in the intervening years has been administered to some 2,000 alcoholics. The elaboration of the phases concept resulting from analysis of these additional materials has been presented by Jellinek in lectures at the Yale Summer School of Alcohol Studies (July 1951 and July 1952) and at the European Seminar on Alcoholism (Copenhagen, October 1951). The summary of these lectures, as published under the auspices of the Alcoholism Subcommittee of the World Health Organization,² is reproduced here in full.

INTRODUCTION

Only certain forms of excessive drinking—those which in the present report are designated as alcoholism—are accessible to medical-psychiatric treatment. The other forms of excessive drinking, too, present more or less serious problems, but they can be managed only on the level of applied sociology, including law enforcement. Nevertheless, the medical profession may have an advisory role in the handling of these latter problems and must take an interest in them from the viewpoint of preventive medicine.

The conditions which have been briefly defined by the Subcommittee as alcoholism are described in the following pages in greater detail, in order to delimit more definitely those excessive drinkers whose rehabilitation primarily requires medical-psychiatric treatment.

Furthermore, such detailed description may serve to forestall a certain potential danger which attaches to the disease conception of alcoholism, or more precisely of addictive drinking.

With the exception of specialists in alcoholism, the broader medical profession and representatives of the biological and social sciences and the lay public use the term "alcoholism" as a designation for any form of excessive drinking instead of as a label for a limited and well-defined area of excessive

¹ JELLINEK, E. M. Phases in the drinking history of alcoholics. Analysis of a survey conducted by the official organ of Alcoholics Anonymous. (Memoirs of the Section of Studies on Alcohol, Yale University, No. 5.) *Quart. J. Stud. Alc.* 7: 1-88, 1946. Published also as a monograph (Hillhouse Press, New Haven, 1946) under the same title; the monograph is now out of print.

² Expert Committee on Mental Health, Alcoholism Subcommittee, Second Report. Annex 2, The Phases of Alcohol Addiction. World Hlth Org. *techn. Rep. Ser.*, No. 48, Aug. 1952.

drinking behaviors. Automatically, the disease conception of alcoholism becomes extended to all excessive drinking irrespective of whether or not there is any physical or psychological pathology involved in the drinking behavior.

Such an unwarranted extension of the disease conception can only be harmful, because sooner or later the misapplication will reflect on the legitimate use too and, more importantly, will tend to weaken the ethical basis of social sanctions against drunkenness.

The Disease Conception of Alcohol Addiction

The Subcommittee has distinguished two categories of alcoholics, namely, "alcohol addicts" and "habitual symptomatic excessive drinkers." For brevity's sake the latter will be referred to as nonaddictive alcoholics. Strictly speaking, the disease conception attaches to the alcohol addicts only, but not to the habitual symptomatic excessive drinkers.

In both groups the excessive drinking is symptomatic of underlying psychological or social pathology, but in one group after several years of excessive drinking "loss of control" over the alcohol intake occurs, while in the other group this phenomenon never develops. The group with the "loss of control" is designated as "alcohol addicts." (There are other differences between these two groups and these will be seen in the course of the description of the "phases.")

The disease conception of alcohol addiction does not apply to the excessive drinking, but solely to the "loss of control" which occurs in only one group of alcoholics and then only after many years of excessive drinking. There is no intention to deny that the nonaddictive alcoholic is a sick person; but his ailment is not the excessive drinking, but rather the psychological or social difficulties from which alcohol intoxication gives temporary surcease.

The "loss of control" is a disease condition per se which results from a process that superimposes itself upon those abnormal psychological conditions of which excessive drinking is a symptom. The fact that many excessive drinkers drink as much as or more than the addict for 30 or 40 years without developing loss of control indicates that in the group of "alcohol addicts" a superimposed process must occur.

Whether this superimposed process is of a psychopathological nature or whether some physical pathology is involved cannot be stated as yet with any degree of assurance, the claims of various investigators notwithstanding. Nor is it possible to go beyond conjecture concerning the question whether the "loss of control" originates in a predisposing factor (psychological or physical), or whether it is a factor acquired in the course of prolonged excessive drinking.

The fact that this "loss of control" does not occur in a large group of excessive drinkers would point towards a predisposing *X* factor in the addictive alcoholics. On the other hand this explanation is not indispensable as the difference between addictive and nonaddictive alcoholics could be a matter of acquired modes of living—for instance, a difference in acquired nutritional habits.

The Meaning of Symptomatic Drinking

The use of alcoholic beverages by society has primarily a symbolic meaning, and secondarily it achieves "function." Cultures which accept this custom differ in the nature and degree of the "functions" which they regard as legitimate. The differences in these "functions" are determined by the general pattern of the culture, e.g., the need for the release and for the special control of aggression, the need and the ways and means of achieving identification, the nature and intensity of anxieties and the modus for their relief, and so forth. The more the original symbolic character of the custom is preserved, the less room will be granted by the culture to the "functions" of drinking.

Any drinking within the accepted ways is symptomatic of the culture of which the drinker is a member. Within that frame of cultural symptomatology there may be in addition individual symptoms expressed in the act of drinking. The fact that a given individual drinks a glass of beer with his meal may be the symptom of the culture which accepts such a use as a refreshment, or as a "nutritional supplement." That this individual drinks at this given moment may be a symptom of his fatigue, or his elation or some other mood, and thus an individual symptom, but if his culture accepts the use for these purposes it is at the same time a cultural symptom.

In this sense even the small or moderate use of alcoholic beverages is symptomatic, and it may be said that all drinkers are culturally symptomatic drinkers or, at least, started as such.

The vast majority of the users of alcoholic beverages stay within the limits of the culturally accepted drinking behaviors and drink predominantly as an expression of their culture, and while an individual expression may be present in these behaviors its role remains insignificant.

For the purpose of the present discussion the expression "symptomatic drinking" will be limited to the predominant use of alcoholic beverages for the relief of major individual stresses.

A certain unknown proportion of these users of alcoholic beverages, perhaps 20 per cent, are occasionally inclined to take advantage of the "functions" of alcohol which they have experienced in the course of its "cultural use." At least at times, the individual motivation becomes predominant and on those occasions alcohol loses its character as an ingredient of a beverage and is used as a drug.

The "occasional symptomatic excessive drinker" tends to take care of the stresses and strains of living in socially accepted—i.e., "normal"—ways, and his drinking is most of the time within the cultural pattern. After a long accumulation of stresses, however, or because of some particularly heavy stress, his tolerance for tension is lowered and he takes recourse to heroic relief of his symptoms through alcoholic intoxication.³ Under these circumstances the "relief" may take on an explosive character, and thus the occasional symptomatic excessive drinker may create serious problems. No psychological abnormality can be claimed for this type of drinker, although he does not represent a well-integrated personality.

Nevertheless, within the group of apparent "occasional symptomatic

³ This group does not include the regular "periodic alcoholics."

excessive drinkers" there is a certain proportion of definitely deviating personalities who after a shorter or longer period of occasional symptomatic relief take recourse to a constant alcoholic relief, and drinking becomes with them a "mode of living." These are the "alcoholics" of whom again a certain proportion suffer "loss of control," i.e., become "addictive alcoholics."

The proportion of alcoholics (addictive and nonaddictive) varies from country to country, but does not seem to exceed in any country 5 per cent or 6 per cent of all users of alcoholic beverages. The ratio of addictive to nonaddictive alcoholics is unknown.

THE CHART OF ALCOHOL ADDICTION

The course of alcohol addiction is represented graphically in Figure 1. The diagram is based on an analysis of more than two thousand drinking histories of male alcohol addicts. Not all symptoms shown in the diagram occur necessarily in all alcohol addicts, nor do they occur in every addict in the same sequence. The "phases" and the sequences of symptoms within the phases are characteristic, however, of the great majority of alcohol addicts and represent what may be called the average trend.

For alcoholic women the "phases" are not as clear-cut as in men and the development is frequently more rapid.

The "phases" vary in their duration according to individual characteristics and environmental factors. The "lengths" of the different phases on the diagram do not indicate differences in duration, but are determined by the number of symptoms which have to be shown in any given phase.

The chart of the phases of alcohol addiction serves as the basis of description, and the differences between addictive and nonaddictive alcoholics are indicated in the text.

The Prealcoholic Symptomatic Phase

The very beginning of the use of alcoholic beverages is always socially motivated in the prospective addictive and nonaddictive alcoholic. In contrast to the average social drinker, however, the prospective alcoholic (together with the occasional symptomatic excessive drinker) soon experiences a rewarding relief in the drinking situation. The relief is strongly marked in his case because either his tensions are much greater than in other members of his social circle, or he has not learned to handle those tensions as others do.

Initially this drinker ascribes his relief to the situation rather than to the drinking and he seeks therefore those situations in which incidental drinking will occur. Sooner or later, of course, he becomes aware of the contingency between relief and drinking.

In the beginning he seeks this relief occasionally only, but in the course of 6 months to 2 years his tolerance for tension decreases to such a degree that he takes recourse to alcoholic relief practically daily.

Nevertheless his drinking does not result in overt intoxication, but he reaches toward the evening a stage of surcease from emotional stress. Even in the absence of intoxication this involves fairly heavy drinking, particularly in comparison to the use of alcoholic beverages by other members of

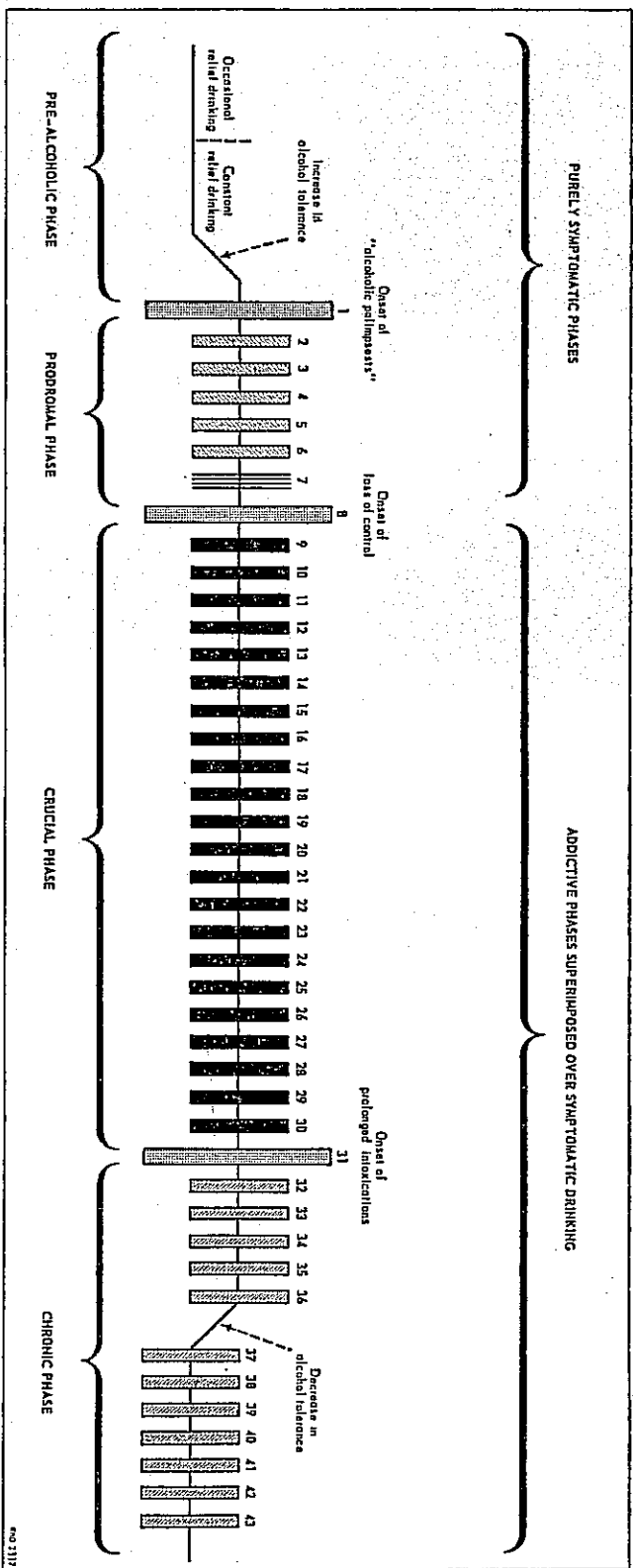


Figure 1.—*The Phases of Alcohol Addiction.* The large bars denote the onset of major symptoms which initiate phases. The short bars denote the onset of symptoms within a phase. Reference to the numbering of the symptoms is made in the text.

his circle. The drinking is, nevertheless, not conspicuous either to his associates or to himself.

After a certain time an increase in alcohol tolerance may be noticed, i.e., the drinker requires a somewhat larger amount of alcohol than formerly in order to reach the desired stage of sedation.

This type of drinking behavior may last from several months to 2 years according to circumstances and may be designated as the prealcoholic phase, which is divided into stages of occasional relief-drinking and constant relief-drinking.

The Prodromal Phase

The sudden onset of a behavior resembling the "blackouts" in anoxemia marks the beginning of the prodromal phase of alcohol addiction. The drinker who may have had not more than 50 to 60 g. of absolute alcohol and who is not showing any signs of intoxication may carry on a reasonable conversation or may go through quite elaborate activities without a trace of memory the next day, although sometimes one or two minor details may be hazily remembered. This amnesia, which is not connected with loss of consciousness, has been called by Bonhoeffer the "alcoholic palimpsests," with reference to old Roman manuscripts superimposed over an incompletely erased manuscript.

"*Alcoholic palimpsests*" (1)⁴ may occur on rare occasions in an average drinker when he drinks intoxicating amounts in a state of physical or emotional exhaustion. Nonaddictive alcoholics, of course, also may experience "palimpsests," but infrequently and only following rather marked intoxication. Thus, the frequency of "palimpsests" and their occurrence after medium alcohol intake are characteristic of the prospective alcohol addict.

This would suggest heightened susceptibility to alcohol in the prospective addict. Such a susceptibility may be psychologically or physiologically determined. The analogy with the "blackouts" of anoxemia is tempting. Of course, an insufficient oxygen supply cannot be assumed, but a malutilization of oxygen may be involved. The present status of the knowledge of alcoholism does not permit of more than vague conjectures which, nevertheless, may constitute bases for experimental hypotheses.

The onset of "alcoholic palimpsests" is followed (in some instances preceded) by the onset of drinking behaviors which indicate that, for this drinker, beer, wine and spirits have practically ceased to be beverages and have become sources of a drug which he "needs." Some of these behaviors imply that this drinker has some vague realization that he drinks differently from others.

Surreptitious drinking (2) is one of these behaviors. At social gatherings the drinker seeks occasions for having a few drinks unknown to others, as he fears that if it were known that he drinks more than the others he would be misjudged: those to whom drinking is only a custom or a small pleasure

⁴ The italicized figures in parentheses following the designations of the individual symptoms represent their order as given in Figure 1.

would not understand that because he is different from them alcohol is for him a necessity, although he is not a drunkard.

Preoccupation with alcohol (3) is further evidence of this "need." When he prepares to go to a social gathering his first thought is whether there will be sufficient alcohol for his requirements, and he has several drinks in anticipation of a possible shortage.

Because of this increasing dependence upon alcohol, the onset of *avid drinking* (4) (gulping of the first or first two drinks) occurs at this time.

As the drinker realizes, at least vaguely, that his drinking is outside of the ordinary, he develops *guilt feelings about his drinking behavior* (5) and because of this he begins to *avoid reference to alcohol* (6) in conversation.

These behaviors, together with an *increasing frequency of "alcoholic palimpsests"* (7), foreshadow the development of alcohol addiction; they are premonitory signs, and this period may be called the prodromal phase of alcohol addiction.

The consumption of alcoholic beverages in the prodromal phase is "heavy," but not conspicuous, as it does not lead to marked, overt intoxications. The effect is that the prospective addict reaches towards evening a state which may be designated as emotional anesthesia. Nevertheless, this condition requires drinking well beyond the ordinary usage. The drinking is on a level which may begin to interfere with metabolic and nervous processes as evidenced by the frequent "alcoholic palimpsests."

The "covering-up" which is shown by the drinker in this stage is the first sign that his drinking might separate him from society, although initially the drinking may have served as a technique to overcome some lack of social integration.

As in the prodromal phase rationalizations of the drinking behavior are not strong and there is some insight as well as fear of possible consequences, it is feasible to intercept incipient alcohol addiction at this stage. In the United States of America, the publicity given to the prodromal symptoms begins to bring prospective alcoholics to clinics as well as to groups of Alcoholics Anonymous.

It goes without saying that even at this stage the only possible modus for this type of drinker is total abstinence.

The prodromal period may last anywhere from 6 months to 4 or 5 years according to the physical and psychological make-up of the drinker, his family ties, vocational relations, general interests, and so forth. The prodromal phase ends and the crucial or acute phase begins with the onset of loss of control, which is the critical symptom of alcohol addiction.

The Crucial Phase

Loss of control (8) means that any drinking of alcohol starts a chain reaction which is felt by the drinker as a physical demand for alcohol. This state, possibly a conversion phenomenon, may take hours or weeks for its full development; it lasts until the drinker is too intoxicated or too sick to ingest more alcohol. The physical discomfort following this drinking behavior is contrary to the object of the drinker, which is merely

to feel "different." As a matter of fact, the bout may not even be started by any individual need of the moment, but by a "social drink."

After recovery from the intoxication, it is not the "loss of control"—i.e., the physical demand, apparent or real—which leads to a new bout after several days or several weeks; the renewal of drinking is set off by the original psychological conflicts or by a simple social situation which involves drinking.

The "loss of control" is effective after the individual has started drinking, but it does not give rise to the beginning of a new drinking bout. The drinker has lost the ability to control the quantity once he has started, but he still can control whether he will drink on any given occasion or not. This is evidenced in the fact that after the onset of "loss of control" the drinker can go through a period of voluntary abstinence ("going on the water wagon").

The question of why the drinker returns to drinking after repeated disastrous experiences¹ is often raised. Although he will not admit it, the alcohol addict believes that he has lost his will power and that he can and must regain it. He is not aware that he has undergone a process which makes it impossible for him to control his alcohol intake. To "master his will" becomes a matter of the greatest importance to him. When tensions rise, "a drink" is the natural remedy for him and he is convinced that this time it will be one or two drinks only.

Practically simultaneously with the onset of "loss of control" the alcohol addict begins to *rationalize his drinking behavior* (9): he produces the well-known alcoholic "alibis." He finds explanations which convince him that he did not lose control, but that he had a good reason to get intoxicated and that in the absence of such reasons he is able to handle alcohol as well as anybody else. These rationalizations are needed primarily for himself and only secondarily for his family and associates. The rationalizations make it possible for him to continue with his drinking, and this is of the greatest importance to him as he knows no alternative for handling his problems.

This is the beginning of an entire "system of rationalizations" which progressively spreads to every aspect of his life. While this system largely originates in inner needs, it also serves to counter *social pressures* (10) which arise at the time of the "loss of control." At this time, of course, the drinking behavior becomes conspicuous, and the parents, wife, friends and employer may begin to reprove and warn the drinker.

In spite of all the rationalizations there is a marked loss of self-esteem, and this of course demands compensations which in a certain sense are also rationalizations. One way of compensation is the *grandiose behavior* (11) which the addict begins to display at this time. Extravagant expenditures and grandiloquence convince him that he is not as bad as he had thought at times.

The rationalization system gives rise to another system, namely the "system of isolation." The rationalizations quite naturally lead to the idea that the fault lies not within himself but in others, and this results in a progressive withdrawal from the social environment. The first sign of this attitude is a *marked aggressive behavior* (12).

Inevitably, this latter behavior generates guilt. While even in the prodromal period remorse about the drinking arose from time to time, now *persistent remorse* (13) arises, and this added tension is a further source of drinking.

In compliance with social pressures the addict now goes on *periods of total abstinence* (14). There is, however, another modus of control of drinking which arises out of the rationalizations of the addict. He believes that his trouble arises from his not drinking the right kind of beverages or not in the right way. He now attempts to control his troubles by *changing the pattern of his drinking* (15), by setting up rules about not drinking before a certain hour of the day, in certain places only, and so forth.

The strain of the struggle increases his hostility towards his environment and he begins to *drop friends* (16) and *quit jobs* (17). It goes without saying that some associates drop him and that he loses some jobs, but more frequently he takes the initiative as an anticipatory defence.

The isolation becomes more pronounced as his entire *behavior becomes alcohol-centered* (18), i.e., he begins to be concerned about how activities might interfere with his drinking instead of how his drinking may affect his activities. This, of course, involves a more marked egocentric outlook which leads to more rationalizations and more isolation. There ensues a *loss of outside interests* (19) and a *reinterpretation of interpersonal relations* (20) coupled with *marked self-pity* (21). The isolation and rationalizations have increased by this time in intensity and find their expression either in contemplated or actual *geographic escape* (22).

Under the impact of these events, a *change in family habits* (23) occurs. The wife and children, who may have had good social activities, may withdraw for fear of embarrassment or, quite contrarily, they may suddenly begin intensive outside activities in order to escape from the home environment. This and other events lead to the onset of *unreasonable resentments* (24) in the alcohol addict.

The predominance of concern with alcohol induces the addict to *protect his supply* (25), i.e., to lay in a large stock of alcoholic beverages, hidden in the most unthought-of places. A fear of being deprived of the most necessary substance for his living is expressed in this behavior.

Neglect of proper nutrition (26) aggravates the beginnings of the effects of heavy drinking on the organism, and frequently the *first hospitalization* (27) for some alcoholic complaint occurs at this time.

One of the frequent organic effects is a *decrease of the sexual drive* (28) which increases hostility towards the wife and is rationalized into her extramarital sex activities, which gives rise to the well-known *alcoholic jealousy* (29).

By this time remorse, resentment, struggle between alcoholic needs and duties, loss of self-esteem, and doubts and false reassurance have so disorganized the addict that he cannot start the day without steadying himself with alcohol immediately after arising or even before getting out of bed. This is the beginning of *regular matutinal drinking* (30), which previously had occurred on rare occasions only.

This behavior terminates the crucial phase and foreshadows the beginnings of the chronic phase.

During the crucial phase intoxication is the rule, but it is limited to the evening hours. For the most part of this phase drinking begins sometime in the afternoon and by the evening intoxication is reached. It should be noted that the "physical demand" involved in the "loss of control" results in continual rather than continuous drinking. Particularly the "matutinal drink" which occurs toward the end of the crucial phase shows the continual pattern. The first drink at rising, let us say at 7 A.M., is followed by another drink at 10 or 11 A.M., and another drink around 1 P.M., while the more intensive drinking hardly starts before 5 P.M.

Throughout, the crucial phase presents a great struggle of the addict against the complete loss of social footing. Occasionally the aftereffects of the evening's intoxication cause some loss of time, but generally the addict succeeds in looking after his job, although he neglects his family. He makes a particularly strong effort to avoid intoxication during the day. Progressively, however, his social motivations weaken more and more, and the "morning drink" jeopardizes his effort to comply with his vocational duties as this effort involves a conscious resistance against the apparent or real "physical demand" for alcohol.

The onset of the "loss of control" is the beginning of the "disease process" of alcohol addiction which is superimposed over the excessive symptomatic drinking. Progressively, this disease process undermines the morale and the physical resistance of the addict.

The Chronic Phase

The increasingly dominating role of alcohol, and the struggle against the "demand" set up by matutinal drinking, at last break down the resistance of the addict and he finds himself for the first time intoxicated in the daytime and on a weekday and continues in that state for several days until he is entirely incapacitated. This is the onset of *prolonged intoxications* (31), referred to in the vernacular as "benders."

This latter drinking behavior meets with such unanimous social rejection that it involves a grave social risk. Only an originally psychopathic personality or a person who has later in life undergone a psychopathological process would expose himself to that risk.

These long-drawn-out bouts commonly bring about *marked ethical deterioration* (32) and *impairment of thinking* (33) which, however, are not irreversible. True *alcoholic psychoses* (34) may occur at this time, but in not more than 10 per cent of all alcoholics.

The loss of morale is so heightened that the addict *drinks with persons far below his social level* (35) in preference to his usual associates—perhaps as an opportunity to appear superior—and, if nothing else is available, he will *take recourse to "technical products"* (36) such as bay rum or rubbing alcohol.

A *loss of alcohol tolerance* (37) is commonly noted at this time. Half of the previously required amount of alcohol may be sufficient to bring about a stuporous state.

Indefinable fears (38) and *tremors* (39) become persistent. Sporadically these symptoms occur also during the crucial phase, but in the chronic

phase they are present as soon as alcohol disappears from the organism. In consequence the addict "controls" the symptoms through alcohol. The same is true of *psychomotor inhibition* (40), the inability to initiate a simple mechanical act—such as winding a watch—in the absence of alcohol.

The need to control these symptoms of drinking exceeds the need of relieving the original underlying symptoms of the personality conflict, and the *drinking takes on an obsessive character* (41).

In many addicts, approximately 60 per cent, some *vague religious desires develop* (42) as the rationalizations become weaker. Finally, in the course of the frequently prolonged intoxications, the rationalizations become so frequently and so mercilessly tested against reality that the entire *rationalization system fails* (43) and the addict admits defeat. He now becomes spontaneously accessible to treatment. Nevertheless, his obsessive drinking continues as he does not see a way out.

Formerly it was thought that the addict must reach this stage of utter defeat in order to be treated successfully. Clinical experience has shown, however, that this "defeat" can be induced long before it would occur of itself and that even incipient alcoholism can be intercepted. As the latter can be easily recognized it is possible to tackle the problem from the preventive angle.

THE "ALCOHOLIC PERSONALITY"

The aggressions, feelings of guilt, remorse, resentments, withdrawal, etc., which develop in the phases of alcohol addiction, are largely consequences of the excessive drinking, but at the same time they constitute sources of more excessive drinking.

In addition to relieving, through alcohol, symptoms of an underlying personality conflict, the addict now tends to relieve, through further drinking, the stresses created by his drinking behavior.

By and large, these reactions to excessive drinking—which have quite a neurotic appearance—give the impression of an "alcoholic personality," although they are secondary behaviors superimposed over a large variety of personality types which have a few traits in common, in particular a low capacity for coping with tensions. There does not emerge, however, any specific personality trait or physical characteristic which inevitably would lead to excessive symptomatic drinking. Apart from psychological and possibly physical liabilities, there must be a constellation of social and economic factors which facilitate the development of addictive and nonaddictive alcoholism in a susceptible terrain.

THE NONADDICTIVE ALCOHOLIC

Some differences between the nonaddictive alcoholic and the alcohol addict have been stated *passim*. These differences may be recapitulated and elaborated, and additional differential features may be considered.

The main difference may be readily visualized by erasing the large bars of the diagram (see Figure 1). This results in a diagram which suggests a progressive exacerbation of the use of alcohol for symptom relief and of the social and health consequences incumbent upon such use, but without any clear-cut phases.

The prealcoholic phase is the same for the nonaddictive alcoholic as for the alcohol addict, i.e., he progresses from occasional to constant relief of individual symptoms through alcohol.

The behaviors which denote that alcohol has become a drug rather than an ingredient of a beverage (symptoms 2 to 6) occur also in the nonaddictive drinker, but, as mentioned before, the "alcoholic palimpsests" occur rarely and only after overt intoxication.

"Loss of control" is not experienced by the nonaddictive alcoholic, and this is the main differentiating criterion between the two categories of alcoholics. Initially, of course, it could not be said whether the drinker had yet reached the crucial phase, but after 10 or 12 years of heavy drinking without "loss of control," while symptoms 2 to 6 were persistent and "palimpsests" were rare and did not occur after medium alcohol intake, the differential diagnosis is rather safe.

The absence of "loss of control" has many involvements. First of all, as there is no inability to stop drinking within a given situation there is no need to rationalize the inability. Nevertheless, rationalizations are developed for justifying the excessive use of alcohol and some neglect of the family attendant upon such use. Likewise, there is no need to change the pattern of drinking, which in the addict is an attempt to overcome the "loss of control." Periods of total abstinence, however, occur as a response to social pressure.

On the other hand, there is the same tendency toward isolation as in the addict, but the social repercussions are much less marked as the nonaddictive alcoholic can avoid drunken behavior whenever the social situation requires it.

The effects of prolonged heavy drinking on the organism may occur in the nonaddictive alcoholic too; even delirium tremens may develop. The libido may be diminished and "alcoholic jealousy" may result.

Generally, there is a tendency toward a progressive dominance of alcohol resulting in greater psychological and bodily effects. In the absence of any grave initial psychopathy, however, the symptoms of the chronic phase as seen in addicts do not develop in the nonaddictive alcoholic. In the presence of grave underlying psychopathies a deteriorative process is speeded up by habitual alcoholic excess, and such a nonaddictive drinker may slide to the bottom of society.