THE ADOLESCENT DRUG ADDICT: AN ADLERIAN VIEW

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The writer, currently director of the psychology department at Riverside Hospital, New York City, bases this paper on four years of treatment experience with adolescent addicts. Riverside is a 140 bed co-educational hospital-school facility, set up specifically for treating drug users aged 14-21, of whom practically 99% have been involved in heroin intoxication. They present certain problems common to adolescents in general, and many problems common to delinquents, 73% having a history of one offense or more prior to drug use. These data are from the Alksne report (2), to which we shall refer throughout; it covers a mean of 27 months of follow-up study of treated narcotic users admitted to Riverside Hospital in 1955.

Understanding the Addict

Basic dynamics. One of Adler's basic constructs is social interest. This can be defined as the capacity to understand and accept one's social interrelatedness, to empathize with one's fellow man, to strive on the socially useful side of life, and thus to be in harmony with its social realities (1, 3). An adequate development of social interest is a characteristic of mental health. In contrast, underdeveloped social interest is a common denominator of persons with all kinds of psychological problems. This is clearly true of the addict. He keeps at a distance socially.

Yet the addict does show a vestige of social interest or social feeling. Despite his reliance on drugs to create a hedonistically structured environment in which he can pursue effortless, pleasurable activities, he feels that his actions in this state are not right and he seeks to disclaim responsibility for them: When he is "high" he is not his "real self." And when he commits crimes when "strung out" (experiencing the distress of withdrawal symptoms), these are typically against property, not against persons.

Another basic construct of Adler is the feeling of inferiority which he found intensified in all problem children and so-called failures in life. Drug addicts are characterized by experiences of inadequacy in meeting external demands. Their constant and intensified feeling of inadequacy, together with the isolation resulting from their under-

developed social interest, are necessarily accompanied by a lack of courage and a desire to be shielded from "dangers," two further outstanding characteristics of young addicts.

The patients' early recollections frequently involve an encounter with some form of interpersonal or physical danger. Examples are:

Patient N: "I was playing in the water on a beach in Puerto Rico. All of a sudden people were shouting and running out of the water. My mother grabbed me and pulled me out also. I found out that sharks were seen and somebody was bitten. My mother crossed herself."

Patient E: "I was sitting on a table, and my mother was putting my shoe on. Somebody knocked on the door. My mother opened the door and a man was there. She yelled and a neighbor came out. The man left. My mother was scared and told me he was a drunk."

Patient M: "I moved to a new street. Whenever I went downstairs, some guys would call me 'dirty spic.' One day they jumped me. My brother ran down to help. After we hit back they didn't bother us so much."

The philosophy of the addict reflects a dim view of the world and is probably best expressed as "live today, there may be no tomorrow." While normally future orientation provides security and protection from danger, the addict is afraid of the future and therefore approaches his goals with the least expenditure of energy and the least danger to self-esteem. Thus he follows the immediacy principle: He obtains gratification "while the getting is good." He cannot defer gratification and is consequently described by some as an "impulse disorder."

Further complicating the situation is the fact that the addict's basic motor orientation makes him restless and easily dissatisfied. Ability for sustained concentration suffers, and he is bored with long-term projects, including psychotherapy. Having an erroneous estimate of his own importance, deriving from his generally pampered perspective, and having meager confidence in being able to achieve his goals unless he "loads the dice in his favor," he endeavors to structure the environment to his advantage and consciously assumes a "better me than you" orientation.

Adjustive value of the drug. The drug elevates the threshold for the perception of threatening stimuli and thereby safeguards against anticipatory feelings of inadequacy.

Our subjects fall largely into two groups, on opposite ends of the spectrum of warding off anxiety and feelings of insignificance, i.e., by withdrawal or by aggression. The *modus operandi* of the first group consists of retreat from provocative outer influences rather than risk-

ing defeat; they avoid direct collision with persons perceived as threatening, and are likely to retaliate by *passive*-aggressive maneuvering for personal advantage. Under the influence of heroin they feel release from self-consciousness, i.e., self-critical evaluation of their worth, and experience heightened self-esteem, as well as a capacity to respond to and enjoy an expanded sector of the outside world.

The second group consists of an *actively*-aggressive core. Hypersensitive to what they interpret as being depreciated, they are ready to perceive and respond to challenge at minimal provocation. When their perceptual threshold is raised under the influence of drugs, they are less likely to be triggered into rage.

Both groups want to safeguard themselves from a hostile environment which activates concern with being personally insignificant. Our experience suggests that the first group is probably the larger. Gold (5) found that in the main the preferred mode for dealing with external sources of frustration tends to be via impunitive, rather than extra- or intra-punitive solutions.

If the addict has difficulties with heterosexual contacts, with a "high" the disruptive sexual desire is diminished. Similarly, other primary and secondary needs become less pressing. The problem of sustenance becomes insignificant. Concern with meeting adult responsibilities to the family or associates becomes dissolved. Indeed, the euphoria accompanying the diminished perception of interpersonal irritants even creates the illusion of working more efficiently when "high." A false courage is generated since one does not have to consider the prospects of failure.

Adolescent crises and pampering. It is generally accepted that though there are frequently intense psycho-biological tensions generated in adolescence, there is no major characterological change. So-called adolescent crises are largely associated with dislocations in the self-concept and with passing new tests that demonstrate that one is no longer a child.

In common with many adolescents, the addict interprets "grown-up" as meaning free from control. Yet beneath assertive posturing to show how grown-up he is, the addict wants to satisfy infantile relationships which he cannot express openly without loss of face. Anamnestic data frequently indicate pampering by the mother, and even more often, *wanting* to be pampered, irrespective of actual experience of having been doted upon. Often the visiting mother inquires of her grown son, "How is my baby?" and will issue forth with endear-

ing terms of "smother love," such as "lover boy," "darling," and will even refer to hospital visits as "dates." It is rare to hear from mothers of addicts, of a son cooperating with household chores. Interestingly, the addict is attracted by women who will "go on the turf" (be prostitutes) for him and make no demands. To be relieved of responsibility and completely taken care of is a common ideal among addicts.

According to the Alksne survey, in over 50% of the cases a significant male figure was missing from the household by the time the patient was eleven years old. Thus it is understandable that the mother exerts an overwhelming influence. This is frequently in the nature of indulgence, interspersed with rejection. The extent to which the addict is indulged by the mother explains the unrealistically heightened value he places on himself. His aggression takes the form of attempting to hurt others by hurting himself and blaming someone in his surroundings. Frequently he justifies his addiction by saying: "My mother got on my back; I told her that if she didn't lay off, she'd drive me to another shot." Or: "I needed a shot because they bug me at home."

When there is a father, he is frequently emotionally remote and would just as soon have the addict out of the house when he starts getting into difficulty. Often the patient seems to monopolize his mother's time, much to the father's disgruntlement. Indeed, the very act of taking drugs and being "found out" is likely to force a showdown in which the mother must make a choice between the son and the husband. Fairly typically in the addict's apperceptive schema, masculine authority equals hostility.

Not infrequently one also finds evidence that the parents unconsciously actually promote deviant behavior as a means of vicariously achieving their own goals of significance and superiority. Hence the occasional panic and even subtle sabotage of the treatment relationship by the parents when the addict improves in therapy.

With regard to ordinal sibling position, no systematic relationship to drug use has been found.

Private logic and lack of social interest. In accordance with the addict's social distance, he follows a private logic, one not influenced by judgments that have been validated via consensual agreement, i.e., by common sense in Adler's use of the term.

The addict frequently has feelings of omnipotence or of being charmed. Thus, though he fully acknowledges that no one can take drugs regularly without becoming an addict, he feels confident that *he*

is different. Even though he has failed in the past, he confidently explains that one day something will happen that will make him stop using drugs precipitously. He believes in a *deus ex machina* solution.

Addicts will often boast unembarrassedly of their ability to get away with criminal activity, or to manipulate the judge when caught. Getting away with infractions is often the theme of the early recollections. Examples of such recollections are:

Patient D: "I was looking for something in my father's closet and money fell out of his pants pocket. I hid it in back of the radio. One morning my mother was cleaning and found money I saved in this way. She looked at me funny and put the money in her bag for herself."

Patient S: "I and my older brother were playing in the house. My mother was out of the house. I went into the kitchen alone and stood up on a table to get some candy that my mother hid in the closet. A dish fell down and broke. My brother didn't know about it but he got hollered at when my mother got back. I was too scared to say anything. My mother never thought I could climb up there."

Patient O: "I gave away two of my father's ties to some kids in the street. Don't remember why. When my father found out he yelled and yelled. But even then I knew his screaming was a load of crap, all bark and no bite."

The addict's private logic also involves a certain rigidity. As with delinquents, he is limited in problem-solving ability, and antisocial action is often seen as the only alternative in a difficult situation. At the same time his rigidity is one of his major safeguarding devices for achieving security.

His language also reflects the social distance. The argot of the addict often conveys his opposition to socially embedded semantic conventions, e.g., "bad" means good, "terrible" means great, and "crazy" is a form of praise. His argot also conveys his ambivalence toward heroin, e.g., "junk" (heroin) has a debasing connotation; yet, the "pusher" is often referred to as "mother."

On the other hand, the addict's argot provides a link with a sector of the outside world, i. e., the "bop" subculture (7). His argot makes him feel that there are people who are sympathetically disposed toward him.

Social relations. This brings us to a consideration of the addict's efforts to deal with the core problems which Adler formulated as the three life tasks: social, sexual, and occupational relations (1, pp. 5-7).

Starting with the first problem, we note that over half the addicts in the Alksne report did not use drugs by themselves. Generally there was at least one other person, a "partner" (a drug-using associate who shares the risks and "benefits" of obtaining drugs). There is an

alliance, however tenuous, directed toward the socially "useless," unproductive side of life. One of the problems encountered in trying to guide the addict to constructive leisure-time activities, is his resistance to being weaned from the illusory security of the company of other addicts. He probably enhances his self-esteem by separating himself from non-users, thereby reaffirming his uniqueness. Fellow addicts are also less likely to threaten him with the demand for social intimacy. Indeed, there is more of a tendency to *react* rather than *relate* to fellow addicts; their association is more like parallel play than interaction.

One consequence of drug use is the corrosion of familial and societal ties, as the addict strives to feel "normal," i.e., personally significant. The addict's alienation from social ties is suggested by his nomadism: He had on the average three addresses during the 27 months covered by the Alksne survey.

The addict generally creates the myth that numerous prominent people also take drugs. By this he imagines himself to be a member of an elite group.

Sexual relations. Addicts of both sexes typically overvalue the masculine role, exemplify the masculine protest. In the case of the male there is almost panicked posturing of ascendancy in order to affirm his virility. His apperception of his sexual role is inevitably influenced by a desire to be pampered by a female who is at his disposal both as a guiding influence to chart his way through difficult situations, and as a sexual object.

Lacking the requisite development of social interest to want to contribute to the well-being of his sexual partner, he functions on a recipient, rather than a give-and-take basis in his sexual behavior. Conquest and acquisition are the keystone of his sexuality. Occasionally addicts will make finding the "right girl" the *deus-ex-machina* solution to their drug use. Marriage of such individuals is doomed to failure. If the wife is not converted to drug use, she and the children usually find themselves without support. Not infrequently addicts become involved in homosexual relations to support the "habit." In the main, the desire for the opposite sex becomes dissolved by the use of the hypodermic needle. With some, bodily attraction brings on the fear of being unable to assume the masculine role. In the Alksne report only one addict out of four had any steady relationship with the opposite sex when off drugs.

The masculine protest is likewise observed in female addicts.

Many have a history of heterosexual aggressiveness and show a facility for imitating males with regard to swearing, gang activity, and sexual freedom. They will frequently resort to prostitution to obtain money for drugs, which further suggests a tendency to devalue the female role.

Occupational relations. A useful occupation implies cooperation with others for a common benefit. The addict's work record is typically spotty. In addition to sabotaging his work situation by taking drugs, the addict, through his pampered life style, comes into conflict with the authority of the boss and the demands for cooperation by the co-workers. The interpersonal substrate of the work situation and its attendant frictions ultimately activate doubt regarding his personal worth. Alksne found that addicts spent on the average only three months on one job during the 27 months of his study; that only one out of ten held a job over a year; and that 15% were never employed.

As to seeking job placement, the addicts, despite their heightened activity to support the "habit," are typically passive and apathetic. Nearly 50% of those employed obtained their job through relatives and friends, rather than through their own initiative.

The addict experiences work as a "necessary evil" and, in the main, wants to "make a fast buck" in the easiest manner, another aspect of his inability to postpone immediate gratification and plan for long-term goals.

Upon closer scrutiny the addict's "work inhibition" reduces itself to a lack of courage to face the prospect of defeat in his vocational striving. This fear is frequently masked by unattainable vocational goals. In these his life style and value system often emerge. His typical occupational or educational choices are painting, ceramics, music or sports. The emphasis is on pleasure and glamour, irrespective of practicality. Even though he often has the intellectual ability, the addict tends to avoid academic subjects. His over-all discomfort with ideative content and concern with failure make academic topics tension-evoking. There seems to be panic at the prospect of struggling.

TREATMENT

Typically the addict enters treatment unmotivated. Initially there are few self-referrals; these seek to recuperate physically, to have a place to stay, to gain weight out of vanity, or more often to ward off impending court action for offenses committed. Thus, the addict enters treatment with the intent to perpetuate his mistaken life style.

He is not interested in being helped to do for himself the things within his power. He would rather not attempt them since he might not make the grade, and consequently would rather have things done for him.

In getting to know the addict, ordinary conversation cannot be relied upon. Language is essentially a social product, a social norm, and the addict has long since challenged, if not repudiated, the validity of societal norms. Thus he will often engage in barren small-talk which leads everywhere but gets nowhere, and he will lie unembarrassedly. Free association, likewise, is rarely effective; it is too abstract and unstructured for the addict who fundamentally distrusts a task involving a chain of ideas without a predetermined goal.

Useful information can nevertheless be obtained, e. g., from concrete verbal tasks that minimize probing connotations, like the telling of early recollections, or of "real" things such as the day's experience with different aspects of the hospital program. Addicts interestingly also do not balk unduly at telling night and day dreams, and with some encouragement will tell favorite jokes that often provide clinically significant information. Also of value are expressive movements and the natural history and background of the addict.

Embedded in the behavior of the addict, as of the neurotic, is a concealed accusation. Determining who is most affected by the symptoms, as Adler advised, reveals quite reliably the victim of the addict's veiled attack. Since his lack of courage is based on experiences of failure, an anamnesis of his defeats has also been of considerable value. It reveals the antecedents of the alibis which the addict uses to safeguard his self-esteem.

Treatment must be holistic and not address itself merely to the addiction. The hospital setting not only facilitates rapid physical recovery. It also short-circuits the frequently reverberating arc of parent-adolescent opposition, removes the addict from the street where his self-respect is at a low ebb, and provides a treatment community which endeavors to understand him. Since the therapist's most reliable ally is the patient himself in his capacity for self-observation, the drugs, which suspend self-criticism, must be withdrawn.

Explaining the patient to himself. Addicts are likely to have a "hidden agenda" beneath the smoke screen of their expressions, an essential but latent communication which must be extricated from their manifest productions. But this does not mean a primarily analytic, uncovering approach. The therapist should avoid such an approach lest he create the impression that he is more interested in the

treatment process than in the patient. The addict can use such an observation for secondary gain.

The best suited method is the synthesizing approach in which the therapist endeavors to help the patient to find, out of the seemingly discordant data of his life, the unifying thread that clearly demonstrates his hidden, largely unconscious goal-orientation. The therapist must have the skill to translate his information into emotionally incisive "gut" language, without making the patient feel humiliated or condemned. Moralistic treatment, upbraiding, and the citing of catchy slogans such as "crime is a coward's imitation of heroism," are unlikely to be of value. Ideally, confirmation of the therapist's understanding should reside in the content of the concrete event that the addict chooses to discuss. The formulation of the life style should come from the addict and not be imposed upon him. Similarly, he frequently resents the so-called "focused question" that usually implies its answer. Because addicts have fantasies of omnipotence, though these may be well masked, the therapist will gain respect if he can make astute predictions regarding the addict's course of action. Therapy progresses with establishing the reality basis of the therapist's views, in contrast to his magical powers and the addict's apperceptive distortions.

The therapeutic relationship. It is probably axiomatic that the patient will accept an interpretation only if he perceives the therapist as reliable, consistent, and straightforward; i.e., there must be a positive emotional relationship. Entering the treatment with distrust of authority, addicts can well discern between honest expresssion and the oblique sophistry of the therapist who hides behind language. The best way to build a relationship with the addict is to avoid a self-conscious effort to do so. One of the most difficult tasks is to control aggressive behavior in a manner which ensures the survival of the hospital service, while operating in the interest of the patient. A frequently effective maneuver in initially dealing with a "hardened" addicted adolescent is to undermine his fantasy of being a colorful desperado by relating to him in a kindly, interested, professional manner. Adults generally have difficulty in reacting sympathetically to these attractive adolescents, whereas with neurotics it is easier to have compassion, since they are manifestly experiencing psychological pain. On the other hand, the therapist must not give in to the demands of the addict, because he would thereby reinforce the addict's mis-

conception of himself as a person who by the mere fact of his existence is of extraordinary value to others.

One way to disturb the addict's magical beliefs is by calling him to account for infractions of hospital rules, regardless of how negligible. Addicts frequently have histories of getting away with petty offenses, of being able when caught, to manipulate the corruptibility of others by "making deals." When devoid of hostility and not experienced by the patient as loss of face, such calling to account is a valuable treatment experience. Probably the basic rule is to demonstrate to the addict that his interests are actually identical to those of society and are therefore best served when his behavior is socially constructive.

Disarming the patient. Addicts are usually manipulative with a desire to rule. This desire must be controlled. Realistic controls are, however, not punitive, just as permissiveness is not necessarily therapeutic.

Addicts will engage in considerable initial testing of the therapist: How gullible is he? Will he get angry if the addict should absent himself from several sessions? To what extent can the therapist be subjugated by the "water power" of tears and complaints? The therapist soon learns that any commitments he makes can be used to defeat him. Though setting limits is part of social reality, it is the way limits are handled by the therapist and interpreted by the addict that determines whether a power struggle will be incited. Frequently the addict tests the therapist by provoking him to anger. As Eissler (4) has well pointed out, if the addict is given the opportunity to anticipate the punishment, he is likely to use this to defeat the treatment. Yet the therapist should not be inconsistent.

For example, a nurse suspected that a patient placed the fever thermometer near a radiator to get an elevated reading so that she would not have to go to school. There was no evidence of illness. After consulting with the therapist, the nurse expressed concern for the patient's health, and disarmingly imposed complete bed rest for the next two days. As a consequence, she missed very desirable weekend activities. There was never further recourse to this maneuver. Months later the patient confided that she had expected a heated argument and verbal reprimands.

When the therapist acts in a manner that is construed as punishment, the addict considers this an affirmation of being at war with society, and a challenge to circumvent the punishment. However, allowing the addict to suffer the natural consequences of his action, without humiliating him, has proven effective.

The patient may try to impose a limitation on the therapist's freedom of action in two ways: explicit, direct maneuvers and implicit, indirect approaches (6). Both ways retain the initiative for the patient, though they are self-defeating.

Among the *direct maneuvers* used by the addict are:

1. Demanding sedatives. Despite the therapist's explanation that sedatives are inadvisable on account of their similarity to narcotics, the patient remains adamant and threatens to lose control and make a fuss on the ward. It has been found, however, that in spite of initial face-saving clamor, these protestations are rarely long-lived, once the patient has been helped to see that it is a part of self-respect to be held accountable for one's actions, and that he has responsibilities not to disturb the others, just as they have toward him.

2. Asking for precise commitments regarding length of stay, assurances of "cure," etc. Despite the patient's intolerance of ambiguity, they are told that the length of their stay and the benefit derived from therapy depend on their participation. They are informed of the lower limits of their hospital stay, but told that the actual period is determined by their progress as reviewed by the staff. This is incorporated in an orientation to the meaning of therapy in general.

3. Setting conditions for therapy, such as asking for special privileges. One way of dealing with this is to explain to the patient that this reflects his wanting to be buttressed by special privileges, and that his feeling of vulnerability is greater than that of his peers who do not need this advantage. The therapist's equal responsibility to all is also pointed out, appealing to the patient's group loyalty.

4. Endeavoring to substitute a phone call for a treatment session, when the addict is on after-care status. When this happens, the basis for the addict's resistance must be explored with him.

Among the *indirect maneuvers* are: (*a*) self-depreciation and manipulation of the therapist's sympathy; (*b*) expressions of hurt, surprise, or disappointment in treatment results, to put the therapist on the defensive; (*c*) "quoting" what other staff members have said in contradiction to the therapist's views, a kind of wedging operation which often provides insight into the patient's behavior at home.

SUMMARY

The adolescent drug addict is socially distant, suffers from heightened feelings of inadequacy, lacks courage, desires to be shielded and pampered. The employment of a "private logic" is seen in his argot and his belief that many laws do not apply to him. His responses to the three major life problems, as these are defined by Adler, show: (*a*) social relationships are limited to a kind of parallel reacting with fellow addicts; (*b*) sexual relationships are characterized by the masculine protest; (*c*) occupational efforts are apathetic, marked by the fear of failure and the inability to postpone immediate gratification. The description of some of these characteristics is supported by early recollections.

Beneath the addict's exterior of a "better me than you" orientation there is a rudiment of social interest to be worked with and strengthened. The interpersonal transactions in the treatment setting afford the addict an opportunity for changing fundamental misconceptions of himself and his social surroundings. His involvement in status operations reflects the core need to be liked and respected by others. It is to channel this into constructive social concern so that he will extend himself to persons in his milieu, which is the prime aim of treatment.

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