Exploring Alcoholism:
Motivation, Adolescence, and Individual Psychology

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By:
Shannon Leigh Dolan

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Abstract

This project explores different elements that influence and contribute, as risk or protective factors, to alcoholism. Examined is motivation, choice making, and expected affective change, as well as biological factors determining motivation and choice. Differing opinions are investigated regarding the disease concept of alcoholism. Adolescent alcohol use is examined, as this is a significant problem in the United States, taking place at a crucial developmental period; this stage in life is when alcohol use disorders usually originate. Alcoholism is considered from an Adlerian perspective, that of Individual Psychology, with particular pieces of Adlerian theory applied.

Alcoholism is a persistent issue affecting many, with numerous theories describing etiology and treatment. Many opinions (some detrimental) have emerged, resulting in social stigma surrounding alcoholism. This researcher hopes to create a better understanding of alcoholic behavior, and in doing so to support those with alcoholism and concerned others as well; this will aid in the healing process.
CHAPTER 1. INTRODUCTION

Introduction to the Problem

Hypothesis: Alcoholism is a persistent, complex issue with much social stigma surrounding it, and many contributing factors. The significance of this study is that alcoholic behavior, like all behavior, has a purpose, and this purpose deserves better understanding. Alcoholism is a multifaceted, complicated issue; misunderstanding and/or lack of desire for understanding are often the response to another’s alcoholic behavior. Better understanding can potentially lead to better relationships with those affected by alcoholism, and ideally to improvement in the quality of life and the successful end of alcoholic behavior.
CHAPTER 2: LITERATURE REVIEW

Literature Review

Many elements influence and contribute, as risk or protective factors, to alcoholism. Different dynamics influence motivation, choice making, and expected affective change; biological factors exist that play a role in determining motivation and choice surrounding alcohol use. Adolescent alcohol use is a significant problem in the United States, and this population is therefore particularly impacted by these different dynamics, motivation, and choice making. Adolescence is a crucial developmental life stage, and is when alcohol use disorders usually emerge. Individual Psychology has much to offer in terms of the foundation of alcoholism.

Alcohol Use: Motivation

Life presents an array of choices on a daily basis, and we make our decisions based on a variety of factors. Cox and Klinger (1988) liken alcohol consumption to this choice making. They believe multiple factors influence drinking, but that all these come down to motivation. Motivation to drink “is closely tied to … incentives in other life areas and to the affective changes [derived] from [these] incentives” (p. 168).

By affective changes, Cox and Klinger (1988) are referring “to the psychological, or experiential, component of an emotional response” (p. 169); by affective change, the authors are referring to “a change in affect from its current state” (p. 169). This change can be quantitative or qualitative in nature, and can be influenced positively or negatively, resulting in, for example, pleasure and happiness or frustration and anger. As humans, we are continually striving to attain pleasure and avoid non-pleasure; the authors believe that our expectations about incentives direct this goal striving. Human motivation has, at its core, this goal-striving as “the organizing force behind behavior and that people strive for goals because they expect that reaching them will
produce affective changes” (Klinger, 1975, 1977; Pervin, 1983, as cited by Cox & Klinger, 1988, p. 169). This writer interprets this as very similar to Adler’s theory of striving; Cox and Klinger (1988) expand by stating, “organisms strive to achieve positive incentives in order to enhance positive affect and seek to rid themselves of negative incentives in order to reduce negative affect” (p. 169).

Clear expectations of alcohol’s effects surround motivation to use alcohol (Cox & Klinger, 1988) well before any is consumed (Christiansen, Goldman, & Inn, 1982, as cited by Cox & Klinger, 1988). The authors are suggesting that one’s motivation to drink (as well as the effects alcohol has on one’s behavior) rests on significant influence by expectations placed on consuming alcohol (Marlatt & Rohsenow, 1980, as cited by Cox & Klinger, 1988). This writer agrees with suggestion by Cox and Klinger (1988): “The many variables demonstrated to … impact … motivation to drink do so by helping to form expectations about the affective changes that will occur if a person drinks, as compared with affective changes produced by nondrinking, alternative behaviors” (p. 169). This is to say, for example, that if one believes that drinking will improve one’s mood but that exercising, while possibly helpful in an effort towards a better mood, will not have as quick or significant impact on improvement of mood. (This certainly does not address drinking while exercising.)

**Affective Change Through Alcohol Use**

When using alcohol, according to Cox and Klinger (1988), attaining affective change occurs in two ways, and equates to two corresponding types of effects expected from drinking. The first is biological: alcohol has a direct, chemical effect on emotion. It alters mood; this is often described as “tension-reducing [or] mood-enhancing” (p. 170, Langenbucher & Nathan, in press; West & Sutker, in press, as cited by Cox & Klinger, 1988). The authors give caveat: often,
more influential than actual pharmacological changes is one’s expectations about alcohol’s mood-altering effects (Lang & Michalec, in press; Marlatt & Rohsenow, 1980, as cited by Cox & Klinger, 1988).

The second effect has a much more indirect result in affective change, and takes place based on the simple “fact that drinking alcohol can be instrumental in regulating the other incentives in one’s life” (Cox & Klinger, 1988, p. 170). This writer is partial to the author’s description of this indirect, yet significant result of alcohol consumption as it influences affect.

Cox and Klinger (White, Bates, & Johnson, in press, as cited by Cox & Klinger, 1988) state:

Imbibing alcohol might either facilitate or interfere with a person’s reaching nonchemical positive or negative goals, thereby indirectly bringing about affective changes … many of the social variables that influence drinking do so indirectly because alcohol is instrumental in achieving peer approval [emphasis added]. (p. 170)

In this writer’s experience, this indirect effect has significance in terms of goal-striving, as well as personal purpose; peer approval achieved via engaging in social activity that includes drinking alcohol creates affective change, e.g., having drinks with friends can create a feeling of acceptance and camaraderie that potentially helps achieve a goal and purpose of solidifying peer approval and friendships.

Cox and Klinger (1988) further describe the affective change produced by alcohol. This writer concurs that whether the change is direct or indirect, “alcohol use is intertwined with people’s incentive motivation and the affective changes that they experience as a result of the incentives in their lives” (p.170). This is to say that the mental state one is experiencing before drinking alcohol, and that state one expects to change by drinking alcohol, is likely a product of the combination of goal striving in life and the success experienced or not experienced in
reaching one’s goals. Drinking alcohol (particularly in large quantities), alters one’s affect, as well as incentive motivation, and one’s motivation to drink more alcohol or not. Alcohol consumption will drive and is driven, either directly or indirectly, by the other incentives in one’s life.

Through their motivational model of alcohol use, Cox and Klinger (1988) suggest that one’s motivation to use alcohol is dependent on several variables, but that this motivation ultimately depends on one’s expectations of the change in affect one will experience by consuming alcohol. The authors stress the importance of acknowledging that the motivational model recognizes that a range of drinking habits and attitudes about drinking exist; they separate these varying styles by describing them as “‘addictive’ versus ‘nonaddictive’” (p. 171), but clarify that these styles exist on a continuum. Explained is the model’s views on the difference between addictive and nonaddictive drinking: When the factors contributing to the decision to drink alcohol surpass the factors contributing to the decision not to drink alcohol (e.g. one’s positive physiological reaction to alcohol is more influential than the adverse consequences drinking may have), addictive drinking occurs. However, the authors recognize that the same means direct choices made for all drinking, and this process carries the same significance whether the outcome is addictive or nonaddictive drinking. As with all decisions, the choice to drink or not is made based on personal values (centered on emotional processes) as well as expectancies about the choice made.

**To Drink or Not To Drink: Decision Time**

As stated above, emotionally-based values help guide rational decisions; Cox and Klinger (1988) believe that the choice to drink or not is fueled by emotional and rational means, with the end decision dependent on the change in affect one believes will occur based on what choice is
made. The authors offer an example: if one with alcoholism rationally expects that they will lose their job and marriage if they carry on with a drinking binge, these outcomes may be enough to create anxiety. In spite of these possible outcomes from continuing bingeing, if one expects immediate relief and/or pleasure from continuing drinking, this expectation may carry more weight than the potential undesirable outcomes. This writer feels this is an interesting example of variables and expectations affecting the decision to drink/continue a binge, but offers another outlook: if one with alcoholism rationally expects that they will lose their job and marriage if they carry on with a drinking binge but are unhappy in either or both their job and marriage, these outcomes of job loss and marriage end may not create anxiety, but reassurance. By continuing bingeing, they can not only expect immediate relief and/or pleasure from continuing drinking, but relief from other, intolerable aspects of life. This portion of the decision to drink (or continue drinking) may be non-conscious.

This writer has witnessed this decision-making firsthand. For example, a woman develops a drinking habit in which she consumes up to a liter of hard alcohol daily, which gradually progresses to begin in the morning to get past “the shakes.” She continues this pattern of seeking physical relief caused by and through alcohol (as well as being drunk all day), until she discovers she is pregnant. At this time, she makes a conscious choice to stop drinking altogether. She has love for and values the health of her unborn child; this is more important to her than continuing her addictive and damaging drinking behavior.

Conversely, a different woman spends 90 days in a residential treatment facility and does well; however, she has been to 12 previous treatments. Upon completion of this 13th treatment, she makes a conscious choice and returns immediately to heavy drinking. Although she claims to appreciate what she learned while in each treatment and the intermittent days spent sober, her
desire for alcohol’s physiological effect is more influential than the adverse consequences relapse has, e.g., her deteriorating health, loss of family members’ trust (again), loss of her apartment. Feeling drunk is more important than losing everything she has worked to regain; she is seeking immediate sensation, and this outweighs any reason to abstain, the ensuing undesirable outcomes of her conscious choice.

This choice process one makes to drink or not drink alcohol is comprised of historical factors, current factors, expected and/or direct chemical effects, and reaction to those expected effects determine the choice. An important element Cox and Klinger (1988) point out is that of Cognitive Mediating Events. Between contributing factors, effects, and response to those effects lies one’s thoughts about any or all of these other elements. For this writer, this has been an influential and important contributor to the choice ultimately made; one identity-confirming experience in particular augmented expected effects, reaction to those effects, and subsequently behavior. Often, purpose in life trumps history of behavior and subsequent outcomes.

**Alcoholism Is a Disease**

Although this writer agrees with the above decision-making process as presented by Cox and Klinger (1988), it appears incomplete in that it does not take into account the “disease concept” when it comes to drinking alcohol; whether or not to drink alcohol may not be based fully on conscious choice. By disease concept, this writer is referring to alcoholism as a disease like any other, with a biological basis and physical symptoms, e.g. delirium tremens (DTs). As mentioned previously, we avoid these uncomfortable symptoms; as humans, we seek pleasure and avoid pain. While in the throes of alcoholism, according to the disease model, biology has advantage, and this pain-avoidance often takes place outside of conscious choice.
Cox and Klinger (1988) do speak to this (although they do not refer to alcoholism as a disease). They state that some are “not necessarily aware of either having made a decision to drink or not to drink or the factors the affected the decision” (p. 171). The authors explain further, that drinking decisions are often automatic and not conscious, and that the conscious portion deciding to drink or not generally takes place at the beginning of the process. The authors offer an example: One may make a conscious decision to play a tennis match, but subsequently makes several decisions in terms of individual strokes throughout the match that are more automatic and not conscious. The authors liken this example to the conscious decision to drink made by an experienced drinker; after the introductory choice to drink has been made, further decisions regarding drinking circumstances, amount that will be consumed, etc. take place more automatically. However, this example, while explanatory to a degree, does not provide biological and/or genetic basis for what ultimately comes down to behavior.

According to Craig (1993), while substance abuse assessment “has been rather atheoretical” (p. 184), many theories exist to attempt to understand the etiology of substance abuse (Baker, 1988; Lettieri, Sayers, & Pearson, 1980, as cited by Craig, 1993). However, the author believes that just a few “have the most immediate clinical use” (p. 184), one of which is the disease concept.

Craig (1993) describes the disease theory of alcoholism:

The disease theory states that alcoholism is a disease, stemming from a biological substrate that results in a loss of control—the essential facet that defines alcoholism. This disease is incurable, but alcoholism can be arrested through cessation and abstinence. Return to social, nonproblematic drinking is impossible (Schuckit, 1987). (p. 184)
The author offers evidence for the disease concept in terms of alcoholism. Several twin and adoption studies have taken place which “show higher concordance rates of alcoholism among monozygotic (identical) than dizygotic (fraternal) twins” (Cotton, 1979, as cited by Craig, 1993, p. 184), with adoption studies showing that sons of alcoholics (whether raised by their biological or adoptive parents) had higher rates of alcoholism than sons of non-alcoholics. This writer interprets these examples as showing a familial component to alcoholism, which, depending on interpretation, supports the disease concept of alcoholism.

Craig (1993) points out other studies that examine the disease concept in terms of alcoholism, ones he deems “high risk.” These studies seek “biological markers (i.e., structural, chemical, neuropsychological, physiological, or electrophysiological markers known to be under genetic control) that would account for loss of control or that might be linked to the subsequent development of alcoholism” (Begleiter, Berg, & Rapoport, 1983; Begleiter, Porjesz, Bihari, & Kissen, 1984; Schuckit, 1987 as cited by Craig, 1993, p. 184). Craig does not expand on these high-risk studies to explain what they involve specifically and/or what makes them high-risk.

Advocates of the disease concept of alcoholism find several benefits of assigning a medical label to heavy drinking; by having medical context, this removes much of the stigma surrounding alcoholism. Less shame surrounds physical and mental disabilities associated with (and perhaps borne from) heavy drinking. Additionally, according to Tracy (2007), in our society, if something is proclaimed a disease, enough solid basis may be provided to encourage a person with an alcohol problem to seek help.

**Biology and genetics.**

Schuckit (1987) examines alcoholism in terms of biological vulnerability. He determined, via twin and adoption studies, “that there is generally consistent evidence supporting the
importance of genetic factors in the development of alcoholism” (p. 303). However, although the author also states “alcoholism is … a polygenic and multifactorial problem, with genetically influenced biological factors” (p. 303), he goes on to also discuss the significance of the interaction these biological factors have with environmental events (Cloninger, Reich, & Yokoyama, 1983, as cited by Schuckit, 1987) in order to contribute to the development of alcoholism. He gives examples of such environmental factors that may be significant in increasing risk for alcoholism: “early-life home instability, a relatively low-status [parental] occupation … and the subject’s need for an extended neonatal hospital stay” (p. 303). The author also includes other factors that may also be important, ones he deems are based on common sense, such as “the availability of alcoholic beverages in society (e.g., the price of liquor and number of liquor outlets), social attitudes toward drunkenness, and peer pressures toward excessive drinking” (p. 303).

In another publication, Schuckit (2000) presents a clinical point of view regarding a genetic risk for alcoholism. The author reviews several studies that look at genetic influences for complex disorders; the author emphasizes how genetic influences can apply to “alcohol abuse and dependence (alcoholism)” (p. 103). (Of note is the fact that, unlike in other clinical presentations, i.e. the DSM-IV-TR, the author describes alcohol dependence as alcoholism.) The author looks specifically at “alcohol-metabolizing enzymes, a low level of response to alcohol, the importance of event related potential (ERP) paradigms, and the use of electroencephalographic (EEG) methodologies” (p. 103). The author believes that the genetic influence for alcoholism is important; he states that “there is a three- to four-fold increased risk for this disorder in close relatives of [those with alcoholism]” (p. 103-104), and mentions
adoption studies that show this same high relative risk in both sons and daughters adopted away from men and women with alcoholism.

*Alcohol-metabolizing enzymes.*

Schuckit (2000) gives the as “the best examples of specific genes related to the alcoholism risk” (p. 105), those that “control the production of the enzymes that metabolize alcohol and acetaldehyde” (p. 105). In the human body, two proteins are principally responsible for the breakdown of alcohol: alcohol dehydrogenase (ADH) and aldehyde dehydrogenase (ALDH). During this alcohol-destroying process, a relatively toxic metabolite, acetaldehyde, is created and then subsequently converted to carbon dioxide and water. For those with different forms of ADH and/or ALDH, the process of more rapid production or slower destruction of acetaldehyde can result in “alcohol-related flushing of the skin, increased heart rate, and feelings of nausea and other forms of discomfort” (p. 106).

Schuckit (2000) discusses the fact that there are at least six different forms (or isoenzymes) of ALDH. ALDH2, found in the mitochondria of cells, “is the most important for controlling the acetaldehyde levels usually produced by drinking beverage alcohol” (p. 106). The author goes on to discuss other, different types of alleles and enzymes in the ALDH family, some more functional for processing alcohol and some that are inactive. Worth mention is the genetic composition that consists only of codes for ALDH2-2 alleles; people with “this genetically controlled enzyme form … develop very high levels of acetaldehyde after consuming small amounts of alcohol. They almost all become nondrinkers and carry virtually no risk for alcohol abuse or dependence” (p. 106).

Wall and Ehlers (1995) point out that those of Asian descent experience lower levels of alcoholism and higher rates of abstinence than other ethnic groups (Helzer et al. 1990; Klatsky et
al. 1983, as cited by Wall & Ehlers, 1995). The authors give two potential explanations for this, one environmentally based, suggesting that Asian culture emphasizes drinking in moderation, and one physiologically based, that which has been discussed here, Asians experience a unique bodily reaction to alcohol. The authors recognize low rates of alcohol consumption by Asians to a combination of these cultural and physiological factors (Sue & Nakamura, 1984, as cited by Wall & Ehlers, 1995).

Schuckit (2000) goes on to discuss different ADH-related genes; the author describes the relationships with alcoholism “equally interesting, although … less clear … ADH genotypes might be associated with a more intense reaction to alcohol or negative sequelae of alcohol intake” (p, 106). This is to say that this genetic makeup (in terms of ALDH2-2) in Asian people converts alcohol into acetaldehyde with greater efficiency (40 to 100 fold in some cases) than other gene variants (Peng, et al., 2010), resulting in an increased level of acetaldehyde.

Accumulation of acetaldehyde creates alcohol flush, “the facial skin-flushing response … characterized by intense cardiovascular arousal; visible redness and feelings of warmth of the facial skin; and, at higher dosages, dizziness and nausea (Wolff, 1972, 1973, as cited by Newlin, 1989, p. 421).” Although this flushing response is believed to have protective, buffering qualities against alcoholic behavior (Wolff, 1972, 1973, as cited by Newlin, 1989), some Asians who experience alcohol flush drink socially. Some drink to excess, although they are less likely to do so than those who do not experience alcohol flush. Additionally, even among those who flush to alcohol, Koreans report relatively high levels of alcohol consumption (Park et al., 1984, as cited by Newlin, 1989). This suggests the relation between flushing and alcohol consumption carries strong environmental determinants.
Newlin (1989) offers an additional, alternative explanation to consumption of alcohol in spite of the flushing response, simply that this represents a “chronic tolerance to the flushing response” (p. 421). A display of fast flushing (i.e., after one drink) would not be expected from heavy drinkers/those with alcoholism if they had become partially tolerant to the flushing response. As many other responses to alcohol exhibit tolerance, it is not known if this holds true with alcohol flush.

Newlin (1989) presents an interesting point, that most research has focused on factors contributing to a high, rather than a low, risk for alcoholism. Alcohol flush in Asians is of interest, as it appears to signify a genetically based, low-risk factor for alcoholism (Harada et al., 1935, as cited by Newlin, 1989). According to the author, the full scope of risk for alcoholism can be examined using facial flushing, as it appears to represent a low-risk factor for the disorder. As mentioned above, the flushing response may impart individuals with protection or buffering from manifesting alcoholic behavior (Wolff, 1972, 1973, as cited by Newlin, 1989). Newlin (1989) offers example; a particular elevated trait within a wide range of diverse high-risk groups may be low among those exhibiting facial flushing, that is, if that particular elevated trait plays a significant role in the emergence of alcoholism. This is especially so if that elevated trait is relevant to the end of alcoholic behavior. Low-risk factors can be defined using information relating to low-risk groups, as “characteristics that protect against the development of alcoholic behavior may be as important in the etiology of alcoholism as those factors that predispose toward the disorder. In addition, high- and low-risk factors may be related in opposite ways to the reward value of alcohol” (p. 422). In other words, high-risk individuals may experience greater innate reinforcement when it comes to alcohol than do low-risk individuals, who may experience an innate aversion to alcohol.
As raised levels of acetaldehyde result in alcohol flush and may discourage drinking (or excessive drinking) in Asians, the medication disulfiram (i.e., Antabuse™) imitates this molecular activity. Disulfiram mimics ALDH2 deficiency by inhibiting the enzyme and this results in increased levels of acetaldehyde after alcohol consumption (Harada et al., 1935 as cited by Wall & Ehlers, 1995), which is hoped to deter those with alcohol problems from drinking.

**Low level of response to alcohol.**

Schuckit and Smith (2001) discuss another area of genetic influence as it applies to risk of alcoholism. The authors call this “a low level of response (LR) to alcohol” (p. 903), which is characterized by the need for larger amounts of alcohol to reach the level of intoxication that others experience with a smaller amount of alcohol. The probability increases that a person with a LR will repetitively consume alcohol in this fashion, growing their tolerance to alcohol and developing “a more heavy drinking peer group, which might then reinforce repeated heavy drinking even in the face of consequences” (Schuckit et al., 1999; Schuckit & Smith, 2000, as cited by Schuckit & Smith, 2001, p. 904).

According to Schuckit and Smith (2001), “a low LR is a genetically influenced phenomenon that is likely to characterize about 40% of the children of [those with alcoholism], and which predicts alcohol abuse and dependence up to 10 and 15 years later” (Pollock, 1992; Rodriguez, Wilson & Nagoshi, 1993; Schuckit and Smith, 1996, 2000; Volavka, Czobor & Goodwin, 1996; Erblich & Earleywine, 1999; Heath et al., 1999, as cited by Schuckit & Smith, 2001, p. 904). In spite of this predictability, the probable impact of a low LR on the clinical course of alcoholism is not well known. The authors hypothesize:

While a low LR might contribute to the probability of repetitive heavy drinking in the teens or 20s, thus increasing the alcoholism risk, once the alcohol dependence
syndrome develops the original predisposing factor might have no influence on the
course of alcohol-related problems. (p. 904)

Conversely, early onset of alcohol use disorder can occur if the LR mediated heavy drinking
takes place and has greatest impact in the teens to early 20s—the time period that the greatest experimentation with alcohol takes place (Johnston, O’Malley & Bachman, 2000, as cited by Schuckit & Smith, 2001).

**Alcoholism Is Not a Disease**

In spite of the above examples offered by Cox and Klinger (1988) and Craig (1993), Craig offers warning: at the time his research was published, the disease concept of alcoholism remained a scientifically unsubstantiated theory, with “no reliable biological marker … found to date” (Nathan, 1991, as cited by Craig, 1993, p. 185). Craig speaks to the efforts of The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) Task Force on substance abuse, that this team concluded that the evidence found is not significant enough to include “a category referred to as *Familial Alcoholism* [with] a criteria set that is essentially biologically and genetically based …any differences between alcoholics with family histories positive or negative for alcoholism can be explained by other variables” (Nathan, 1991, as cited by Craig, 1993, p. 185).

More recently, as Tracy (2007) points out, “‘alcoholism’ is not a medical term” (p.86). According to The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR), terms referring to alcoholism are described as “alcohol dependence,” “alcohol abuse,” and several other alcohol-related afflictions are included, e.g. Alcohol Intoxication and Alcohol Withdrawal (2000). These terms and afflictions exist on a continuum; the term ‘alcoholism’ is not mentioned.
Tracy (2007) goes on to say that although the behavioral consequences of heavy alcohol use (as well as the organic consequences therein) are “well recognized by the medical community” (p. 86), a person with a drinking problem is equally likely to receive help from a behaviorist, attend an Alcoholics Anonymous (AA) meeting, or see a medical doctor. This writer interprets this fact as reducing the significance the disease concept carries.

According to Tracy (2007), the policy statement of the American Society of Addiction Medicine (ASMA, which is affiliated with the American Medical Association [AMA]), states “alcoholism is a complex primary physiological disease, and neither a primary behavior disorder nor a symptomatic manifestation of any other disease process” (p. 86). Dedicated, present-day support for the disease concept of alcoholism can be found with nonprofessional organizations such as AA.

Critics of applying a medical label to alcoholism believe that this absolves the drinker from responsibility for their condition (and any consequences from it), as well as removing accountability for treatment. This is also interpreted by some as a change in nosology that demonstrates “a failed intellectual construct” (Tracy, 2007, p. 86), taking place simply for the purpose of third-party reimbursements. The author goes on to discuss further opposition to the disease concept of alcoholism; she gives reminder of the social and economic conditions that may contribute to problem drinking, specifically unemployment, discrimination, and poverty. The author adds to this perspective: “The act of diagnosis may allow us to liberate sick individuals from their plight, but it can also be a powerful instrument of social control. In this sense, disease is both clinical pathology and social commentary” (p. 86). This speaks to the biopsychosocial impact alcoholism carries.
Based on these differing descriptions of the disease concept of alcoholism (which, in the opinion of this writer, both offer valid points and important features to consider when it comes to alcoholism), it is apparent that there is not a simple way to explain alcoholism in terms of disease with respect to biology, genetics, behavior, predisposition, economic condition, etc. It would appear that the disease concept is not a panacea, nor is a strict behavioral outlook at alcoholism.

Conclusion

Decisions regarding alcohol use are similar to any other decision life presents: it is influenced by many things, but ultimately falls on motivation and affective change one expects based on the decision made. Affective change can occur through alcohol use in two ways: biological and/or more indirectly, by helping to regulate other incentives in life, e.g., achieving peer approval. Much of the affective change experienced via alcohol use is dependent on one’s expectations of the change to be experienced; this can create a variety of drinking styles, namely addictive and non-addictive, and these exist on a continuum. Personal values drive the choice to drink or not, as does expectations regarding this choice. Additionally, other factors play into this value system/expectation choice making: emotionality and rationality also determine the decision to drink or not. Alcoholism is viewed by some as a disease, with a biological basis and physical symptoms; several twin and adoption studies support this. Some believe that viewing alcoholism as a disease removes stigma and shame. Through genetics, some are lacking a particular protein to ease alcohol processing in the body; moreover, this is viewed as a protective factor. Another genetic influence is characterized by a need for larger amounts of alcohol to reach the level of intoxication that others experience with a smaller amount of alcohol, often leading to heavy drinking and dependence. Some are of the mind that alcoholism is not a disease, that this is unsubstantiated and may absolve a drinker from responsibility. However, those who do not
believe it is a disease do recognize the behavioral and organic consequences of heavy alcohol use, and believe several factors contribute to heavy alcohol use beyond biology: social and economic conditions may contribute to problem drinking, specifically unemployment, discrimination, and poverty. The factors leading to alcoholism are numerous; there is not a simple way to explain alcoholism. This writer is left believing even more fully that alcoholism is a complex issue that is ultimately determined by the intricate details of all of these components; the interplay of biology, genetics, behavior, predisposition, economic condition, personal values, expectations, etc. makes for a puzzle not easily solved.

**Adolescents and Alcohol**

As Sussman, Skara and Ames (2008) point out, “substance use, misuse, and dependence are among the most prevalent causes of adolescent morbidity and mortality in the United States” (Brannigan, Schackman, Falco, & Millman, 2004; Newcomb and Bentler, 1988a; Sussman, Dent, and Galaif, 1997, as cited by Sussman, Skara, Ames, 2008, p. 1802), with teens and emerging adults in the United States using or misusing substances of all types (Johnston et al., 2004 as cited by Sussman, Skara, Ames, 2008). Although this misuse of all substances by adolescent presents as an important issue, for this paper, this writer will focus specifically on alcohol use and misuse by teens and emerging adults, why they choose or choose not to drink, risk factors during childhood, and how patterns during this developmental stage affect chemical health in adulthood.

**Prevalence of Alcohol Use in Adolescence**

Alcohol consumption in adolescence is a significant issue. According to Johnson et al. (2003, as cited by Caldwell et al, 2005), well over half (58%) of American adolescents have gotten drunk by the 12th grade. Of these 58%, 6% meet the Diagnostic and Statistical Manual,
Fourth Edition, Text Revision (DSM-IV-TR) criteria for an alcohol use disorder (AUD) (SAMHSA, 2003, as cited by Caldwell, et al., 2005). According to Windle et al. (2009), several nationally representative surveys (i.e., Monitoring the Future [MTF], National Survey on Drug Use and Health [NSDUH], and Youth Risk Behavior Surveillance System [YRBSS]) have confirmed that among American adolescents (over the age of 12), alcohol is the drug of choice (Masten, Faden, Zucker, and Spear, 2008, 2009).

Generally, alcohol use begins in adolescence. First use is defined as consuming a whole drink, and this typically occurs at 13-14 years of age (Faden, 2006, as cited by Masten et al., 2008, 2009). Rates of alcohol use increase markedly between the ages of 12 and 21; this increase between ages 12 and 21 includes any alcohol use (at least one whole drink in the past month), binge use (defined as drinking four or more drinks on one occasion for women, and five or more on one occasion for men), and heavy use (defined as drinking five or more drinks on five or more days within the past month). Figure 2 shows this marked increase in rates of alcohol use by teens: past-month alcohol use increases from under 5% of 12-year-olds to nearly 75% of 21-year-olds; binge alcohol use increases from under 2% of 12-year-olds to 50% of 21-year-olds; heavy alcohol use increases from < 1% of 12-year-olds to just under 20% of 21-year-olds (SAMHSA, 2007, as cited by Masten et al., 2008, 2009). Data from the NSDUH indicate that the number of individuals who have consumed one or more whole drink increases sharply during adolescence, leveling around 21 years of age (SAMHSA, 2006, as cited by Masten et al., 2008, 2009). The authors present additional data from the NSDUH showing that while adolescents drink alcohol less often than adults of any age do, they drink more per drinking occasion, averaging a consumption of five drinks; as mentioned above, this characterizes binge drinking (Masten et al., 2008, 2009).
The 2005 MTF study (Johnston et al., 2006, as cited by Windle et al., 2009) presents similar data when it comes to prevalence of alcohol use by adolescents. Of those surveyed, 41.0% of 8th graders and 63.2% of 10th graders, respectively, reported they had used alcohol in their lifetime, with 19.5% of 8th graders and 42.1% of 10th graders, respectively, reporting having been drunk in their lifetime (Windle et al., 2009). Results from the MTF study also show that numbers such as these increase as adolescents age, with over 75% of 12th graders reporting having tried alcohol at least once, and nearly 60% reporting having been drunk at least once. The MTF study also examined current alcohol use by adolescents, and reveals these numbers: 33.2% of 10th graders and 47.0% of 12th graders surveyed reported having used alcohol at least once in the past 30 days; 17.6% and 30.2%, respectively, reported having been drunk in the past 30 days; 21.0% and 28.1%, respectively, reported binge drinking (five or more drinks in a row) in the past two weeks; and 1.3% and 3.1%, respectively, reported daily alcohol use (Johnston et al., 2006a, as cited by Brown et al., 2008, 2009).

**Predicting Alcohol Use and Alcohol Use Disorders: Childhood Factors**

Early alcohol use and/or dependence has been consistently preceded and predicted by a particular set of risk factors. According to Masten et al. (2008, 2009), substantial research (i.e., National Research Council and Institute of Medicine 2004; Zucker 2006; Donovan 2004; NIAAA 2004–2005, as cited by Masten et al., 2008, 2009) has shown specific risk factors include the following:

- Prenatal exposure to alcohol, including that which gives rise to fetal alcohol spectrum disorder (FASD) including fetal alcohol syndrome (FAS);
- A family history of alcohol abuse, antisocial behavior (by either parent), and depression (in the mother);
- Poor parenting of the child (e.g., maltreatment, neglect, poor monitoring);
- Childhood antisocial behavior;
- Childhood smoking or other kinds of substance abuse
- Early signs of cognitive and learning problems, including academic failures; and
- Self-regulation problems also predict antisocial and risk-taking behavior, such as attention problems, difficulty regulating emotion or behavior, poor impulse control, and effortful control problems. (Effortful control refers to the ability to make oneself perform tedious tasks, such as doing repetitive math homework.)

This writer calls attention to the fact that Masten et al. (2008, 2009) also discuss that many of the risk factors for early alcohol use (and AUDs) are “nonspecific to alcohol involvement” (2009, p. 10), meaning that these risk factors can also foreshadow many other types of problems other than those with alcohol. According to the author’s research, these additional problems can include “conduct and learning problems, risk-taking behaviors, dropping out of school, early sexual activity and pregnancy, antisocial personality disorder, and mood disorder” (Dodge and Pettit 2003; Evans et al. 2005; Kendler et al. 2003; NIAAA 2004–2005; Tsuang et al. 1998; Zucker 2006, as cited by Masten et al. 2008, 2009, p. 10). This writer imagines that any or all of these additional problems could easily coincide with adolescent alcohol use.

**Risk and Protective Factors Have Age-Related Patterns**

According to Masten et al. (2008, 2009), research shows age-related patterns tied to both risk and protective factors. These factors can either increase or decrease the risk of alcohol use/dependence.

Expectancies about using alcohol and its effects shift during late middle childhood and early adolescence, from primarily negative to positive (Dunn and Goldman 1996, 1998, as cited
by Masten et al., 2008, 2009), with the intent to use alcohol increasing during elementary school (Donovan et al. 2004, as cited by Masten et al., 2008, 2009). The authors believe this change in attitude may be “linked to the transition from childhood to adolescence or from elementary school to secondary school” (Masten et al., 2008, 2009 p. 10). The authors mention analysis from the Pittsburgh Girls Study, that “positive expectations about alcohol use rose and negative expectations fell between ages 8 and 10” (Hipwell et al. 2005, as cited by Masten et al., 2008, 2009, p. 10), as well as findings from another study that indicate expectations surrounding alcohol shift earlier than the move from elementary school to middle school (Dunn and Goldman, 1996, 1998, as cited by Masten et al., 2008, 2009). Additionally, over the course of childhood and adolescence, access to alcohol generally increases (Johnston, et al., 2006 as cited by Masten et al., 2008, 2009).

Other risk factors also related to age or development can emerge. A risk factor (that typically begins in early adolescence) for alcohol use is smoking (Klein, 2006, as cited by Masten et al., 2008, 2009). Popularity with peers matters: it is associated with a lower risk for alcohol use in elementary school (Zucker, 2006, as cited by Masten et al., 2008, 2009), but potentially a higher risk for high school students (Diego, et al., 2003, as cited by Masten et al., 2008, 2009). The authors speculate that this heightened risk may be due to popular youth attending more parties with alcohol. Timing of physical maturation matters, and can have “significant ramifications for social interactions and alcohol use” (Masten et al., 2008, 2009, p. 10). The authors give example: Girls that mature early may date older boys who drink, and this may increase the risk for alcohol consumption for early-maturing girls. Many American parents (as well as many American adolescents) see underage drinking as a rite of passage (Jessor and Jessor, 1977; Maddox and McCall, 1964, as cited by Masten et al., 2008, 2009). Conversely,
childhood drinking is not culturally acceptable. For that reason, adult expectations shift surrounding adolescent drinking, and for some, an implicit approval of drinking given.

Yet another shift in expectancies about drinking can occur with the transition to college. The risk for binge drinking increases significantly with college students, especially during the first months of the first year (White et al., 2006, as cited by Masten et al., 2008, 2009). The authors point out that “a subset of college binge drinkers already have been drinking at high levels in high school and continue this practice in college. Another group increases their alcohol consumption at the beginning of college but then reduces it” (Masten et al., 2008, 2009, p. 10), and for others, a decline in the risk of binge drinking occurs.

Peer and family relationships carry risk or protective factors. Involvement with deviant peers and delinquent behavior with such peers are both significant risk factors for alcohol use. These “increase in early adolescence, especially among youth characterized by a cluster of risk factors for antisocial and risk-taking behavior” (Dishion and Patterson 2006 as cited by Masten et al., 2008, 2009, p. 11). Risk can be heightened if parental (and other adult) monitoring decreases and unmonitored adolescent time increases. Adult/parental monitoring can be protective.

With all of these potential risk factors in mind, Masten et al. (2008, 2009) stress that “many influences and interactions involving the complex interplay of genes and environment shape the course of human development” (Gottesman and Hanson 2005; Masten 2007a, as cited by Masten et al. 2008, 2009, p. 11), and that a given problem or disorder can have many contributing causes, all potentially leading to an array of outcomes. Alcohol problems can arise for an individual with a healthy childhood with few risk factors, just as for one troubled from the start with many risk factors. Additionally, children with similar or equal risk factors for alcohol
use may show markedly different outcomes; alcohol-related problems will develop for some, which some completely avoid.

Adolescent Cognitive Abilities, Coping Strategies and Purpose in Life

Purpose in life and coping skills can be influential in the mediation of the connection between cognitive abilities (e.g., fluid and crystallized intelligence) and alcohol (among other substances) use. Minehan, Newcomb and Galaif (2000) discuss this interaction, “based on the premise that childhood and adolescence are critical years for developing coping skills” (e.g., Newcomb, 1996a, b; Newcomb et al., 1981 as cited by Minehan, Newcomb & Galaif, 2000, p. 34). The authors’ study examined “cognitive and coping elements as precursors (or risk factors) for substance use” (p. 45).

Significant changes in cognition take place during adolescence, such as “increased speed of thought, ability for critical thinking, capacity to process more information, increased content knowledge constructs, more complex combinations of knowledge, and the ability to develop problem solving strategies” (Santrock, 1993, as cited by Minehan, Newcomb & Galaif, 2000, p. 46). These cognitive abilities interact and process information, leading to observable behavior. As adolescents’ abilities (e.g., practical problem solving skills, verbal skills, social capability) increase, detailed intellectual qualities (e.g., fluid and crystallized cognitive abilities) can be determined (Minehan, Newcomb & Galaif, 2000).

Minehan, Newcomb, and Galaif (2000) specify that “fluid cognitive abilities are those biologically determined intellectual skills that encourage inductive reasoning and analytical thinking, [while] crystallized cognitive abilities are intellectual skills learned within a cultural or social context that are largely shaped through personal experience” (p. 47). Inadequate crystallized intelligence may suggest an underdeveloped system of thought, a system needed for
successful coping with life stressors successfully. With these descriptions in mind, “the developmental patterns of fluid and crystallized cognitive abilities may differentially affect adolescent [alcohol] use” (p. 47).

Crumbaugh and Maholick (1964) suggest that, “a vacuum of perceived meaning in personal existence … [leads] the individual [to become] ‘existentially frustrated’” (Frankl, n.d., as cited by Crumbaugh & Maholick, 1964, p. 200), and that depending on other relevant and driving factors, this existential frustration may lead to psychopathology. For the purposes here, this writer interprets this as suggested by Minehan, Newcomb, and Galaif (2000): “A keen awareness of life’s possibilities may lead one to strive for meaningful ends and develop strengths to resist drug [and alcohol] use” (p. 47). In the authors’ study, adolescents with stable crystallized intelligence (e.g., skills learned in school that society considers valuable) claimed to have higher purpose in life (than those with less stable crystallized intelligence), and reported less alcohol use. The authors suggest that this may indicate that strong academic ability (particularly in language, reading and math) in adolescents may help them gain a sense of accomplishment, as these skills are often socially and culturally rewarded; a positive attitude about life grows from this feeling of accomplishment, and this has been shown to be associated with less alcohol use. The authors believe “that the more modifiable type of intelligence, which is learned in school and derived from one’s social environment, should be fostered in adolescents to discourage the use of drugs [and alcohol], while increasing motivation and meaning in life” (Hawkins, Catalano, & Miller, 1992, as cited by Minehan, Newcomb, and Galaif 2000, p. 47). According to Hawkins, Catalano, and Miller (1992), the effects of exposure to risk factors is mediated or moderated by protective factors (Cowen & Work, 1988; Garmezy, 1985; Rutter, 1985; Werner, 1989, as cited by Hawkins, Catalano, and Miller, 1992). With this in mind,
adolescents that are able to build strong crystallized intelligence (and, in turn, have that intelligence fostered and encouraged by parents, teachers, and other important and influential adults) will have a better outlook on and a higher purpose in life, and will be less likely to use alcohol.

**Impact into Adulthood**

Dependence on alcohol generally emerges during late adolescence or early adulthood. As discussed above, alcohol is the drug of choice among American adolescents (Masten, Faden, Zucker, and Spear, 2008, 2009), and as alcohol use generally increases during adolescence (SAMHSA, 2006, as cited by Masten et al., 2008, 2009), with adolescents generally taking part in more binge drinking than any other age group (Masten et al., 2008, 2009), it is logical that dependence would emerge at this point in life.

Alcohol Dependence is defined by the criteria of the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision, American Psychiatric Association, 2000) as

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   a. a need for markedly increased amounts of the substance to achieve Intoxication or desired effect
   b. markedly diminished effect with continued use of the same amount of the substance

2. Withdrawal, as manifested by either of the following:
(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Past-year prevalence of DSM-IV alcohol dependence increases significantly between ages 12 and 20 (2% to just over 12%, respectively, of the United States population) where it peaks between ages 18-20 (see the National Epidemiologic Survey on Alcohol and Related Conditions, 2001-2002, and the National Survey on Drug Use and Health, 2003 for more information). Figure 2 shows children/youth who begin using alcohol earlier (childhood or early adolescence) are much more likely to develop alcohol dependence, regardless of family history when it comes to alcoholism. The trend demonstrated in Figure 1 shows how multiple, combined risk factors (e.g., early age of first use plus family history of alcoholism) increase the likelihood
for meeting the DSM-IV-TR criteria for alcohol dependence at some point in life, with this risk decreasing as age of first use increases when combined with all types of family history. Although Figure 1 does not show the influence of other, potential risk and/or protective factors that may exist, this writer believes it demonstrates well the danger present for potential alcohol dependence for those who begin drinking at a young age.

**Conclusion**

Alcohol is the drug of choice among American adolescents; over half have been drunk by the 12th grade. Some meet criteria for an alcohol use disorder. Alcohol use generally begins during adolescence, with rates of use increasing sharply during these years. Early alcohol use and/or dependence has been consistently preceded and predicted by a particular set of risk factors to include: prenatal exposure to alcohol; family history of alcohol abuse; mental illness in the parents; poor parenting; childhood antisocial behavior; childhood smoking; early signs of cognitive problems; problems with attention, regulating emotion or behavior, poor impulse control. Many risk factors have age-related patterns. Peer and family relationships carry risk or protective factors; deviant peers and delinquent behavior are significant risk factors for alcohol use, as is decreased parental/adult monitoring. Adolescent purpose in life, coping skills, and cognitive abilities influence alcohol use; the greater the levels possessed by an adolescent, the lower their risk for drinking. Alcohol dependence generally emerges during late adolescence or early adulthood; age of first use and family history of alcohol dependence are weighty contributors. Multiple elements contribute to adolescent alcohol use, as well as abuse, and potentially dependence. Encouragement from important adults can lead to greater sense of meaning for a young person; the healthier they can remain, the lower the risk for alcohol use.
Individual Psychology and Alcoholism

Alcoholism, according to Dreikurs (1932/1990), “originates from deficient social interest” (p. 214), with social interest represented by “a concern for and commitment to the welfare of the community” (Shifron, 2010, p. 11). Alcoholism can be understood in Adlerian terms of Individual Psychology “as not an unconscious behavior but rather a goal-oriented, creative, and chosen solution to achieve significance” (Shifron & Reysen, 2011, p. 144). Shifron explains that "addictions [including that to alcohol] are … creative behaviors to deal with the hardships of life" (1999, as cited by Shifron & Reysen, 2011, p. 144). According to Shifron, the goal of alcoholism, this "creative chosen repetitious developing behavior," is to "escape existential fears" (2010 & 1999, as cited by Shifron & Reysen, 2011, p. 137). This writer believes that these examples demonstrate how alcoholism as a way of dealing with life’s hardships and escaping existential fears speaks to its affect on the life tasks; success at love, work, and friendship may be challenging for some.

Dreikurs (1932/1990) expands on these principles, also from an Adlerian standpoint. He states, “Individual Psychology believes that it has contributed the essentials for understanding addiction … deeper connections exist between addiction, neurosis, [and] educational difficulties” (p. 209). Keeping with Individual Psychology, according to Dreikurs, people suffering from addictions “exhibit a defective development in their posture toward life and the human community” (p. 209). He describes this defective development as a “rejection of life” (p. 209), as well as a rejection of the aforementioned human community, and believes that an understanding of the whole person will make sense of this life rejection in terms of addiction. With this whole-person understanding in mind, Dreikurs states what this writer believes fully, that alcoholism is “only curable when the patient, as a whole person, changes himself [emphasis added]” (p. 209).
Dreikurs believes that although no two cases of addiction are alike and each depends on the lifestyle of the individual, we can establish characteristic features for addiction. Dreikurs states that addiction is borne from a "deficiency in social interest," and that it is used as a "substitute for a correct conduct of life" (1932/1990, p. 209). This deficiency and substitution begins with improper preparation, during childhood, for the tasks of life. This writer affirms that this improper preparation can result in addiction in the aforementioned fashion of avoiding the life tasks. For example, as a child, if one is not properly prepared and instilled with an adequate work ethic, one will be ill prepared, later as an adult, to successfully attend to and meet the expectations of keeping a job. This ill-prepared person, because of this deficiency, may not attempt to keep or even acquire a job, instead avoiding work; this may not necessarily be a conscious choice. Along with this avoidance (and perhaps including other factors explored throughout this writing), other socially useless habits can take over: addiction.

Pampered Children

Dreikurs suggests that addicts are often pampered children who have grown up depending upon others, and therefore improperly prepared for the life tasks; pampered children have not “correctly learned the requirements of practical living” (1932/1990, p. 210). For many Adlerians, the term “pampering” does not simply imply “spoiling.” As Krausz states, “…pampering does not only mean tenderness or spoiling by means of tenderness, but rather the privilege of being spared having to master difficulties suitable to a specific age level” (n.d., as cited by Dreikurs, 1932/1990, p. 214).

Adler (1926/1988) expands on this definition of pampering. When a mother supports her child to the degree that she is
always ready to help, always making suggestions—and the child keeps asking for them—always giving in, protecting him from every possible harm. Ever anxiously at his side, she does not allow the child to function, to move, to express himself. And since the mother does everything for the child, there is nothing left for him to do. Such a child does not even have to think, nor to act, because mother takes care of everything. (p. 412)

A pampered child/future addict has the opportunity for and advantage of keeping others in their service, while simultaneously exploiting the social interest of these others (Dreikurs, 1932/1990). Adler (1930/2009) concurs, stating, “of those people who experience failure in life, we have found that most were originally pampered children” (p. 106). Due the disservices imparted upon them, pampered children lack courage and self-confidence, and develop fear of (rather than desire to overcome) life’s challenges.

This writer takes issue with Adler’s use of the word ‘failure’: in this writer’s opinion, a problem with addiction does not constitute failure in life. For the purposes of what this paper is striving to communicate, when it comes to growing up as a pampered child, misuse of alcohol (and, for that matter, addictions of all kinds) as an adult is a compensatory response, a behavior signifying one’s attempt at moving from a felt minus to a perceived plus, a striving to find personal significance. Addiction is seen by Adler as existing on the “useless side of life … [with a group of solutions that are] inferior, nonconstructive, nonconsensual, irrational, ineffective, and unsuccessful” (Mosak, 1995, p. 47). Pampered children, with addiction in mind, are not adequately prepared to face the tasks of life in a useful way: addict behavior can be interpreted as social interest in the only way an addict knows. This is to say that, as Dreikurs states, pampered children (and for the argument here, adult addicts) have not “correctly learned the requirements of practical living” (1932/1990, p. 210). This writer believes this can manifest as skewed social
interest: drinking is their way of contributing, and this, although atypical as far as usefulness goes, is not failure.

**The Four Goals of Misbehavior**

Shifron and Reysen (2011) point out the similarities between goals of addiction and the escape of existential fears with the four goals of children’s disturbing behavior (later worded as the four goals of children’s misbehavior), a concept formulated by Rudolf Dreikurs. Some consider this concept to be one of his “best known contributions to understanding the behavior of children” (Shulman & S. G. Dreikurs, 1978, p. 156-157, as cited by Ansbacher, 1988, p. 282), as well as “one of his ‘major and finest contributions to Adlerian psychology’” (Mosak & Mosak, 1975, p. 14, as cited by Ansbacher, 1988, p. 282). These four goals of children’s misbehavior, arranged in order of “increasing ‘social discouragement’” (Ansbacher, 1988, p. 283), are attention getting (this was originally designated as AGM: attention-getting mechanism), power, revenge, and demonstration of inadequacy.

When discussing addiction having its roots in childhood experience, Dreikurs does not mention these mistaken goals. Rather, he keeps with the idea of an addict having grown up as a pampered child. However, as this writer sees it, an overlap exists with Dreikurs’ idea here and the four goals of mistaken behavior in children. As shown by Ansbacher (1988) in Figure 2, Dreikurs related the four goals of misbehavior to four types of behavior patterns; these are formed by two important dimensions, active-passive and constructive-destructive. The outcome is four types: active-constructive, passive-constructive, active-destructive, and passive destructive. Similar to the weighted listing of the four goals of mistaken behavior, these are arranged in order of “diminished social interest” (Ansbacher, p. 283).
Ansbacher (1988) explains how to understand the figure, that the dotted lines show “frequent deteriorating sequences” (p. 284), with lines a through c depicting most to least frequent deterioration. The author then gives examples that illustrate why this writer believes that Dreikurs’ four goals of mistaken behavior in children overlap with the qualities of a pampered child in terms of addiction:

With the active-passive dimension Dreikurs associated self-confidence, courage, and self-esteem, respectively their opposites, when he wrote: “Whether the child responds actively or passively depends on his self-confidence and courage. This basic pattern … reflects the [child’s] evaluation of himself.” (n.d. p. 29, as cited by Ansbacher, 1988, p. 284)

Ansbacher goes on to say, “the constructive-destructive dimension also includes further characteristics … where constructive is combined with useful and more social interest; destructive, with useless and less social interest” (p. 284).

In the interpretation by this writer, the outcomes of these four mistaken goals in children align with the characteristics of a pampered child; in both circumstances, the child lacks courage and self-confidence. This, according to Individual Psychology, is a combination primed for deficient social interest; the absence of social interest (along with aforementioned neurosis, educational difficulties, improper preparation for the tasks of life, etc.) begets socially useless behavior: addiction.

**Inferiority Feelings**

Ansbacher and Ansbacher (1956) suggest that when we, as humans, experience inferiority due to “an organ which is developmentally retarded, which has been inhibited in its growth or altered in whole or in part” (p. 24), we attempt to compensate for this inadequacy. The organ affected can “include the sense organs, the digestive apparatus, the respiratory tracts, the
genito-urinary apparatus, the circulatory organs, and the nervous system” (p. 24); this is to say that an “organ” experienced as inferior can be any part of one’s body, to include thought and emotional processes by the brain.

Compensation that takes place due to an inferior organ can be an attempt to maintain equilibrium. Ansbacher and Ansbacher (1956) point out that “the fate of … inferior organs is extremely varied” (p. 24) and that since “development and the external stimuli of life press toward overcoming the expressions of such inferiority” (p. 24), several potential outcomes, existing on a continuum with countless intermediary points, are present, to include:

Inability to survive, anomaly of form, anomaly of function, lack of resistance and disposition to disease, compensation within the organ, compensation through a second organ, compensation through the psychological superstructure, and organic or psychological overcompensation. We find pure, compensated, and overcompensated inferiorities. (p. 24)

Dreikurs mentions organ inferiority experienced in childhood and its influence on addiction, aligning it with pampering. He states, “when a child, due to pampering or organ inferiority, takes things hard which others take lightly—which the child becomes inclined to avoid—there occurs an attraction to the kind of development which characterizes the majority of addicts” (1932/1990, p. 210). This writer infers that Dreikurs is referring to the influence organ inferiority has on neurosis, that this inferiority can influence addiction similarly. This is to say that when one experiences organ inferiority, there is a potential to use alcohol (or other substances) as a coping strategy to overcome this inferiority. In order to avoid things that are difficult, one with organ inferiority may turn to alcohol to cope.
Nash and Nash (2010) give a more contemporary look at organ inferiority. They state that rather than referring to organ inferiority as Adler did in the past, “we might more usefully speak of individual differences in neurophysiology” (p. 253). The authors also suggest that compensatory behavior “people make in response [to these individual differences in neurophysiology] can be usefully understood and updated in terms of individual differences in brain function” (p. 253). The authors tie this difference in neurophysiology (organ inferiority) and subsequent response (compensation) together with an example of quantitative electroencephalogram (qEEG) results from a client with chronic alcoholism.

[Those with chronic alcoholism] have been shown to have unusually low power in delta, theta, and alpha bands during eyes closed rest (Coutin-Churchman, Moreno, Añez, & Vergara, 2006). This corresponds to a mind that does not rest easily, that fails to go on idle. Alcohol chemically elevates alpha and theta amplitudes, producing an artificial relaxation of the brain's cognitive and emotional systems (Tran, Craig, Bartrop, & Nicholson, 2004). For someone who has lived for years with a brain that will not let go and not letdown and who is unable to just relax and forget about problems for a while, alcohol can become an irresistible draw. They develop the mistaken belief that the only way they can let down and relax is with alcohol. Proper psychophysiological diagnosis with the qEEG coupled with neurofeedback treatment can show a person predisposed to alcoholism what is wrong and how to find a way to be calm and centered without alcohol. This can result in high rates of long-term abstinence (Saxby & Peniston, 1995). (p. 262) This finding speaks to personal experience of this writer: it can be a challenge to find “calm” and “centered” in a natural state.
Adler (1931, as cited by Dreikurs, 1948) suggests that although imperfect organs can present many handicaps, these are by no means an inevitable end. “If the mind is active on its own part and trains hard to overcome the difficulties, the individual may very well succeed in being as successful as those who were originally less burdened” (Adler, 1931, p. 35, as cited by Dreikurs, 1948, p. 43). Adler believes a handicap can be an advantage, that one may employ it as a means to excel. “Thus an imperfect organ can turn out to be the source of great advantages; but only if the mind has found the right technique for overcoming difficulties” (1931, p. 35 as cited by Dreikurs, 1948, p. 43).

About finding this right technique, Adler states, "only a child who desires to contribute to the whole, whose interest is not centered in himself, can train successfully to compensate for defects" (1931, p. 36, as cited by Dreikurs, 1948, p. 43). Dreikurs emphasizes Adler’s viewpoint on developing social interest in children and how this relates to organic deficiencies:

It is not the organic deficiency which is to blame for failure, but our method of education. If we used the right method, children with organic deficiencies would be interested in others as well as themselves. A child burdened with imperfect organs is only interested in himself alone if nobody is at his side to develop his interest in others. (1931, p. 207, as cited by Dreikurs, 1948, p. 43)

Social Interest & Alcoholism

According to Dreikurs (1948), Adler termed the idea of interest in others as "Gemeinschaftsgefuehl.” This term translates into English in many ways (e.g., "social interest" or "social feeling") and “it became Adler's basic concept of human motivation” (Dreikurs, 1948, p. 43). Adler believed that all maladjustment and psychopathology are outcomes of flawed or poorly developed social interest.
It can be challenging to differentiate the above-mentioned Organ Inferiority from Social Interest. According to Dreikurs, Adler (1940, as cited by Dreikurs, 1948) discusses the relationship of an organ defect with the development of social interest: "Organic inferiority . . . may have misled the child into forming his particular style of life and may have cramped the development of an adequate amount of social feeling" (p. 133, as cited by Dreikurs, 1948, p. 43). Adler also discusses another factor that can contribute to the organ defect/deficiency of social interest equation. "Early illnesses that impair the physical . . . development and may also lead to more or less serious deformities . . . are most likely to do injury to social feeling (if) the anxiety and care of the persons around the child give him a great sense of his personal worth without his contributing anything himself" (p. 226, as cited by Dreikurs, 1948 p. 43). This speaks directly to the final paragraph in the above section, that children, well and ill, need encouragement and assistance to build interest in others, and therefore grow their personal sense of worth.

Social interest, as described by Adler, is a social *feeling*; this is inborn in us all. Social interest requires development of cooperation in a child, in order for it to evolve from a mere feeling into a way of being in the world: a life attitude (Ansbacher and Ansbacher, 1956). Adler gives a definition of social interest from an unnamed English author: “To see with the eyes of another, to hear with the ears of another, to feel with the heart of another” (p. 135). Adler goes on to reflect this writer’s point of view, that “for the time being, this seems to me to be an admissible definition of what we call social feeling” (p. 135).

Dreikurs discusses deficiency in social interest, and how this may manifest, pointing out adult characteristics that are borne from “false psychological attitudes developed in childhood” (1932/1990, p. 210), these being impatience and “sweet-toothedness” (Adler, n.d., as cited by Dreikurs, 1932/1990, p. 210). Dreikurs explains these as attitudes existing in people who have a
lack of interest in others, and, when confronted with the tasks of life, “do not feel grown up. These are not the traits of people who feel strong. People who are impatient fear the threat of defeat if success does not occur immediately” (Dreikurs, 1932/1990, p. 210). Sweet-toothedness, according to Adler, is a “direction of interest toward the pleasure principle without the great basic melody of social interest” (n.d. as cited by Dreikurs, 1932/1990, p. 210).

Addictive behavior is, according to Dreikurs (1932/1990), explained by this striving for pleasure. It is human nature to seek pleasure and avoid non-pleasure; however, when pleasure seeking takes place by desertion of the community, as in the behavior of an addict, it is different than pleasure-seeking within the community. This in-community seeking of satisfaction can occur when a child experiences real achievements and contributes to his or her family, therefore gaining recognition and becoming worthwhile. Courage will be instilled in this child, and he or she will be equipped to face difficulties in life with a social feeling.

This writer believes that when pleasure seeking takes place by desertion of the community (e.g., with substance dependence/alcoholism), it may be in response to a deserted feeling had by the addict. This is to say, for example, that if one with alcoholism feels abandoned and deserted by the community (e.g., friends, family, coworkers, etc.) because of their personal practice (e.g., drinking, regardless of the reasons behind this method) of pleasure seeking (as this is human nature), they most likely feel judged for their behavior. In turn, this feeling of judgment extends past behavior onto character, and this person is left with no sense of “in-community” recognition; they have both created and been pushed into the role of a pariah. This judgment feeling (non-pleasure) is to be avoided (as this is also human nature), and so the cycle of desertion of community by the addict/desertion of the addict by the community is perpetuated. All of this may be nonconscious.
Adler relates alcoholism with “adult daydreams” (n.d., as cited by Dreikurs, 1932/1990, p. 211), occurring when one experiences humiliation or disappointment, or to evade a requirement of life. This type of pleasure seeking is done by people who, as children, have “already wished to withdraw from life’s difficulties … out of a feeling of … weakness … [and seek] substitute satisfactions, perhaps in daydreams” (Dreikurs, 1932/1990, p. 210). As an adult, this person will continue to resort to similar means of pleasure seeking, not recognizing that the difficulties they are trying to avoid will magnify and the relief temporary. Quite evidently, pleasure seeking on this useless side of life results in lack of confidence as well as diminished social interest.

**Need to Belong**

As social interest grows in a child, so does a feeling of belongingness. Ansbacher and Ansbacher (1956) give the belief of Adler, that social interest and belongingness are interchangeable, and that “the development of the child is increasingly permeated by the relationships of society to him” (p. 138). This community feeling (and therefore belongingness) “takes root in the psyche of the child and leaves the individual only under the severest pathological changes of his mental life” (p. 138).

Shifron (2010) shared Adler’s belief that we are all born needing to belong and with the ability for connection with others. This connection requires learning the process of connecting, and from this learning comes the basis for well-being. The author believes that three significant groups exist in one’s life: family, friends, and work associates. She states, “Feeling a sense of belonging to these groups is the primary universal issue of mental health. Individuals with psychological disorders can lessen their psychopathology by learning more effective methods to belong” (p. 10).
Alfred Adler’s Individual Psychology is centered on the concept that psychopathology is an effect of a lack of feeling belonging. Every individual makes choices, and by making different choices, through their own creativity, can learn how to feel belonging. This desire to belong is, as stated above, common to all people, as well as a common theme within the unique problems of each individual. It is not necessarily overt, however, and is often a hidden goal that the individual will meet in creative and assorted ways, some effective, some not (Shifron, 2010).

To feel as though one belongs extends beyond these ideas; Shifron (2010) expands on this concept of the individual as a whole system. She points out that to further explain Adler’s concept of belonging, it is important to understand that although the individual does operate individually as “a whole system … the individual is also a cooperating and interacting part of larger systems, like the family, the community, and the universe” (p. 11). This writer seconds the emphasis placed on one’s sense of belonging equating to feeling that one is “an actively contributing part of the larger whole” (p. 11); to attempt active contribution to something that one does not feel they belong appears futile. Conversely, when one has been encouraged and appreciated for their talents and creative abilities, a feeling of belonging and importance in the larger systems will emerge.

Ansbacher (1991) describes this contribution (that of an individual who feels belonging, significance, and value) as social interest. This writer again emphasizes what Shifron (2010), Adler and Individual Psychology believe, that “belonging [is] the primary factor for the individual’s and the community’s mental health” (p. 11). This writer links this feeling of belonging to self-esteem and secure attachment; Mosak (1991) embodies this writer’s thoughts with his statement, “Closeness is a transcendent variable. It encourages people to look outside of
and beyond themselves to the need of others in the community itself. It encourages the feeling of intimacy, empathy, and identification” (p. 315).

**Holism**

Shifron (2010) further explains Adler’s concept of belonging, emphasizing the concept of holism:

In a holistic system, the whole is a dynamic, moving, developing, growing, creative system. It operates through the inner links within all parts of the system. Each part has a specific role or place that enables the other parts to operate and to move. The movement is the consequence of the interrelations and the contributions of each part. In a holistic system, the cooperative interactions of the parts constitute the whole. (p. 11)

As humans, we are more than the sum of our parts. “If these parts are taken to pieces the organism is destroyed … these parts are in active relations to each other” (Smuts, 1926, p. 101, as cited in Linden, 1995, p. 254). This writer believes this description is an excellent summary of the complexity and symbiosis of an individual; a strong connection exists between mind, body, and spirit. When an individual suffers from addiction, all elements of the whole person are affected, as well as affect the others; as Shifron (2010) describes, the separate elements of the whole person interact to both feed and defeat the disease of addiction.

Nash and Nash (2010) give another example of the interactions of mind and body as discussed by Adler. “He understood and wrote that it was no longer an ‘either or issue’: ‘We see that both mind and body are expressions of life: they are parts of life as a whole’” (Adler, 1931, p. 33, as cited by Nash & Nash, 2010, p. 266). This writer appreciates this recognition by Adler, and echoes his beliefs that mind and body affect and are affected by one another.
Striving For Success

According to Adler (1935/1982), and within Individual Psychology, an individual relates to the world “always according to his own interpretation of himself and of his present problem” (p. 3). Adler goes on to describe this relating to the world, that the “limits are not only the common human limits, but also the limits [one sets for one’s self]” (p. 3). Adler explains that therefore, heredity or the environment does not determine one’s relationship to the world—although these are not discounted. Heredity gives specific abilities and environment specific impressions, and one experiences these abilities and impressions in a particular way. The subsequent interpretation of these experiences is what guides the creative way in which one’s life attitude is built, and as a result, establishes one’s relationship with the outside world.

Since this relationship is established based on one’s individual experiences and interpretation of these experiences, any problem presented by life is unique for that individual. This unique perspective is the creation of the individual. Adler (1935/1982) expands on this:

“There is a task in life which no individual can escape. It is to solve a great number of problems … [which are] in no way accidental … [these are] problems of behavior toward others; problems of occupation; and problems of love … the manner in which [one] behaves toward these problems … that is [one’s] answer to the problems of life.” (p. 4)

From the combination of these elements, every person is striving for significance and security in a way unique to only them. Although, as described, this way of being in the world is different for each person, every person has a similar goal. Lombardi, Florentino and Lombardi (1998) discuss a presentation by Ansbacher on Adler’s theory of personality, which “speaks of the unitary concept of motivation, a single dynamic force which derives from the growth and forward movement of life itself” (p. 67). The authors simplify, stating, “Adler spoke of striving

Because of this unique relationship each person has with the world, the different reality experienced and created for and by each person, what an individual considers success will forever be subjective. Therefore, the way in which one takes on problems (and strives to find success and personal significance, as well as compensating for inferiority feelings and in so doing seeking security) can go awry, and potentially develop into abnormal behavior.

Lombardi, Florentino and Lombardi (1998) discuss how this striving for success (with one’s subjective nature in mind) aligns with psychopathology: “The unitary concept of motivation is paralleled by the unitary concept of psychopathology. A dynamic similarity exists in all incidences of psychopathology in that the various abnormal behavior patterns are efforts to find personal significance” (p. 67). This is to say that as humans, we operate using our available resources. For example, as mentioned in the discussion on organ inferiority, a physical feature may be deficient in some way. Every individual will respond to this differently, depending on available resources, or in other words, how much this inferiority affects the individual and how much compensation takes place. Compensatory behavior is subjective in that it may be healthy or psychopathological. The authors stress the Adlerian standpoint of a “psychology of use” (Ansbacher and Ansbacher, 1956, as cited by Lombardi, Florentino and Lombardi, 1998, p. 68), stating “it is not what you have or posses, whether it be genetic or environmental, that is important, but rather the use you make of what you possess. The psychology of use helps resolve the heredity-versus-environment controversy” (p. 68).
Striving for perfection.

Lombardi, Florentino and Lombardi (1998) discuss perfectionism, defining it “as the need to be first, best, perfect, and without any shortcomings, blemishes or deficiencies” (Lombardi, 1991, as cited by Lombardi, Florentino and Lombardi, 1998, p. 61). The authors give several potential hazards faced by people focused on this type of striving, to include excelling at any cost, futility/doing nothing, concealing shortcomings at all costs, anxiety/apprehension, sadness/depression/guilt, and abnormal behaviors (Lombardi, 1991, as cited by Lombardi, Florentino and Lombardi, 1998). Although this writer feels that all of these potential hazards of striving for perfection are important, abnormal behavior speaks best to the topic at hand; abnormal behavior, specifically alcoholism, can be a result of striving for perfection.

“Psychopathology is often a response to perfectionism” (p. 62).

Ferguson gives examples from Adler in terms of striving for superiority and perfection. In one writing, Adler suggests, “that no one can reach a ‘final goal of superiority, of being complete master of his environment’” (1931/1958, p. 56, as cited by Ferguson, 1989, p. 357). The author points out that by environment, Adler is referring to “obstacles, situations, and tasks, not superiority over other persons” (p. 357), and spoke similarly of striving for perfection: accomplishment occurs by overcoming obstacles, not others.

Lazarsfeld (1991) expands on the description of striving for perfection. She explains that striving for perfectionism, although it seems illogical to think of it as a departure from reality, makes sense this way if considered within the neurotic person’s “private logic.” The author draws a clear distinction between “sound striving for perfection and … neurotic wanting to be perfect. The first is a useful realistic attitude; the second involves the neurotic tendency to withdraw from reality, in as much as perfection per se is not within human reach” (p. 93).
According to Lazarsfeld (1991), although Adler viewed perfection as an unreachable ideal, he believed that it has use as a marker, a tool to keep moving towards improvement:

By going from big mistakes to ever smaller ones, trying to perfect all one’s capacities but avoiding the pitfalls of perfectionism. In perfectionism, the fiction of perfection takes the place of real achievement and this façade then has to be maintained at all cost, whatever may happen. (p. 93-94)

The Shadow

A significant part of every individual, according to Jung, is what he termed the shadow. Casement (2003) points out that Jung believed that although the shadow is a fundamental piece within everyone, it is “experienced by the subject’s ego as the inferior, base and primitive side of the personality – one’s own dark side” (p. 29). However, this does not fully explain the shadow. The author points out that Jung believed that the shadow contains “potentialities of the greatest dynamism” (p. 29), and that the vigilance and the attitude of the conscious mind will determine perception, if the ideas and images presented by the shadow are beneficial or detrimental.

According to Casement (2003), much of Jungian analysis is concerned with accepting the shadow. Jung believes a split exists within the human psyche, and offers contributions to revealing this break “between the light and dark sides of the human psyche” (p. 29). Jung believes the shadow relates to the phenomenon termed “double consciousness,” that humans naturally have two different personalities co-existing within. Jung identifies this personal shadow with the essence of the personal unconscious; these are things that have been repressed because they are “unacceptable to the individual’s ego” (p. 31).

Jung believes the unacceptable and repressed elements of the personal unconscious coincide with that of the collective unconscious, and that “shadow contents from both realms
may be activated at the time of a rite of passage in an individual’s life” (Casement, 2003, p. 31). This writer imagines this can occur more readily when one is in an emotional state, as rites of passages often are. The corollary of this event may be, as the author warns, “an encounter with evil” (p. 31); she balances this with the belief from Jung, that this is purely a “psychological reality in opposition to good. Evil … expresses itself symbolically in religious tradition as well as in personal experience” (p. 31). This writer interprets this as everything existing with a counterpart: good cannot exist without evil, hot without cold, light without dark. The author gives thoughts from Jung:

The contents of the shadow are often marked by strong affect, which is often obsessional and possessive. Above all, shadow contents are autonomous and usually represent all those aspects of an individual that they prefer not to know about—the weak, inferior, regressed parts. All these attributes can coalesce to form another personality in opposition to the conscious ego personality. (p. 31)

As mentioned, Jung believes the shadow exists in us all as the dark side of the personality. The shadow is similar to the Id, in that it is only interested in instant gratification, often employing mistaken beliefs to get what it wants. We all know people who are pleasant and kind, but become evil when they drink; this example appears to reflect Jung’s belief of an opposition to good. Casement (2003) points out that for many, “confrontation with the shadow is an ethical problem of the first magnitude,” one that “often presents in a pathological way through, for instance, a neurosis, when the individual is forced to take responsibility for his psychic condition … at other times, there may be … an eruption of shadow into consciousness” (p. 32). This writer recognizes the value of assimilating and integrating the shadow with the conscious ego, and agrees with Casement (2003), “the shadow is the humanizing part of every
individual and cannot be avoided” (p. 32). However, this writer also recognizes that for many, there is much in the way of coming to terms with their dark side.

Conclusion

Individual Psychology views addiction as an outcome of deficient social interest and that it is comprised of goal-oriented, creative, chosen behaviors used to deal with life’s hardships. Individual Psychology also sees addiction as a rejection of life and the community, and is curable only when a person changes himself. Addiction manifests differently for everyone, but has characteristic features, specifically a lack of social interest and its use as a substitute for conducting one’s life correctly; several other factors play into these and can contribute to addiction. Individual psychology has much to say about addiction; presented here are the aspects most compelling for this writer.

CHAPTER 3: METHODOLOGY

Methodology

The methods used to study the hypothesis of this paper were to conduct an in-depth research. When conducting this research three distinct areas were the focus, which are motivation for alcohol use, adolescents and alcohol, and Individual Psychology and alcoholism. Each aspect was based on the concept that alcoholism is a complex issue with many impacting factors. Numerous resources were collected to gather facts and review previous data collected from other researchers. Through this research, it is expected that the findings will relate to the hypothesis: The data will prove that alcoholic behavior, like all behavior, has a purpose, and this purpose deserves better understanding, as it is a multifaceted, complex issue. This improved understanding could lead to better outcomes for those dealing with alcoholism.
CHAPTER 4. RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Results

The results that were retrieved from numerous research methods yielded information that was compatible to the hypothesis of this study. By remembering that all behavior has purpose, alcoholic behavior can be better understood. Much stigma is attached to alcoholism; knowing and understanding the origins of this behavior can help alleviate guilt and shame felt by those with alcoholism. Motivation for and choices regarding drinking alcohol apply to all age groups; adolescence is a crucial time for these events and can be determinant for the future drinking habits of the adolescent drinker. Individual Psychology is applicable in all areas of this research, can help shape this understanding and potentially offer healthier options to alcoholic behavior.

Conclusions

In conclusion, based on the data collected from research, the hypothesis reflects the results. This writer wanted to know why some people are able to drink alcohol in a fashion that is not detrimental to their well being, and why “moderation” is impossible for others. Information presented surrounding motivation to drink alcohol provides answers in terms of choice making, expectations, and the impact biology has on these, but does not speak fully to the bases behind this choice making and expectancies. For example, when it comes to a desire for affective change, this is better addressed by Individual Psychology.

In writing the Motivation section, this writer was surprised to discover new viewpoints of her own. For example, after writing about the disease concept of alcoholism, she is left seeing value in both arguments on this matter; both sides have important, compelling reasons as to why alcoholism is or is not a disease. This writer believes that as humans, we are responsible for our behavior, which seems to say that alcoholism is not a disease. However, because of the complex
interplay of influences leading to alcoholism, much of which is out of our control, if we are ill equipped to face challenges, we make the best of what we have in order to survive and make life bearable, which may lead to physical dependence. Physical dependence seems to say that alcoholism is a disease. As mentioned, we are responsible for our behavior, we make decisions for ourselves, but sometimes, this writer believes, the decision to drink is outside of consciousness. It is a challenging, back and forth issue for this writer; we are responsible for our behavior, and being absolved from this responsibility does not seem just, but when one’s physical body is dependent on alcohol to survive … at this point, it would seem to this writer, that “rational” choice and decisions made for one’s self have been taken over by disease.

Individual Psychology offers much to this writer’s research question. In particular, this writer believes that with adequate social interest (which implies that as a child, one received adequate encouragement and had confidence instilled), remaining on the useful side of life is much more reasonable. Discouraged children, perhaps those who have been pampered, may feel the need for “affective change,” in other words, an escape from reality. They are stricken with defective development; this may be viewed as an Organ Inferiority in that it becomes cognitive and brain-based. Conversely, a deficiency in ALDH, leading to alcohol flush, can be viewed as organ inferiority, but the research presented here shows that this “inferiority” is a protective factor for most with this deficiency, and is used as an advantage.

Similarly, adolescents seem to be imbued with risk factors. Nevertheless, depending on social interest and the benefits it brings (e.g., connections with other socially interested peers, coping skills, sense of purpose in life), an adolescent may have enough protective factors to avoid some of the typical pitfalls of being a teenager. As the research shows, an adolescent who is aware of the possibilities life has, has enough intelligence to do well in school and feels
rewarded and valued because of this, and has a higher purpose in life reports drinking less than those who do not experience life this way. This writer is reminded of a classmate during 8th grade; she was all of these descriptions listed here, but had a birth defect and was missing the bottom part of her right arm. She is a perfect example of someone overcoming a deficiency and excelling; this writer can only speculate that she grew up encouraged, self-confident, and with a sense of belonging.

**Recommendations**

Ultimately, all of the research presented here comes down to how one is prepared as a child to face difficulties in life. Some of the information presented here is out of immediate control, such as genetics. However, with all of it in mind, this writer is left believing fully that children, from the beginning, need to be accepted for who they are, encouraged, supported, valued, challenged, allowed to fail, and helped to understand that it is all right if something goes wrong. Instilling belief in self is crucial in order to create courage and self-confidence. A child who is self-reliant and confident will naturally carry social interest.

This writer encourages anyone experiencing problems with alcohol or any other substance; please, seek outside help. It might be scary or difficult to do so, but there are people (this writer included) who are here to help. Change can be scary, and routine is comfortable, but everyone has people who need them to remain healthy (e.g., kids, grandkids, spouses, parents). Seeking help from a professional is not shameful; this writer believes every person has value and deserves to be here.
References


Figure 1. Association between age at initiation of alcohol use and lifetime dependence (i.e., meeting the DSM-IV criteria for dependence at some point in life). The red curve represents all respondents, the green curve represents respondents with a family history of alcoholism, and the blue curve represents respondents without a family history of alcoholism. Adapted from 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions, in Alcohol Research & Health, 2009, Vol. 32 Issue 1, Graph, p. 11, as cited by Masten et al., 2008, 2009.
Destructive
Useless
Low social interest

Constructive
Useful
High social interest

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* Outstanding goals for the respective types.

Figure 2. The Four Goals of Children’s Disturbing Behavior as Related to Four Types of Behavior Pattern. These four goals were later termed The Four Goals of Children’s Misbehavior.