SOME COMMENTS ON THE PSYCHO-PATHOLOGY OF DRUG ADDICTION*

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In recent years more and more investigative work has been carried on in the field of narcotic-drug addiction. As these studies have progressed, it has become increasingly apparent that the fundamental problem is a psychiatric one; for, after the phenomena of tolerance and physical dependence are explained, and the physiological changes during addiction and during withdrawal are known and understood, there will still remain to be answered vital questions, such as the reasons for addiction in physically well individuals and the conscious and unconscious reasons for repeated relapses. That the answers to these questions depend upon a psychiatric understanding of the addict and his problems, nearly all workers in the field will agree; yet it was only sixty years ago that Earle\(^1\) refused to consider addiction as a disease, and regarded it rather as a vice and addicts as vicious individuals.

The treatment of drug addiction, like that of any other medical condition, depends upon a thorough understanding of the etiology, physiology, pathology, epidemiology, and symptomatology of the illness. This must be recognized as true for drug addiction as it is for schizophrenia, appendicitis, or pneumonia, if rational, humane, and effective therapy is to be instituted. The present paper will attempt to give some explanation of the pathology in the psychic sphere as it is understood by the staff of the United States Public Health Service Hospital at Lexington, Kentucky, an institution devoted exclusively to the treatment and study of drug addiction.

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The psychiatric aspects of the problem have been recognized by some writers for many years, although until recently the stress seems to have been upon the physical side of addiction—that is, the phenomena of physical dependence and withdrawal. A number of authors have mentioned a "neuropathic constitution" or "neuropathic heredity," but few have gone further in this direction. Before the turn of the century, Stille in 1874, Hartwell in 1889, and Wilson and Eshner in 1896, all attributed addiction, in part at least, to psychopathological states.

Since 1900, an increasing number of authors have mentioned the importance of psychogenic factors, among them Lichtenstein, Stanley, and Mackin. Crothers, in 1902, recognized the part psychic trauma may play in the development of an addict, for he stated, "The sufferings and hardships growing out of the perils of war often react in illness, nerve or brain instability, and feebleness; and the use of morphine is a symptom of damage from this source." In 1920, Rhein went so far as to state that any effort to correct the evils of drug addiction must be based on a thorough understanding of the psychologic factors underlying the...
cause. Claude,\(^1\) in 1923, described intellectual and imaginative, sensitive and effective, and self-willed types of addict. The first group take drugs because of an unhealthy curiosity, the second because of an abnormal sensitivity to pain and pleasure, and the last because of loss of will power or indifference. Rees,\(^2\) in 1932, stated that, in his opinion, drug addiction was in almost every case a symptom of psychological maladjustment, since, through drugs, the addict obtained relief from a sense of oppression resulting from an unequal and losing battle with life, which resulted in feelings of self-consciousness and inferiority.

On the basis of personality studies which included life history, heredity, native intelligence, emotions, make-up, temperament, and other characteristics, Kolb\(^3\) has divided addicts into five groups. Because of the practicability of this classification, it has been used, with slight modification and the addition of a sixth grouping, as a basis of classification at this hospital. This classification, as described by Kolb and Ossenfort,\(^4\) is as follows:

Type 1. Normal individuals accidentally addicted.
Type 2. Individuals with psychopathic diathesis or predisposition.
Type 3. Psychoneurotic individuals of all types.
Type 4. Individuals without psychoses, but with psychopathic personalities of all types, including constitutional psychopathic inferiority.
Type 5. Addicts with inebriate personalities.
Type 6. Drug addicts with associated psychoses.

For the purposes of this paper, only three types will be considered: namely, the psychoneurotic, the psychopathic personality well crystallized, and the psychopathic diathesis or predisposition. The normal individual accidentally addicted presents a special problem and must be considered separately. The psychotic individual has completely broken,

\(^3\) *Types and Characteristics of Drug Addicts*, by Lawrence Kolb, M.D., *Mental Hygiene*, Vol. 9, pp. 300-13, April, 1925.
and, from the standpoint of a study of the usual types of drug addiction, his problem is that of psychotics in general. His problem prior to the development of the actual psychosis is comparable to the problems we wish to consider here, and need not be dealt with separately. Since the inebriate will fall into one of the three classes remaining, he will not receive special mention. What is said concerning the addict is equally true for many alcoholics; in fact many addicts become introduced to drugs through the use of alcohol. The use of either is, in a great many cases, merely an expression of the same fundamental problem, but in this discussion remarks will be confined to the individual who has become addicted to narcotics. It is interesting that those alcoholics who do take up narcotics usually discontinue the use of alcohol.

The concept of the psychopathic-diathesis group may not be as clear as that of the other two, but probably can best be described as a state in which, because of some ill-defined instability of personality, no better than a border-line adjustment is made. The individual is not fundamentally anti-social and, with some artificial assistance, can make an acceptable adjustment. The most striking characteristic of this group is the fact that, as a whole, they were adjusting marginally before they became acquainted with narcotics. After their first few experiences with the drug, they felt an exhilaration and a sense of relief comparable to the solution of a difficult problem or the shaking off of a heavy responsibility. Many of them also felt an increase in efficiency which, in some cases at least, appears to have been an actual improvement. Having once found this new world of greater happiness and efficiency, they attempted to regain it and to live therein for all time.

This phenomenon is not so prominent in the other two groups. The psychoneurotic takes his drugs to relieve himself of whatever type of symptom he may have. The psychopath uses narcotics rather as an aggressive behavior reaction—that is, he feels a desire to be more important or prominent among his associates. He wishes to excel in deeds of daring, to be more clever than his fellows, or to stand out as an object of admiration. Under narcotics he feels that he has
more nearly accomplished these ends. As Kolb¹ has put it, his use of drugs is "comparable to the compensation of little men who endeavor to lift themselves to greatness." In other cases, he uses this means to gain an experience of pleasure over and beyond the requirements for comfortable living. He is a hedonist. What he desires to do he does for the pure pleasure to be derived from it. He is morally defective and hence does not consider social or ethical standards a check upon his activity. The only restraint he recognizes is painful or physical in nature. The patient with a psychopathic predisposition, however, takes his opium as a medicine which he believes—sometimes with good reason—helps him to make a more satisfactory total adjustment to life as he finds it, and without which he feels inadequate to meet many of life's problems.

The same fundamental drive, then, is present in all cases—namely, the desire to derive from life more pleasure and satisfaction, which, after all, is a striving present in all mankind. The differentiations made above are probably of theoretical rather than practical importance, but it is felt that they help to clarify the problem.

Kolb² distinguishes between two types of pleasure, one of which he calls positive pleasure, or a pleasure that results from rising above the usual emotional plane, and the other negative pleasure, or a pleasure or sensation that follows relief from anxiety and pain. He feels that after the first stage of addiction, during which tolerance and dependence are established, the positive pleasure disappears, and the motive for continued use of drugs becomes purely an avoidance of discomfort and pain. He further feels³ that relapses are usually due to an attempt to regain the sense of pleasure originally experienced.

If the addict began the use of drugs in an effort to derive satisfaction of one kind or another, we may safely assume that, either consciously or unconsciously, he was not satisfied

¹ Types and Characteristics of Drug Addicts, loc. cit.
² Pleasure and Deterioration From Narcotic Addiction, by Lawrence Kolb, M.D. MENTAL HYGIENE, Vol. 9, pp. 699-724, October, 1925.
with the quality of the adjustment he was making. This can only mean that there was not an adequate attainment of the objects of his fundamental drives. He was then caught between desire and the impossibility of its attainment, and the resultant frustration caused an inevitable rise in emotional tension. This tension may not be of sufficient intensity to rise into consciousness; it may appear only as dissatisfaction, restlessness, or vague depression; or it may take the form of anxiety, obsessions, hypochondriacal complaints, or similar symptoms.

The majority of writers in recent years agree that the addict was falling short of making a satisfactory adjustment before he began the use of drugs. However, as one would expect, there is a wide difference of opinion as to what are the most important factors contributing to this. If the personality is interpreted as an expression of autonomic functions, then the greatest contributing factors would probably be anxiety and fear, which the individual is unable to endure, and which are due to segmental cravings resulting in visceral tension. The sexual sphere, particularly that of homosexual conflict, has been strongly stressed by some, while others have felt that feelings of inferiority were of greatest significance. Strong arguments can be advanced in favor of any of these views and cases can be cited that bear out the arguments. As is true with most problems of which there are several explanations, a combination of answers is more satisfactory than any one alone.

I do not mean to imply that the philosophy of the school of Individual Psychology should be utilized exclusively in our attempt to understand the psychopathology of the drug addict, but the more addicts studied, the more frequent is the observation of feelings of inferiority with resultant strivings to overcome them.

There seem to be three great drives that influence the life of man—the drive for security, the sexual drive, and the drive for power and achievement or attainment. Psychic tension seems to rise as a result of the thwarting of one or more of these drives, and the relief of this tension by some means becomes necessary to emotional tranquillity.

Some children at an early age grow to feel that they are not succeeding as well in the struggle with life as their fel-
lows, usually because of a sense of insufficient attainment in some field of endeavor, or because of serious threats to their security. As a result of past experiences which have forced them to this belief, they have acquired feelings of inferiority, usually expressed in an attitude of anxious expectation or tension. Depending upon the individual make-up of the child, the strivings to dissipate this tension will take a healthy or so-called normal form, or it will follow an unhealthy pattern, an attempt being made to gain a feeling of security and contentment through various means of escape, or by partially meeting the problem. Whatever form these strivings may take, two factors must be satisfactorily met—one is an unresolved feeling of inferiority, and the other is an urge to achieve peace, security, and social equilibrium, and to demonstrate some power over environment.

If this tension is not resolved during childhood, it will naturally carry over into adolescent years, where the situation is complicated by the problems peculiar to that period of life. As adolescence merges into adulthood, the goal of living becomes the attainment of a feeling of superiority and an elevation of the personality to a point where life has a real meaning. Because of utilization of the mechanism of rationalization, the tension caused by falling short of the goal often is not recognized as such; in fact, the goal itself is not admitted into consciousness.

This drive for a feeling of superiority may be so strong, because of pronounced feelings of inferiority, that the individual appears to be egocentric and power-hungry. He no longer sees his relationship to his fellow men as a problem of mutual adjustment, a matter of give and take, but considers merely the "take" without the "give," and, disregarding all else, drives forward toward his goal. He is striving for what will give him pleasure, and considers his fellow men only in so far as it is necessary to do so to avoid physical pain or limitation of activity. We consider this individual to be an inferior who shows psychopathic behavior.

The following case is illustrative of this type of psychopath:

S. N. V., a twenty-four-year-old white male pugilist, is the seventh of eight siblings of Italian immigrant parents. The father has "nervous spells"; one brother is an addict, another is a drug peddler, and another
is serving a twenty-year sentence for shooting a policeman. The home environment was poor economically and socially, but the family life was harmonious during the patient's childhood. The patient's school adjustment was fairly good, but formal education terminated with the fifth grade at thirteen years of age, when he began boxing for small sums of money. He has not done any legitimate work other than prize-fighting, and has squandered his earnings on whatever struck his fancy, replenishing his finances through extra-legal activities, such as bootlegging and the sale of drugs. He has never married and has lived a nomadic existence, in the course of which there have been arrests for shooting with intent to kill, petty larceny, fighting, and two prison sentences for drugs.

His first use of drugs was at nineteen years of age, when he was seeking new and different ways of experiencing pleasure. The only periods of abstinence were during imprisonment, and relapse promptly followed release on each occasion. According to the patient, there is no physical or emotional need for drugs, nor do they reinforce any conscious defect in his personality; they have been taken, rather, for the pleasure produced.

During the patient's hospitalization, the impression gained of him was one of evasion and grudging cooperation, based on a feeling that the use of drugs was a personal affair and that any interference was an intrusion. The patient warned the staff that he would tolerate no remarks from other patients relative to the fact that he had on occasions acted as an informer, and that if any were forthcoming, serious trouble would result. His entire attitude was that the institution would have to adjust to him since he would make no attempt to adjust to it. As a result it was found necessary to keep him segregated from the general population for his own protection, although even then he was in trouble on several occasions, at one time even being found with a knife in his possession.

The psychopath need not be as aggressive as this, but rather may seek to dissipate his feelings of inferiority by attempting to stand out among his fellows through his daring deeds. He is the "little man endeavoring to lift himself to greatness." Such an individual is illustrated by the case below:

J. J. M., a forty-year-old white male hotel clerk, whose family history is negative, comes from a home of average economic and social status. The family life was harmonious. The patient left high school at seventeen years of age without any good reason and has made a poor occupational adjustment since that time.

Feelings of inferiority developed early in life, according to the patient, and have persisted, causing, among other things, so much shyness where women are concerned that he has never married. As a young man he realized that he possessed no qualities that would recommend him for a position of leadership, but he observed that those of his companions who seemed to be most admired and respected by their fellows took occasional doses of narcotics, and, in an effort to gain more prestige for himself, he, too, began taking small amounts of the drug now and
then. Before he developed physical dependence on narcotics, he joined the army and entered upon what he still thinks was the most enjoyable period of his life, since the uniform and the military discipline appealed to him, and he was given occasional opportunities to stand out from his comrades. The event that he considers to be the high point of his life occurred at this time, when he acted as company commander for two days. He used no drugs during this period of his life, and had no desire for them.

Upon return from the war, the patient was thrust into his old position as a hanger-on of people of more forceful character, but this was now more intolerable than ever before, requiring some outside aid to help him make the adjustment, and narcotics were easily available. With these factors interacting, he rapidly became addicted, and felt that he was able to make a much better adjustment with the aid of drugs.

Upon examination, he was found to be a small, insipid, and inconsequential-appearing individual who seemed to be depressed and under some tension, manifested by tremors of the hands, bowed head, unkempt appearance in general, and the low, expressionless monotone in which he talked. When withdrawal of the drug occurred, he became more depressed and self-accusatory, changing to shyness and a self-effacing manner as he recovered physically.

The feelings of inferiority may not be so pronounced as in this case, however, the individual rather appearing restless and a pleasure-seeker, constantly striving to ease the boredom of an unsatisfactory existence by means of various stimuli designed to produce emotional comfort. The following case is representative of this type:

H. D., a thirty-year-old white male bell-boy, whose family history is negative, is the only child of middle-class farming parents who died within seven months of each other when the patient was eleven years old, leaving him in the care of a friendly neighbor family. He remained with this family until he had completed high school at fifteen, and then, moved by restlessness and dissatisfaction with his station in life, began a nomadic and occupationally unsatisfactory existence, changing his location with the seasons and never holding any job longer than nine months. He was in serious trouble on one occasion when he was found guilty of stealing an automobile and served a reformatory sentence.

At twenty-four years of age he was introduced to morphine while on parties with friends, and continued to use the drug because of the thrill he derived from it, and because it prevented his feeling so "disgusted" with himself. Whenever he secured a job, he would discontinue the drug, but would invariably return to it again when out of work, which was quite frequently.

Upon examination he was found to be sullen, irritable, restless, impulsive, and cocksure, often interrupting the conversation to air his own views on subjects about which he knew little or nothing, and wearing an air of chronic boredom. He adjusted fairly well during his hospitalization and, while sly and tricky, was able to dodge any serious trouble except on one occasion, when he forged his supervisor's name on a pass
to enter a part of the institution into which he was not supposed to go. But even then he accepted the resultant disciplinary action with the philosophical attitude that one cannot always win in a gamble. It was especially difficult to establish rapport in this case, and it was probably because of this that our treatment was unsatisfactory.

The individuals who fall into the three subgroups just described all show well-crystallized personality defects. They encounter drugs in the course of their search for pleasure and achievement, and continue the practice because they find new levels of satisfaction in it, or because they are loath to go through the discomfort of withdrawal. They like the effect of the drug so well that they have little regard for the consequences.

The psychoneurotic uses drugs for an entirely different reason from that of the psychopath. He can no longer face his problem squarely and adjust to it. To flee from it would be an admission of defeat; in other words, it would demonstrate, to the world and to the individual himself, his inability to compete in the race of life. Some method must be found for avoiding the heat of battle that at the same time will not force even a secret admission of inferiority for which no satisfactory compensation can be made. If the problem can be partially met and partially avoided, a workable compensation is secured. If it should happen that a partially or wholly incapacitating anxiety, weakness, physical disease, phobia, or obsession should appear, the ugly fact that one is inadequate to the situation could be kept hidden deep in the psyche.

The neurosis is used as an explanation for the fact that reality has been only partially met. It is a protection against a devastating admission. It can now be reasoned that if only one were strong and well, everything would be different, and it would be possible for one to fill one’s place in an active world. Since illness prevents this active participation, decisions as to a course of action can be postponed, and ambitions that have been achieved can be highlighted as further proof that difficulties could be overcome if health were regained.

If, in the course of such a patient’s illness, narcotics are given as a sedative or to ease discomfort of any kind, a new peace and relaxation are attained, the like of which
has never been experienced before. Morphine raises the threshold to painful psychic, as well as somatic, stimuli. The patient now has less need for his neurotic elaboration. Psychic pain being lessened, there is less need than ever to meet the original conflict; the philosophy of letting sleeping dogs lie can be adopted. So the patient seeks again and yet again to experience the sensation of delicious relaxation and satisfaction to be found through the use of narcotics.

Soon, however, a new complication presents itself. If the tension is decreased, the physical symptoms will decrease, since they serve no further purpose. But when the physical symptoms decrease, there is no further excuse for the narcotic. Without the drug, the tension rises and the physical symptoms must return for the same reason for which they originally appeared. Thus a vicious circle is established. Continued use of the drug results in addiction, and to the average individual, addiction without a physical reason is a deplorable state. Now, more than ever, must the original neurosis be continued.

Thus the drug which was at first inadvisedly given for the relief of distress has more firmly fixed the neurosis and has vastly complicated the problem of therapy. All of us who have treated addicts have encountered this group and know how extremely difficult they are to handle. During withdrawal, added to everything else is real physical suffering, or at least discomfort. This situation tends to depress the patient even more and to bring his inadequacies into sharp relief, until life becomes so intolerable to him that he may attempt the extreme adjustment of death. A case illustrative of the psychoneurotic addict is given here:

C. C., a sixty-two-year-old white male grocer and tavern-keeper, whose family history is negative, lost his father by death at the age of three. From the age of seven onward, however, he had the benefit of a congenial and kindly stepfather. He was more or less restless from an early age and finally, at sixteen, he left home because of what he describes as "wanderlust." At forty-one he married an addict out of sympathy and at her request, in an effort to cure her.

In giving his history, the patient spoke of "inherited syphilis," which could not be verified, and stated that he had been more or less ill all of his life, with the result that he had been unable to work and to get ahead as did his early companions. He began smoking opium at about twenty because of gastrointestinal distress, and has continued to use drugs in one form or another for the greater part of his life since then,
since he has a number of physical complaints all of the time, which become much worse when he is off drugs. He was apprehensive about his physical condition, stating that besides feelings of weakness and numbness, his bowels did not move properly, he had "gas on his stomach," something pushed against his ribs which he thought to be an enlarged and "gummy" liver, he had pains in his back, and suffered from crops of skin eruptions which he feared were cancerous. Obviously, since he could not give up drugs until his health improved, he should not be treated for addiction until the therapy for his other ailments was successful. Upon physical examination, he was found to have some senile changes such as moderate arteriosclerosis and presbyopia, but nothing more, and both his blood and spinal-fluid serology were negative.

During his hospitalization the patient frequently complained that he was being neglected physically, since he was not being treated for his various complaints, and suffered periods of irritability and depression, during which he sometimes considered suicide.

The condition of psychopathic diathesis or predisposition is seen sufficiently frequently at the Lexington Hospital to be considered as a separate entity. The individuals so classified do not fall into any other groups. They appear to have been laboring under a more than usual amount of conflict and resulting tension, but not of a sufficient degree to result in more than border-line maladjustment. These individuals, like the two types just described, are reacting to ingrained feelings of inferiority, based on defective personalities, psychic trauma, physical defects, or other factors which had their genesis, in many cases, in very early life. In the present instance, however, these feelings have not been of sufficient intensity to cause a marked departure from normal behavior.

As I have stated earlier in this discussion, many of these individuals felt fairly satisfied with their adjustment up to the time of their first experience with narcotics. At this time, as in the case of the psychoneurotic, an unbelievably pleasant sensation was experienced, together with relief from tension. This sensation can be most closely compared to that of a normal individual when suddenly relieved from some chronic, low-grade discomfort to which the organism has accommodated. Once the potential addict has experienced the relief from the psychic tension which he had carried for so long, its return becomes unbearably unpleasant. He has discovered that thought flows more smoothly, conversation is more free and sparkling, and life has more of a meaning during the effective period after the administration
of the drug. It is only natural that, finding themselves more satisfied with life and life seemingly more tolerant of them, these individuals continue the use of the medicine that has brought this beautiful and unexpected world into being. It is common to hear such expressions from this group as: "After the first shot, I knew I had found something that I had been looking for all of my life without knowing it!" or, "I never knew life was really worth living until after I had my first shot or two!"

It cannot be conceived that a normal personality, making a satisfactory adjustment, could experience this sensation of relief to such a degree that he would return to drugs again and again until he was addicted. Psychiatric examinations on accidental addicts with normal personalities seem to bear this out. A further inference to be drawn is that there are many potential addicts in society who are free from addiction only because they have never been introduced to the drug.

As the patient with psychopathic diathesis repeats his narcotics over days and weeks and months, three phenomena occur—tolerance to the drug is developed, physical dependence is built up, and the newly made addict becomes habituated in the psychological sense of the word. These phenomena may not occur simultaneously, but all do appear eventually. Once physical dependence is established, the degree of positive pleasure originally experienced cannot be produced. The original tension can now no longer be completely resolved and is more unbearable than ever, since it is now in the forefront of consciousness. The addict of this group, not being a fundamental nonconformist, has a distinct aversion to being set aside from the rest of society. As soon as he is aware of his addiction, however, he realizes his position and, as a result, has this conflict added to his original feelings of inadequacy, which means an increase in tension. He now experiences the further difficulty, in many cases, of obtaining a constant supply of drugs and of avoiding detection. At this stage in his addiction life, the multiplicity of conflicts he is experiencing results in more or less acute anxiety or depression. There is now self-depreciation and hence, usually, conscious feelings of inferiority.

If the addict has attempted to free himself of his addiction
and has then relapsed again for the same reasons that caused him to become addicted in the first place, or if he has run short of funds and has been forced to steal or to peddle drugs to obtain money for his narcotics, thus making himself a felon, the feelings of inferiority are augmented by discouragement and a sense of defeat. A fatalistic or resigned attitude is usually developed, since it would be impossible to endure the acute conflict continuously, and some rationalization is necessary to provide sufficient comfort to make life bearable.

This new and more serious problem can be met in one of several ways:

1. The dosage can be increased over and above the physical requirements in an effort to recapture the original sensation of pleasure. In this way it may be run up to relatively high amounts, but eventually it levels off. The reason for this is not entirely clear, but one fairly plausible theory is that for every individual there is a certain dosage over and above which physical dependence does not go. If slightly more than this dosage is used, a degree of relief of tension, but by no means complete relief, is obtained. For many addicts this dosage is sufficiently large to be beyond their financial grasp. Such individuals will voluntarily submit to cure, only to relapse in search of the pleasure that they originally obtained and that has ever after danced before them like a will-o’-the-wisp, just out of reach.

2. The addict may adjust at this new level of life and carry a moderate habit for many years. These are usually the more intelligent addicts who have some insight into their fundamental difficulties.

3. Other addicts find the added conflict of addiction too much for their endurance and are forced to make a new adjustment altogether, by rationalizing the entire difficulty on the basis of somatic complaints. Thus at one extreme the psychopathic-diathesis group shades into the psychoneurotic.

A pronounced case of psychopathic diathesis is presented here to illustrate this group:

J. K., a thirty-four-year-old white male butcher, whose family history is negative, is the son of congenial middle-class parents. He had a sixth-grade education, having left school at thirteen because he lacked interest and desire to proceed further. His marital adjustment has been satis-
factory except for the wife's growing disinclination to tolerate his use of drugs, and there is no history of extramarital affairs. The occupational adjustment has been fairly good, although the patient has changed jobs on several occasions and was unsuccessful at operating his own butcher shop. Aside from difficulties over drugs, he has been in conflict with the law on one occasion only, when he attempted to make some "quick money" by selling illegal whisky, but after being arrested, fined, and warned that a second arrest on the same charge would result in more serious difficulty, he discontinued this sort of activity.

The onset of addiction followed an attack of lead poisoning, for which three doses of morphine were given for the relief of vomiting and purging. But the drug also caused such a sensation of pleasure that the patient continued its use for this reason alone. He stated that he sincerely enjoys the effect of narcotics since they "settle and satisfy" him and seem to improve his personality; he said that he can think faster, respond more quickly to situations, carry on a better conversation, and is in general a more convincing and energetic salesman and business man when using drugs. He cited numerous instances to show that he has advanced farther, in so far as promotions and inspiring confidence in his employers are concerned, when he has not abstained from narcotics.

He seemed to have a very sincere desire to leave drugs alone permanently, since he realized the inevitable legal consequences of continued use, and for this reason he was apparently anxious to understand the mental mechanisms at work in his case; but, even with this desire, he was unable to make an acceptable adjustment in the hospital. On two occasions he assaulted other patients and it was found necessary to segregate him as a potentially dangerous man; but even in segregation he continued to get into trouble, engaging in a fight on one occasion and on another creating a rather serious disturbance when cautioned by an attendant to watch his behavior. During the series of interviews with this man, he expressed sincere regret at his actions and, while he could not explain them, would talk of them frankly enough and in an increasingly discouraged manner, since he realized that he did not feel the same at the time of the interviews as he did on drugs, and felt that he would be unable to adjust to a non-narcotic existence.

Thus far we have considered the addict as an isolated individual more or less preoccupied with his individual problems. The adjustment that he makes is not acceptable to society, and his rejection causes a counter-reaction in him. The satisfactorily adjusted individual is sufficiently outgoing in his behavior to be socially acceptable, whether he is an introvert or of the extravert type, but present-day civilization is so complex that the range within which normal adjustment can be made is rather narrow, and an individual may be so drawn into himself, because of conflicts and psychic tension resulting from frustrations of one form or another, that he cannot make the necessary adjustment. Society, therefore, avoids him as it always does the depressing and
the unpleasant, and he finds his sphere of contacts narrowing, which adds further conflict to that already present. While a protective reaction of indifference may be developed, even to the point of removing the conflict from the conscious mind, it nevertheless persists in the psychic depths and makes its presence known in one way or another. Kolb, however, found the majority of the addicts in his studies rather of the outgoing type, and remarked that this was contrary to expectations.

If, now, we grant that narcotics raise the threshold to painful psychic stimuli in a manner analogous to that observed in the phenomenon of raising the threshold to painful physical stimuli, we can conceive of the problem of the individual mentioned above unraveling in the reverse order to that in which it was tangled. He becomes less conscious of his exclusion, and as a result drops his compensatory indifference. At the same time, his threshold to psychic stimuli being raised, he is no longer so painfully conscious of his conflicts and frustrations. He is not so preoccupied with his difficulties and becomes more outgoing because he has released part of his bound attention. Because of this, added to the dropping of the protective attitude of indifference, he finds himself adjusting more satisfactorily. He has more self-confidence and less feeling of inferiority, and therefore can be, and usually is, more spontaneously outgoing.

Thus we visualize addicts as individuals who, through drugs, are striving for the same goal as all mankind. Their methods of attainment are not socially acceptable, and some overshoot the mark in the attempt to reach it. They are, however, psychiatric cases and not vicious felons. To consider them as vicious or fundamentally antisocial is to do them an injustice. They will not be cured through punishment, but rather by means of intelligent psychotherapy in the hands of trained and experienced psychiatrists who have a sympathetic understanding of the problem and who are not fettered by prejudice. It is hoped that the day is not far distant when this concept of therapy will be sufficiently widespread to yield results.

1 Types and Characteristics of Drug Addicts, loc. cit.