ALCOHOLISM

A COMPLEX PATHOLOGY

In the clinical practice of alcoholism difficulties of relational nature take the main part of the scene. But we are not faced with a diagnosis which indicates the impossibility of confession, as delirious. Admittedly there is a strong temptation to evoke the refusal and the denial. But these concepts suppose, the unconsciousness of the act. They are thus not easily applicable. We must consider with another category of disturbances of the language, in which the stating only is inhibited, while the statement (the message) remains present in the thought.

***Key words**: alcoholism, language, delirium, modesty, hidden supplies,* (3345 words).

relational difficulties

The difficulties which one encounters in the clinical practice of alcoholism, are seldom problems of diagnosis. This is very obvious when difficulties of relational nature take the main part of the scene. It is known that all the resources of the alcoholic mind contradict the current medical practice. Nobody is fooled when he persists in trickery and cants the normal course of the consultation. To dissimulate his alcoholization, he uses a faultless system which sems to divert any authentic dialogue about his disease.

Can one say that, with alcoholism, we are faced with a diagnosis which indicates the impossibility of confession, as delirious? No, because two symptoms contradict this assimilation.

- The first is related to the frequently discussed question of the conscience of the process. Nobody can easily admit that this inexpressible act is an unconscious act. Moreover, this conviction causes accusations of "bad faith". Admittedly, there is a strong temptation to evoke the refusal and the denial. But these concepts suppose, precisely, the unconsciousness of the act. They are thus not easily applicable. We must consider with another category of disturbances of the language, in which the stating only is inhibited, while the statement (the message) remains present in the thought.

- the second symptom is that, in the psychosis, the language diverted or reversed, gives the meaning of the symptom. It is not so in the alcoholic conducts which, apart from the characteristic the linguistic deformations, never dissimulates any hidden meaning. Only an anxiety appears to emerge, even a subjacent terror, faced with the idea of therapy or, worse, of the cure and abstinence. On this point, all participants, doctor and patient, will be put to the test. No medical answer is innocent, knowing the weight of the cultural surdeterminations concerning alcoholic drinks.

It is not sufficiently recognized, that the therapist who accompanies the patient in his abstinence, in fact, accompanies him towards a social marginality. This fact opposes, very radically, alcoholism with other drug-addiction. A heroin addicted person, when weaned return to the norme (or its appearances). The abstinent alcoholic will experience a marginal position which will includes a too certain disqualification of his person.

Alcoholic dependence is very marked by the fact, that no causal factor of the disease can be really indicated to the patients. But they will persistently evoke these factors, convinced by their own subjective feelings. So, these psychological pseudo-justifications are, too often, the only elements by which the patients can, by themselves, understand their illness.

misleading illusions

The clinical practice, must thus avoid a more or less sophisticated psychologism. It is still darkened by misconceptions, of another nature, which have led astray research itself. It is obvious that the alcoholic disease appears to be the toxic consequences of a superabundant alcohol ingestion. But toxicology, in spite of its progress, does not bring enough information on the phenomenon of dependence. If it is agreed without difficulty that encephalopathy and poly-neuritis, are only consequences, we must notice that the interpretation of delirium tremens has been undoubtedly the most misleading.

The reason is that the disorders of weaning, in spite of the intensification of the need for alcohol that we note there, do not have, in the current state of knowledge, any direct relationship with the alcoolo-dependence which we are studying. Is not, and does not become dependent who wants it. But, as any laboratory rat, each one is exposed to this physical dependence, which accompanies the weaning disorders after a sufficient and durable overconsumption, for all conceivable reasons...

two very distinct problems

This autonomy of the weaning disorders, with respect to the condition of the dependent, was erroneously perceived. It canted, more than one thinks the clinical, and also the scientific regard on this illness. The need, and the search for alcohol, which accompanies these states, the effect produced, formerly therapeutic and preventive, always alleviating, give to the disease the appearances of an exacerbated need. *But this, proved by the rat, is not the same need as that which, after months or years of sobriety, induces a relapse after a first glass, a long way from any impregnation.* This, and only this phenomenon, justifies the prescription of a continued abstinence, with all its consequences. Another aspect of this affection is its sequential evolution, which produces, in the same person, two clinical faces each one having its own symptoms:

- *alcoholized*, all the the patients appear assigned to the same reality; they recognize in each other similar behaviour patterns;
- *without alcohol*, another face puts us in the presence of subjects very diverse, in their normality, as in their pathology.

a part of the induced disorders

It is remarkable, for example, that the alcoholic, solicited by his need for alcohol presents a typically narcissistic character, repeatedly underlined. It is no less remarkable that our patients present the same symptoms with an astonishing similarity. But it is essential to observe that these strongly marked clinical symptoms are erased when they become sober. That leads to the following question:

- are we in the presence of constitutive elements of the personality, or is it necessary to admit the existence of an induced pseudo-narcissism?

In its daily appearance, the symptomatology of alcoholism must give a large place to the induced disorders. This means to say that certain symptoms observed, even if they occupy the first plan of the clinical scene:

- do not have an immediate link with the generating cause of the dependence itself;
- are not specific to alcoholism;
- are not the consequence of the individual history of the patients;
- are without relationship to a nevrotic or psychotic element of their personalities, with which they can coexist, and even do "good housework";
- and indicate nothing other than perfectly orthodoxe adaptive behaviors.

In clinical practice, the recognition of such disorders make it possible to reduce the well known relational rupture.

hidden supplies

For the clarity of our *exposé*, we put to the forefront the constitution of hidden supplies. *"A typical attitude of the alcoholic"*, in truth, a permanent concern for the drinker. In its appearance, this symptom appears to be utilitary: to meet the need, to withdraw from the regard an accumulation of alcohols and their too personal use. But it indicates another thing.

This dissimulation of supplies has analogies with the authentic reflexes of survival, caused by the periods of food shortage. The constitution of provisions, when food becomes rare, inferior to foreseeable needs, belongs to the biological behaviour of all beings. Egoist "by destination", this conduct is generally secret and discret. The family which, in fear of a shortage, constituted a food stock takes care not "*to proclaim from the rooftops*".

In the alcoholic disease, the lack of the object of addiction defines the reality in the same way. This concern is dissimulated. It induces the same silence, and the same preventive attitude. It will be useful to remarck, in the patient, the misuse of a universal reflex of survival. He will be interested to learn something about himself. This reflex, useless under the ordinary conditions, is far from the usual unconscious processes. One will not be surprised, in not encountering resistances and the refusal, which otherwise would not fail to occur.

impossible stating

On the question of the language, the drinker is different from all the other patients - except bulimics.

The linguistic disturbances, so tenacious in this affection, do not bring it closer to either neurosis, psychosis or perversions. We will try to show that they are a completely normal phenomenon, which is the modest reserve, of which it is necessary to say a few words.

It is known that the deformations and cuts introduced by modesty, always intervene in the suspension of the symbolic system, in particular when a constraint of obedience to the body, substituting nature with the law, subjects the human being to *"the intangibility of the natural laws"*.

But modesty does not prohibit anything, and this is very important in alcoholism. The same goes for sexuality: decency is not opposed to the act, but, and in a rigorous way, with the communication of the act. Better, this phenomenon, eminently conscious, by the means of a major emotive influence, makes known to us what can be said and shown of an act. Another characteristic, the human being does not feel modesty, no therefore culpability, with respect to his own secret ideas.

Modesty, censures neither the pleasure nor the desire; it does not control the interdicts derived from the Oedipus. Where the language is censured, the desire and the pleasure are not. By way of consequence, in this affection, however generater of social rejection and moral censure, the deformations of the speech, by their modest nature, go hand in hand with the freedom of "circulation" of the desire.

This helps us to understand this phenomenon, unique to alcoholism, that the deformations, so important, of the speech, are autonomous and are not associated with an intimate debate about renouncement of alcohol. There is no drama, no problem. When those exist, there is no direct articulation with the speech difficulties, always present, but no-specific of alcoholism. One thus understands that this affection regularly thwarts the psychotherapy and the psychoanalysis.

Placed, like each one, in fundamental and spontaneous unconsciousness of their origins, the subject fully lives these inhibitions, undergone for a long time, and is unaware of them. In alcohologic consultation, this inhibition must not be violated by the therapist, but on the contrary taken well into account, as in, for example, a sexology consultation.

Better than whoever, the patient and his family will appreciate information on the phenomenon which can be explained in this way: the human being speaks "*straight forwardly*" when the body obeys the mind, but "*inversely*" when the mind must obey the body. The sexual life is an example easily understood.

One can specify, that in work, leisure, taking a walk, the mind decides and the body executes; all that can be recounted without problem. When sexuality functions well the mind must, on the contrary let itself be guided by the body: it is something that is not spoken of and which must not be spoken of; modesty stops the language; it obliges silence and the lie. This, for us, means to say that the stating is impossible when the symbolic mediation system is missing.

That confirms, at the same time, that, with the alcoholic, the act of drinking belongs to the non-symbolized. Most generally, the act of nature is no longer authorized for the man in society; natural behavior is erased in front of the social ritual. Drinking is a convivial gesture; people drink to celebrate, accomodate, commemorate, appreciate "*to accompany a meal*", one clinks glasses to conclude a belote. But, if the dependent person is the first to join her comrades at the bar, a usual place of consumption, it is not for any of these reasons, which have become "alibis"; his only motivation is the occasion for drinking.

Around this diverted use of the social protocol and its symbolic syntax system, plays the question of language: for our patient certain representative gestures no longer achieve their significant function. The apparent report is not authentic. The normal components of the saussurian sign, signifier and signified, no longer return to a same referent. Let us say that there is no more relationship of the signifier with the signified between the social protocol, and the act of drinking. The inadequacy of the signifier stops the normal operation of the stating. The linguistic units are not executable, beyond their significance in a cultural rite.

The linguistic difficulties of the alcoholic indicate a phenomenon which thwarts all the symbolic or ritual (and possibly nevrotic) regulations of the act of drinking. The same constraints which prevent the patient from telling to us how much he drinks, when, how and in which circumstances, are the same which prevent each one from stating the facts of sex.

But there is more. Let us reflect that, in sexual scenography, the statement becomes impudic if it indicates the real object, and in "ungallant" remarks, detail becomes obscene. One could be astonished, but for our patient, the simple question: " *how much do you drink?* " has an obscene character; and especially, upon the clinical relation, an impression of lewdness. It is not surprising that the deformations of the speech of the alcoholic reproduce certain subtleties of the speech in love, beginning with the elective omission of the body intrigue.

deformations of the speech

Among the deformations of the speech, the contrary assertion is very current. The patient uses the grammatical negation, (- *I am not alcoholic* -) or the semantic negation (- *I drink like everyone* -).

The preferred drink, the moments and the places of consumption are indicated by preterition: he who does not drink at the house, attends the bars; he who does not drink wine, drinks beer, etc... temporal displacement is also usual: the patients, unable to express the reality of the moment, refer to the future or to the past time: (- *I calmed down, but I used to drink a lot* -).

The quoted speech is often used (- *My wife says that I drink. - Did'nt my doctor telephone you?*): thus, using a third person, the speaker avoids, being the subject of the impossible statement.

The indefinite pronoun goes in the same sense: the sentence - *"one is dragged into it"* avoids the use of the first person ("I" could not return to an enunciator other than he who emits the message).

Concerning modest inhibition the patient is more at ease with a written document ("*here is my checkup, for me it is all Greek*") or at a distance (by the telephone) everything that it is necessary to put to profit. For, as in the love relationship, he who cannot speak, wishes above all to be understood, even when he is reduced to silence.

not to say, not to let see...

Better than anyone, the patient generally recognizes these blockages of communication which imposed themselves on him, and put him at such a distance from the others, whereas his progressive loss of autonomy required the opposite. But modesty affects all the modes of communication, thus, it is not only linguistic. What cannot be said cannot be shown; and like the sex act of each one, the act of drinking of the alcoholic cannot be shown.

There still, when he becomes aware of this phenomenon, the subject can acquire a better knowledge of the bases of his behavior, in particular on this clandestine consumption which is generally recognized as "shameful". Again, what he learns about himself does not register directly in the private field of the unconscious. (Again let us add an important point concerning modesty: if it causes difficulties of speaking or of showing, it does not produce any resistance to know the matter of modest reaction.)

This modest phenomenon, also regulate the food conducts and table manners; it is thus takes first place in medical alcoology. This eminently normative process is common to all; it makes one discover that the psychic attitudes which nourish the symptoms and scramble the speech, are not specific to alcoholism. These disorders, which we have described as induced, are also without relationship with the psychotropic effects of alcohol which, rather, abolish reserve.

the fight against the depression

The act of drinking, cannot be said and cannot be seen; thus the secrecy and loneliness finally impose a depressive and culpabilic processus. The deactivation of the symbolic system chain, in which the subject is represented, alienates language and, correlatively, “outlaws” the person.

So the suspension of linguistic faculties opens the door to antiquated reviviscences of libido and introduces pre-oedipian terrors and culpabilities. This can account for the silence and the guilt feeling, which one also finds in indecent assault and for the same reasons.

To speak would be the best solution, but the more it is necessary, the more it is impossible. The only possibility, to avoid depression, is to validate drinking by symbolic gestures. For this purpose, the patient looks for a ritual of accompaniment which can appear to be a link with the social protocol. To deny the submission to impulse, the subject seeks to reintroduce the forms and the standards of a regular consumption. He disguises the drinking of alcohol behind the pseudolegitimity of agreed uses: the alibis of which we spoke about above. This diverted use of the rites and convivial reasons preserves, in appearances, the standards of the group; it is also a concession to the power of signifier.

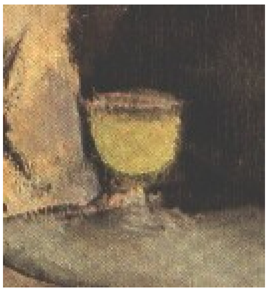
Another strategy consists of seeking places, moments, or social contexts where it is legalized to depass normal consumption, where disproportion is recognized. Mixing with other drinkers is an effective recourse against isolation and depression: the depressogene culpability is the crucial point of the clinical relation in alcoology.

These singularities of social and family behavior are usually attributed to the psychotropic effects of alcohol, to physiological deterioration, to the personality. People underestimate the brittleness which can generate a backlash towards the pre-linguistics universe and its weight on the social face of the personality. The clinical relation needs these disturbances of the language to be correctly evaluated. It is true that the clinical impression often leads to antidepressants, whereas the patient initially has need for words.

But we must once again underline the heterogeneity of the pathogenic factors in the alcoholic symptoms. In the majority of the cases, the depressive context can be attributed exclusively to the linguistic phenomenon. Because it deprives the patient of speech, the revealing of the impudic returns to pre-oedipian culpabilities. It is thus the setting out of language which feeds the depression and not, directly, alcoholic disproportion nor the "out-law" pleasures in which these culpabilities do not take root. These appear to be protected by an effective narcissistic rampart in which pleasure and desire freely circulate.

That explains on the one hand these appearances of cleavage, so peculiar to this affection and on the other hand these resistances to usual psycho-analytic therapies. It is conceived that a true therapeutic work can only really start when the various factors of antagonisms are well located.

In finishing we will notice that, on the contrary to other pathologies, the existence of strong linguistic disturbances, of an obstinate "*refusal*", will not be an indication of a personality disorder. One can see there on the contrary, reflected by this verbal modesty, the correct integration of the taboos and prohibitions which structure the human being: a psychotic alcoholic does not make mystery of his abuses. In the same way hiding-places and clandestine overconsumption are contrary to the behavior of racket and provocation which one knows in the psychopath. It is only when these constraints are less obvious, when the patient describes easily his disproportion that we can evoke a possible nevrotic or psychotic pathology. In this matter, the perfect frankness does not however guarantee the facility of the therapy.



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