The Tiebout Collection

Written by Dr. Harry M. Tiebout, M.D.

Dr. Harry M. Tiebout, a psychiatrist, was an early pioneer in coupling the principles and philosophy of Alcoholics Anonymous with psychiatric knowledge of alcoholism. A strong supporter of A.A. throughout his life, he consistently worked for acceptance of his views concerning alcoholism in the medical and psychiatric professions. He served on the Board of Trustees for Alcoholics Anonymous from 1957 to 1966 and was named chairman of the National Council on Alcoholism in 1950.

The 12 Steps as Ego Deflating Devices - What does Surrender Mean? - a letter from Dr. Tiebout

For reasons still obscure, the program and the fellowship of AA could cause a surrender which in turn would lead to a period of no drinking. It became ever more apparent that in everyone's psyche there existed an unconquerable ego which bitterly opposed any thought of defeat. Until that ego was somehow reduced or rendered ineffective, no likelihood of surrender could be anticipated.

AA, still very much in its infancy, was celebrating a third or fourth anniversary of one of the groups. The speaker immediately preceding me told in detail of the efforts of his local group—which consisted of two men—to get him to dry up and become its third member. After several months of vain efforts on their part and repeated nose dives on his, the speaker went on to say: "Finally, I got cut down to size and have been sober ever since," a matter of some two or three years. When my turn came to speak, I used his phrase "cut down to size" as a text around which to weave my remarks. Before long, out of the corner of my eye, I became conscious of a disconcerting stare. It was coming from the previous speaker.

It was perfectly clear: He was utterly amazed that he had said anything which made sense to a psychiatrist. The incident showed that two people, one approaching the matter clinically and the other relying on his own intuitive report of what had happened to him, both came up with exactly the same observation: the need for ego reduction. It is common knowledge that a return of the full-fledged ego can happen at any time. Years of sobriety are no insurance against its resurgence. No AA's, regardless of their veteran status, can ever relax their guard against a reviving ego.

The function of surrender in AA is now clear. It produces that stopping by causing the individual to say, "I quit. I give up on my headstrong ways. I've learned my lesson." Very often for the first time in that individual's adult career, he has encountered the necessary discipline that halts him in his headlong pace. Actually, he is lucky to have within him the capacity to surrender. It is that which differentiates him from the wild animals. And this happens because we can surrender and truly feel, "Thy will, not mine, be done."

Unfortunately, that ego will return unless the individual learns to accept a disciplined way of life, which means the tendency toward ego comeback is permanently checked. This is not news to AA members. They have learned that a single surrender is not enough. Under the wise leadership of the AA "founding fathers" the need for continued endeavor to maintain that miracle has been steadily stressed. The Twelve Steps urge repeated inventories, not just one, and the Twelfth Step is in itself a routine reminder that one must work at preserving sobriety. Moreover, it is referred to as Twelfth Step work—which is exactly what it is. By that time, the miracle is for the other person.

- Dr. Harry M. Tiebout, M.D.

The Tiebout Collection

Written by Dr. Harry M. Tiebout, M.D.

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The Tiebout Collection consists of four papers written during the 1950s, drawing from 'personal stories and the author's vast experience.

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Tiebout Collection

By Harry M. Tiebout, M.D.

Dr. Tiebout was an outstanding psychiatrist and pioneer in the field of addictions.
The four papers described below present several of his significant concepts,

- The Act of Surrender in the Therapeutic Process
- Direct Treatment of a Symptom
- The Ego Factors in Surrender in Alcoholism
- Surrender Versus Compliance in Therapy

THE ACT OF SURRENDER IN THE THERAPEUTIC PROCESS

Harry M. Tiebout, M.D.

INTRODUCTION: The Importance of a Positive Attitude

A year and a half ago, I wrote a paper in which I discussed a phenomenon which I labeled "conversion." In that paper I broadened the concept of conversion to cover any major switch from negative to positive thinking and feeling irrespective of a possible religious component. Two points stood out to me as important: first, the fact that the positive frame of mind could appear under a given set of circumstances without special help, psychiatric or otherwise; and second, that the new state of mind had a decidedly healthier tone to its thinking and feeling than that which prevailed when the negative tone was uppermost. Without saying so, I then believed that the positive frame of mind could become a legitimate aim in therapy as, once it was brought about, the individual's attitudes and responses were much healthier.

While I no longer believe that therapy is simply a matter of reaching a positive relationship with reality, I remain convinced that the creation of a positive attitude is one of the essential features in a successful therapeutic program, and that any experience that brings about such an attitude or frame of mind deserves careful study for the light it may throw on treatment in general. Consequently, I continued my observations on the conversion experience and have arrived at the conclusion that the key to an understanding of that experience may be found in the act of surrender which, in my opinion, sets in motion the conversion switch. My paper will therefore consist of (1) a discussion of the act of surrender, and (2) an endeavor to relate it to the therapeutic process as a whole.

Before I go ahead, it may be wise to recapitulate the contents of my previous paper. In it I described how, with the conversion switch, many aspects of the patient's attitudes underwent profound and often remarkable alterations. I pointed out how, in eight major ways, the individual switched or changed. Rather than go through the whole list again, I can sum up these changes briefly by saying that the person who has achieved the positive frame of mind has lost his or her tense, aggressive, demanding, conscience-ridden self that feels isolated and at odds with the world and has become a relaxed, natural, more realistic individual who can dwell in the world on a Live and Let Live basis. The difference in the before and after state of these people is very real and represents, I believe, a fundamental psychic occurrence.

The Act of Surrender

With respect to the act of surrender, let me emphasize this point: it is an unconscious event, not willed by the patient even if he or she should desire to do so. It can occur only when an individual with certain traits in his or her unconscious mind becomes involved in a certain set of circumstances. Then the act of surrender can be anticipated with considerable accuracy, as I shall soon show. It cannot be defined in direct conscious terminology but must be understood in all its unconscious ramifications before its true inner meaning can be glimpsed. The simplest way to picture what is involved in the act of surrender is to present a case in which there was a conversion experience that seemed to follow an act of surrender..

One Man's Story

The patient is a man in his early fifties, very successful in business, and referred to by his associates as Napoleon because of his autocratic methods when he was stirred up. For years, heavy drinking to the point of frequent intoxication was present, interfering to some extent with his efficiency, but never to the degree that his business really suffered. My first contact came some six or seven years ago when he

came to Blythewood to dry out. Pursuant to our policy of trying slowly and from time to time to educate patients about the danger of their condition, we permitted this man to remain just for the drying out, at the same time telling him that, in our eyes, he was headed for trouble if he continued on his present trend. Without putting any pressure on him and thus arousing his resistance, we placed the facts before him and let it go.

We continued the policy of letting him come and go pretty much as he pleased, always, however, keeping uppermost before him the need to do something about his drinking, and always making it evident that we were not interested in drying him out, but in the real problem of helping him stop his drinking. Later on and in retrospect, the patient, in referring to these tactics, said, "I used to like to come here; you didn't always argue with me. I always knew just where you stood and knew I wasn't fooling you any."

During all this time, however, I was working on his life situation so that ultimately it would provide the necessary dynamite to jar him loose from his whirl of self-centeredness. Gradually, his wife gave up her protectiveness and, before the time of this last admission nearly two years ago, she had determined to leave him if his drinking continued. Moreover, as a result of some discussion with me, his business partner had decided that he, with several key members of the firm, would tender their resignations if the patient did not make a real effort to mend his ways.

After a particularly severe bout, the patient was induced again to enter Blythewood. This time, however, I told him flatly that he would sign himself in for thirty days or he would go elsewhere; we were through with him running his case once and for all. He looked startled, picked up his hat, fiddled with it, and then put it on his head, saying, "Where's your pen? I'll go to Hilltop where I belong," referring to the cottage where he had dried out on previous occasions. Within three or four days he was off the liquor and thinking reasonably straight. He was then informed of his wife's decision and, instead of ranting around and making it clear where she could go, he discussed for the first time the real hell he had put her through and really seemed regretful. By the end of the first week, quite prepared for trouble, the partner told him of the pending resignations if the drinking persisted, only to be surprised and pleased with the patient's quiet acceptance of their decision and an acknowledgment of his own real wish to be different. He soon joined A.A. and is now an active member of that organization in his home community. The patient has stayed sober.

What Happened ?

Recently in discussing his experience the man in the story explained, "You did something to me when you made me sign that card. I knew you meant business. I knew my wife was getting sore and that Bill *his partner* was fed up, but when you showed me you were through fooling, that was a clincher. I knew I needed help and couldn't get out of it myself. So I signed the card and felt better right off for doing it. I made up my mind that I wasn't going to run my own case any longer but was going to take orders. Then later I talked with Chris *his wife* and learned how she felt, and then Bill came along and I knew deep inside my heart they were right. But, I didn't mind. I didn't get angry and want to argue like I used to. I kind of surprised myself by agreeing with them. It sure was nice not to have to fight. I felt calmer and quieter inside and have ever since, although I know I'm not out of the woods yet."

Here is the story of a patient who has been through a conversion experience and is still in the positive phase. His own account of what happened stresses the signing of the card as the turning point in his experience, and I am also convinced that he is right. We can sum this man's experience up by saying that after trying to run his own case to his own ruination, he gave up the battle and surrendered to the need for help, after which he entered a new state of mind that has enabled him to remain sober.

THE ACT OF SURRENDER IN THE THERAPEUTIC PROCESS

Harry M. Tiebout, M.D.

Breaking Down The Act Of Surrender

This man's experience, which is not limited to alcoholics, raises three questions:

I . What qualities were there in his nature that so long resisted help and finally were forced to give in?

1. What were the circumstances that brought about the final act of surrender?
2. Why does a positive phase follow the surrender experience?

My answers to these questions are derived primarily from my studies of alcoholics, but not entirely, as I have witnessed surrender with a typical aftermath in at least four cases among the students at Sarah Lawrence. I hope through my discussion in reply to these questions not only to define the act of surrender, but also to give you some feeling for it as a psychological entity or event.

Internal Qualities

To turn then to the first question, "What are the qualities in a patient's nature that make him or her put up such a battle before finally surrendering?" In the alcoholic, my observations have led me to see that the two qualities that Sillman selected as characteristic -- *defiant individuality and grandiosity* -- may very well explain that the alcoholic is typically resistant to the point of being unreasonable and stubborn about seeking help or being able to accept help even when he or she seeks it. Defiant individuality and grandiosity operate in the unconscious layers of the mind and their influence must be understood if one is to see what probably goes on at the time of surrender.

Defiance

Defiance may be defined as a quality that permits an individual to snap his fingers in the face of reality and live on unperturbed. It has two special values for handling life situations. In the first place, defiance, certainly with alcoholics, is a surprisingly effective tool for managing anxiety or reality, both of which are so often a source of anxiety. If you defy a fact and say it is not so and can succeed in doing so unconsciously, you can drink to the day of your death, forever denying the imminence of that fate. As one patient phrased it, "My defiance was a cloak of armor." And so it was a most trustworthy shield against the truth and all its pressures.

In the second place, defiance masquerades as a very real and reliable source of inner strength and self-confidence, since it says in essence, *Nothing can happen to me because I can and do defy it.*

With people who meet reality on this basis, life is always a battle with the spoils going to the strong. Much can be said in favor of defiance as a method of meeting life. It is the main resource of the chin-up and unafraid type of adjustment and, as a temporary measure, it helps people over many rough spots.

Grandiosity

Grandiosity, the second quality noted by Sillman, permeates widely throughout the reactions of the alcoholic. Differing from defiance -- which seems almost uniquely structuralized in the psyche of the alcoholic -- grandiosity springs from the persisting infantile ego. As in other neurotic states, grandiosity characteristically fills a person with feelings of omnipotence, demands for direct gratification of wishes, and a proneness to interpret frustration as evidence of rejection and lack of love. The effect of this persistence in the alcoholic is not a bit different from the effect of any other neurotic. Perhaps in the

alcoholic the typical arrogance and sense of superior worth are kept nearer the surface by the associated defiance that feeds the childish ego constantly by its succession of victories. By and large, however, there is nothing in the alcoholic's grandiosity that distinguishes him or her from the neurotic, whose infantile ego survives to become a significant factor in adult life; it is part of the typical egocentricity of that group, and its presence is confirmed by any careful study of them.

Defiance and Grandiosity at Work in the Alcoholic

We are now in a position to discuss how these qualities operate in alcoholics. On the one side, the defiance says, *It is not true that I can't manage drinking* . On the other side, the facts speak loudly and with increasing insistence to the contrary. Again, on the one side, grandiosity claims, there is nothing I cannot master and control, and on the other side, the facts demonstrate unmistakably the opposite. The dilemma of the alcoholic is now obvious: the unconscious mind rejects -- through its capacity for defiance and grandiosity -- what the conscious mind perceives. Hence, realistically, the individual is frightened by his or her drinking and at the same time is prevented from doing anything about It by the unconscious activity that can and does ignore or override the conscious mind.

Let us see how this clash between the conscious and unconscious response manifests itself in the clinical setting. A stimulus from reality, such as a recognition of the downhill pattern of the drinking, impinges upon the conscious mind and creates acute anxiety which, for the moment, dominates the conscious processes and is recorded as worry, distress, fear, and concern. The patient, in this state, is fired with a desire to quit and eagerly grabs at any kind of help. He or she is in a state of crisis and suffering.

In the meantime, however, the stimulus of reality is hitting the unconscious layers of the mind and is stirring up the reactions of defiance and grandiosity. Since, characteristically, it takes a certain amount of time before the unconscious responses are sufficiently mobilized to influence conscious mental activity, there is always an appreciable lag before the conscious mind evidences signs of the underlying unconscious activity. Then slowly and gradually these attitudes supervene. Patients express less concern about their drinking, complain that they were rushed into seeking help, that they're no worse than anybody else, and that the worry of others is silly and a gratuitous invasion of their rights. Finally, the memory of their own acute period of anxiety is swallowed up by the defiance and grandiosity. Thus the patient loses the effectiveness of the anxiety as a stimulus to create suffering and a desire for change. This cycle will go on repeating itself as long as the defiance and the grandiosity continue to function with unimpaired vigor.

External Circumstances

We now come to the second question: "What were the circumstances that made that patient give in and sign that card?" Let me review them for you briefly. He had been drinking for years, and he knew his drinking was getting worse in the eyes of family and friends. However, he knew that his condition had reached the point where both his wife and his business associates were leaving him and thereby withdrawing their support and protection. He was threatened with the task of managing himself and his condition entirely on his own, so he sought my help and protection to dry him out and thus allow him once more to resume his role of successful defiance and grandiosity. This time, however, I refused to follow my previous role. I had established myself as not arbitrary, not willing to fit what he needed. But when I asked him to sign the card, I knew that his other circumstances were different and that I represented the one way for him. When I told him, in essence, that he was not running his case or me anymore, his last prop was thus removed. He had no place to take his defiance and his grandiosity; nor could he become defiant with me: someone who stood for his last bit of hope and who actually

had become established as an ultimate resource when he was in difficulty. So he staged a brief inward debate and then signed the card.
In short, the patient signed the card, first, when all support was withdrawn; second, when he could not in anger defy those who withdrew their support because he knew they had been patient and long-suffering; and third, when he found himself desperately needing help and had no grandiose ideas left about being able to drink like non-alcoholics. He had neither unconscious defiance nor grandiosity left to fight with. He was licked, and he both knew it and felt it.

The Positive Phase

We now reach the third question, "Why does the positive phase follow?" Here, we frankly reach speculation. I know the positive phase comes, but not just why. Surrender means cessation of a fight, and cessation of a fight seems logically to be followed by internal peace and quiet. That point seems fairly obvious, but why the whole feeling tone switches from negative to positive without all the concomitant changes is not so clear. Nevertheless, despite my inability to explain the phenomenon, there is no question that the changes do take place and that they may be initiated by an act of surrender.

THE DIFFERENCE BETWEEN SUBMISSION AND SURRENDER

One fact must be kept in mind, namely, the need to distinguish between *submission* and *surrender* . In submission, an individual accepts reality consciously, but not unconsciously. He or she accepts as a practical fact that he or she cannot at that moment lick reality, but lurking in the unconscious is the feeling, *there'll come a day* , which implies no real acceptance and demonstrates conclusively that the struggle is still on. With submission, which at best is a superficial yielding, tension continues.

When an individual surrenders, the ability to accept reality functions on the unconscious level, and there is no residual of battle; relaxation with freedom from strain and conflict ensues. In fact, it is perfectly possible to ascertain how much acceptance of reality is on the unconscious level by the degree of relaxation that develops. The greater the relaxation, the greater the inner acceptance of reality.

We can now be more precise in our definition of an act of surrender. It is to be viewed as a moment when the unconscious forces of defiance and grandiosity actually cease to function effectively. When that happens, the individual is wide open to reality; he or she can listen and learn without conflict and fighting back. He or she is receptive to life, not antagonistic. The person senses a feeling of relatedness and at-oneness that becomes the source of an inner peace and serenity, the possession of which frees the individual from the compulsion to drink. In other words, an act of surrender is an occasion wherein the individual no longer fights life, but accepts it.

Having defined an act of surrender as a moment of accepting reality on the unconscious level, it is now possible to define the emotional state of surrender as *a state in which there is a persisting capacity to accept reality.* In this definition, the capacity to accept reality must not be conceived of in a passive sense, but in the active sense of reality being a place where one can live and function as a person acknowledging one's responsibilities and feeling free to make that reality more livable for oneself and others. There is no sense of "must"; nor is there any sense of fatalism. With true unconscious surrender, the acceptance of reality means the individual can work in it and with it. The state of surrender is really positive and creative.

To sum up, my observations have led me to conclude that an act of surrender is inevitably followed by a state of surrender that is actually the positive state in the conversion picture. Because of the two always

being associated, I believe they represent a single phenomenon to which I attach the term "surrender reaction."

RELATING THE ACT OF SURRENDER TO THE THERAPEUTIC PROCESS

Having at last made as clear as I could my use of the term "surrender," I must now try to relate that concept to the therapeutic process. While, a recognition of the dynamic force of the event has proven enlightening in many directions, it has been particularly helpful in understanding the fluctuations in moods of patients and in certain aspects of therapy.

The following patient's problem took on meaning for me when I grasped the fact that he had experienced an act of surrender at the time he attended his first A.A. meeting. A man in his middle thirties, he tells his story this way:

"I was licked. I'd tried everything, and nothing had worked. My wife was packing to leave me; my job was going to blow up in my face. I was desperate when I went to my first A.A. meeting. When I got there, something happened. I don't know to this day *a year later* what it was, but I took a look at the men and women there and I knew they had something I needed, so I said to myself, *I'll listen to what they have to tell me.* From that time on, things have been different. I go to meetings, work with other drunks, and study all I can about alcoholism. I know I'm an alcoholic, and I never let that fact escape me."

Now, if you stop and review this man's account, you will note the statement, "I'll listen to what they have to tell me." In that comment to himself, the patient initiated his act of surrender. There was no lip-service in his willingness to listen; he really wanted help. There was no defiance or grandiosity available at the moment to dilute his listening. He was accepting, without inner reservation or conflict, the reality of his condition and the need for help. And, significantly enough, at this point he goes on to say, "From that time on, things have been different." Subsequent events clearly indicate that this man did experience the typical change I have been calling *conversion* , and from that time on "things were different." His wife, commenting on this change, said feelingly, "It's the most remarkable thing I ever could imagine. The only trouble is that I still have to keep my fingers crossed because it still doesn't make any sense to me."

The patient, however, consulted me because he "didn't like the way things were going." By that, he meant that he was finding himself cranky at home and irritable in business, signs that his A.A. experience had taught him were ominous. When I asked him why he gave up drinking, he replied that he had made up his mind to quit so he, did, although he had to admit that A.A. was helpful. A little surprised at this simple assertion and doubting it somewhat, I plied him with further questions and got the real story, which showed to me that he had a typical surrender experience, followed by a typical positive aftermath. But I also saw that the change did not last and that, after several months in which the patient had lived in a state of surrender, he slowly reverted to his former attitudes and ways of feeling. In other words, the surrender reaction did not fix itself into his personality and thus allowed the return of his previous state of mind.

Differing acts of surrender

The fate of the surrender reaction is in itself an interesting study. With some, the surrender experience is the start of genuine growth and maturation. With others, the surrender phase is the only one ever

reached, so that they never lose the need to attend meetings and to follow the program assiduously, apparently relying on the constant reminders in their daily existence to supply the necessary impetus to the surrender feeling, at least insofar as alcohol is concerned. For a few, there seems to occur a phenomenon of what might be called *selective surrender* . After the effects of the initial surrender experience have worn away, the individual returns to pretty much the same person he or she was before, except for the fact that the person doesn't drink. His surrender is not to life as a person, but to alcohol as an alcoholic. Many other differing aftermaths undoubtedly occur, but a study of any or all of them would, I am sure, disclose the same basic fact: the surrender experience is followed by a phase of positive thinking and feeling that undergoes various vicissitudes before it becomes established in some form or other in the psyche -- or it is lost completely, becoming merely a memory and a mirage.

Recognizing the Surrender Reaction

From the standpoint of therapy, recognition of the surrender reaction throws a challenging light upon many clinical phenomena that are generally held to be of significance in the process of getting better. For instance, in catharsis it is not what is revealed but the act of surrender (that preceded and permitted the revealing to come to light) that, in my opinion, produces the characteristic afterglow of positive feeling. It also explains its temporary effect just as with the conversion experience of the alcoholic. Again, the frequent unexpected lifts derived from seemingly ordinary first interviews, while they may be considered transference phenomena, seem to me more in the nature of "surrender reactions" based upon the fact that the client found the interview palatable, and the client made a decision to continue, which by implication means "surrender", to the psychiatrist. The very decision to come to a psychiatrist, through its surrender significance, often has an ameliorating influence and certainly accounts for the remark of a patient who said, "Once I rang your doorbell, I felt 75 percent better". The phenomenon of release, which makes people realize that, in losing their lives they are finding them, becomes explicable if one sees that the surrender that preceded the sense of release stills the inner fight and hostility, thus permitting the spontaneous creative elements of the Inner Self outlet for expression.

Resistance

It is in the area of resistance, however, that an understanding of the surrender reaction sheds the greatest light on the therapeutic process. Regularly, therapy goes ahead by fits and starts. For a while there is a period of resistance that is worked through, permitting progress, insight, and awareness of the emotional interplays in the unconscious life. Then another point of resistance is encountered, and again it must be ferreted out and dissolved before further constructive steps may be taken. Meeting resistance and working it through are the everyday tasks of therapy.

Breaking Through Resistance

Where before the patient has been in full resistance -- bucking treatment, difficult to manage, getting nowhere -- suddenly there is a marked change, almost like the sun bursting through the clouds, bringing everything into focus and making what was once a confused jumble take on form, significance, and meaning. For the time being, the resistances have disappeared and the treatment proceeds apace.

We have been accustomed to saying that the patient has a flash of insight and understanding that brought clarification and a greater awareness of his or her individual emotional makeup. Actually, if you examine the state of mind that breaks through when the resistance melts, you will find it is strikingly parallel to the positive state of mind an individual may have after a conversion experience. In fact, the parallel is so striking that I am more and more becoming convinced that the two are identical. In other words, I now believe that the giving up of resistance during treatment is in reality an act of surrender

that typically, as in the conversion experience, is followed by a positive state of mind where elements of resistance are no longer present. This "giving in" may be sudden, causing the patient to enter the positive phase so rapidly as to constitute a sudden turnover with dramatic results. Generally, as in the conversion change, the change is slower, but the alteration is in exactly the same direction.

CONCLUSION

No one recognizes more than I do the sweeping nature of any such observations. No one is more aware than I am of the need to substantiate these observations with clinical material. Someday I may be able to support more conclusively my present hypothesis with case material. I can point out, however, that the positive aftermath of the so-called "successful interpretations" is no more lasting than the positive phase of the so-called "conversion experience". They are both temporary; they are both slowly supplanted by a new crop of resistances or negative feelings. Also, they both require further change in the unconscious mind before the act of surrender becomes a settled state of surrender in which defiance and grandiosity no longer raise havoc with adjustment, serenity, and the capacity to function as a human being.

To recapitulate, my studies of the conversion experience have led me to see that:

- It is the act of surrender that initiates the switch from negative to positive behavior.
- It occurs when the unconscious defiance and grandiosity are for the time being rendered completely powerless by force of circumstance or reality.
- The act of surrender and the change that follows are inseparable since it is safe to assume that if there is no change, there has been no surrender.
- The positive phase is really a state of surrender that follows the surrender act.
- In several places, as in catharsis, the so-called improvement or feeling better is actually a state of surrender induced by an act of surrender.
- The state of surrender, if maintained, supplies an emotional tone to all thinking and feeling that does insure healthy adjustment.

I have tried in this paper to establish the fact that there is such a psychic event as surrender and that once the fact is appreciated in all its ramifications, it is illuminating clinically and provides a basis for understanding much that goes on in the therapeutic process.

THE EGO FACTORS IN SURRENDER IN ALCOHOLISM

Harry M. Tiebout, M.D.

Therapists with alcoholics have a twofold task. They must treat the disease alcoholism and they must treat the person afflicted with it. Psychiatrists have tended to bypass the disease and treat the individual, but again and again under this approach the patient has proved recalcitrant to all therapeutic endeavor. As a result, alcoholics have been considered very unlikely prospects for therapy of any sort.

The difficulty, of course, was in the main symptom of the disease: the fact that the patient would get drunk, which repeatedly nullified all attempts at assistance. As a consequence, work with the person who drank was stymied by the fact that he drank. In the face of this dilemma, therapists have thrown up their hands in dismay and have turned to greener pastures.

The mistake we made was our failure to recognize that the task was twofold. In rather doctrinaire fashion, we persisted in treating the alcoholism as a symptom which would be cured or arrested if its causes could be favorably altered. The drinking was something to be put up with as best as one could while more fundamental matters were being studied. The result of this procedure was that very few alcoholics were helped. The drinking continued and the symptom remained untouched.

In other medical treatment this concept of getting at causes is not considered sufficient. No one ignores a cancer, for instance, while searching for its origins. It is cut into or treated with x-ray or radium in the hope that the growth will either be removed or will stop advancing. Once the cancer is detected, the question of etiology is academic.

Exactly the same thinking applies to the treatment of alcoholism. It is a symptom which becomes dangerous in itself. Until it has been effectively stopped, little of real help can be offered. Alcoholics Anonymous stresses the danger of the first drink and Antabus simply stops the ability to take it. Both attack the symptom and both have recorded a substantial measure of success.

The advent of these new tools not only has given us a means of treating the symptom directly, it has focused attention upon a factor whose importance was hitherto insufficiently appreciated. That factor is the significance of the first drink and what it represents to the psyche of the drinker.

Such focusing has two results. First, it directs thought toward the problem of stopping, that is, of not taking the first drink. Second, it leads to a new approach to the understanding of what must transpire in therapy if the alcoholic is to remain sober.

This paper will discuss both those points, namely, the direct treatment of a symptom and the individual's reaction to such a direct approach.

1. The Direct Treatment of a Symptom

The direct treatment of a symptom is and has been the subject of much controversy. A review of the past is necessary to set the controversy in perspective.

THE EGO FACTORS IN SURRENDER IN ALCOHOLISM

Harry M. Tiebout, M.D.

Roughly, we can divide the past into the time before Freud and the time after. Prior to his epoch-making revelations about the unconscious and its controlling influence over behavior, all treatment perforce was direct. If a person was acting in a disturbed manner, he was placed in an institution. If he broke the law, he was imprisoned. A naughty child was spanked. Treatment was aimed at behavior and was essentially disciplinary, the big stick. For the most part, it was applied blindly, woodenly, as the only known means of combating the behaviors being encountered.

Then through Freud's work conduct was recognized as an outgrowth of unconscious functioning, and, before long, the field of psychiatry embraced as one of its major tenets the principle that all behavior sprang from the unconscious, and that therapy, when necessary, had as its goal the determination and elimination of the pathology behind upsetting behavior. The validity of such a shift was indisputable. Since former blind methods could be replaced by much more precise measures, direct treatment of a symptom lost all caste. The day of scientific therapy had arrived.

Strangely, though, a new kind of woodenness then appeared. Anything prior to Freud was out, to be viewed dimly and with alarm.

I, too, was an early believer and expounder of the theory that all behavior was symptomatic. 1, as much as anyone, searched energetically for unconscious forces to help alcoholics, and 1, too, fell flat on my face. It just did not work.

Then, as related elsewhere, Alcoholics Anonymous came along and I saw it succeed not only in arresting the drinking, but in helping a person to mature. All my' pet assumptions were knocked into a cocked hat (and it took me many a year to realize the full import of what I had seen happen to my patient as she made the grade through Alcoholics Anonymous).

Unconcerned with causes and not bewitched by dogma, the A.A. program was designed to get the individual to stop drinking, and really nothing else. The aspects of personality inventory and of spiritual growth were useful in A.A. chiefly because they tended to insure the individual's capacity for not taking the first drink. They had nothing to do with causation. The whole program was direct treatment of a symptom.

When this dawned, most of my previous thinking on getting at causes had to be shelved, placed to one side, so that this new fact could be studied open-mindedly.

Antabuse came along to confirm the soundness of tackling the symptom, and the need to find an explanation for that heretical fact became more imperative. Finally, the significance of the first drink became apparent, and then the corollary fact that the individual must stop taking even "one".

With the recognition that total abstinence was the goal of both methods, pre-Freud direct management of symptoms took on a different significance. This, too, was to be seen as an effort to change the individual's behavior either by putting him in an institution for the mentally ill, or by jailing him, or by inflicting punishment. To be sure, these techniques might be applied without much precision and perhaps too often, but they nevertheless effectively stopped the symptoms, and perhaps that, in and of itself, was not

only useful but necessary. Certainly, insofar as helping the alcoholic was concerned, the direct method worked. In my eyes, such treatment had been reestablished as a sound clinical procedure and a valid tool. Hopefully, it could be applied with more skill and finesse now that the Freudian insights were available, but to dismiss it totally would be inexcusable rigidity and evidence of very unscientific dogmatism.

2. The Individual's Reaction

With the acceptance of the validity of the direct approach, the treatment of the alcoholic individual takes on a new dimension. Instead of determining causes, the therapeutic aim is directed toward helping the patient to utilize available techniques, A.A., Antabus, and/or psychiatry, to aid in his battle to stop drinking. The therapist, so to speak, has his prescription. His job is to sell it to the patient.

At this point, we run into a fundamental issue. Most patients take their doctor's prescription. Very few alcoholics respond that simply. As a result, the doctor has the task of inducing the patient to take the medicine offered, and it is ' here that we must consider the nature of the alcoholic, the individual who balks at taking the remedy suggested. This brings us to our second point, namely, the nature of the individual who so stubbornly refuses to stop drinking.

More accurately, the topic of this section is the nature of the individual's reaction to direct treatment. The physician for the alcoholic, regardless of his personal inclinations or his theoretical convictions about the function of the therapist, is placed in the role of someone who is trying to stop the patient's drinking. And although the alcoholic may desperately want help consciously, this does not necessarily overcome his unconscious resistance to such authoritative handling. The therapist inevitably acts as a depriving person.

To try to avoid that role is silly, misleading, and a very poor example. Silly because it denies the obvious, and misleading because it is attempting to sugar-coat an unpalatable truth. A poor example, because the therapist is denying realty-behavior at which the patient is already expert. Fundamental respect can never be established on such a false basis.

As a consequence, the therapist must not fight the patient's identification of him as a depriving figure. There is no loophole from that position. The only hope is to help the patient learn to accept deprivation and therefore reach a state in which, as a mature person, he will realize that all his wants and demands cannot be satisfied and that there are some things he cannot have.

The therapist must not sidestep his depriving role; instead he must freely acknowledge it and let therapy begin right there. To do so clears the atmosphere and paves the way for establishing a sound working relationship.

The following clinical material shows not only these new tactics which must be adopted but also the patient's reaction to them. The patient is a man in his middle thirties who, after six years of stumbling success with A.A., decided to try psychiatry because, to quote him, "I'm almost as bad as when I started with A.A. I've got to do something." It

was clear that he was strongly motivated, and consequently he was accepted for therapy. The patient was told that his immediate problem was drinking and that it could ruin his chances of profiting from assistance. There would be no insistence on total sobriety, but there would be the following stipulation: if in my opinion his drinking was interfering with therapy, I could require him to take Antabuse, which would insure sobriety over a period long enough to settle whether or not he could profit from treatment, so that later on he might be able to get along without the medication.

The patient promptly accepted this proviso, saying it made complete sense to him. On the surface he seemed completely receptive. He remarked in confirmation, "I know when I'm drinking it would be a waste of your time to try to help me; I just wouldn't get a thing." No trace of protest could be observed and I am sure none was felt. In fact the patient seemed to welcome a forthright statement of what lay before him. He at least knew where he stood.

Also during the first interview the patient was asked to record his dreams. At the next session, he reported the following:

I . Irritated and teased pet bird.

2. Vaguely remember X.Y. Think was drinking with him.

3. Accidentally pulled all the tail feathers out of pet bird.

The first dream he then expanded, adding, "the pet bird was mine and it was caged and visibly annoyed." Little imagination is required to read the unconscious thoughts at this point. Birds stand for freedom, i.e., "free as a bird." A caged bird is not free and, therefore, is "irritated" and "visibly annoyed," feelings which every freedom loving person would show if caged. And no one would deny that a caged bird was a stopped one. The first dream pinpoints the fact that therapy was designed to stop drinking.

The next dream finds the patient drinking with a boon companion, a person he was prone to turn to after sobriety had begun to pall. In this dream, quite literally, the bird becomes the patient, escaped from the cage, and the cage which has been escaped from is the knowledge about the danger of the first drink.

The report of the third dream also received interesting amplification. The patient volunteered that the bird flew by him and that, as it did, he grabbed at it and "pulled every last tail feather off, and all that was left was a bare little butt end." Again the message of the dream is clear. The free bird, again in the picture, presents its butt end to the world, an unequivocal gesture of defiance.

The story that these dreams have to tell seems unambiguous. The patient is coming for help about his alcoholism, which he knows can be treated only by his not taking the first drink. The symbol of the caged and annoyed bird is a brilliant condensation of three aspects of his own self as it reacts to his new situation. First,

the bird is a symbol of freedom; second, it represents the sense of restriction which is the cage; and third, it shows the "visible annoyance" and "frustration" which the bird feels

as it is confronted by the fact that it is not at liberty. In the second dream the patient is no longer stopped. The third dream reveals this clearly as a defiant response to the therapy.

No doubt other interpretations with which I would have no dispute may be offered for these dreams. The point is, however, that the theme of stopping is also unmistakably present in the patient's unconscious which shows a completely understandable reaction to the idea of being stopped and frustrated.

Despite the note of defiance on which they end, these dreams actually started therapy off on a good sound basis. First and foremost, the patient learned that he had unconscious attitudes. Although he protested vigorously that he had no feeling of defiance toward either the doctor or the treatment, he knew that on many occasions he had shown and felt just such inner attitudes. He could now appreciate that defiance was in his system even contrary to his desires and in spite of his failure to be aware of it. From now on, he would have to recognize the presence of an inner-feeling life which psychiatry might help him reach and learn to handle better. Any lurking misgivings regarding psychiatry were to some extent lessened.

In addition, the patient had to face his inner demand to be free and that inside he balked at any curbing. Recognition of this fact was comforting, for it gave him a belief that further insights might be forthcoming and that the possibility of help might exist.

Still a third advantage to his start sprang from the discussion of defiance and the insistence upon freedom. The patient's immediate reaction was to scold himself for acting that way and to feel guilty that he had allowed such attitudes to persist. When he could realize that these forces were deep-seated and real, he could drop his punitive reactions of guilt and focus upon the more important issue of how he could rid himself of his tendency to defy and his desire to cherish his freedom at the expense of his sanity. The burden of guilt could be lifted and with it the tensions which contributed so much to his drinking. Therapy was obviously under way.

As this example shows, the patient's negative responses to the direct approach need not be feared, because they can be used to suggest to the patient the idea that their very presence, while easy to comprehend, is an indication of where his trouble lies.

Let me summarize briefly the points made so far. First, the treatment of the alcoholic must initially focus on his drinking. To say this is not to ignore the person or his body. They must always receive attention regardless of the ailment. However, the primary emphasis on the control of the drinking is essential if treatment is to succeed. Second, the patient's reactions to direct treatment not only do not undermine the therapeutic relationship, but may actually enhance it. As those reactions are discovered and faced, a solid foundation for a good therapeutic experience is created. To act otherwise can only result in confusion.

Before closing, a few comments are in order. First, the importance of timing cannot be overemphasized. The patient who reacted well to an active technique was ripe for the plucking. He wanted to quit and had been trying to for several years. He was a perfect candidate for the direct approach.

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Actually he was at the end of a very long trail. It began with his drinking blithely and unconcernedly. It was nearing its conclusion hopefully with his' earnest desire not to take the first drink. Space limitations prevent my identifying and discussing all the various sections of that trail. Suffice it to say that he could now seek help with no conscious reservations.

Actually, such direct methods can be applied only when the patient is in a receptive frame of mind. A whole paper could be devoted to a discussion of how the patient's defenses must weaken so that he is willing and able to turn for help. To be direct when it is certain that such an approach will bounce off a shell proof exterior is obviously bad timing. It wastes ammunition which could later be effective. Other measures must be used first in an effort to soften these defenses. The direct approach can be ventured only when the patient is sufficiently vulnerable to make its success likely.

Secondly, what should be the doctor's attitude toward the patient's drinking during therapy? In the "platform" placed before the patient, I included a "wait-and-see plank." This I did for three reasons. In the first place, I did not want to give the impression of acting before I, too, was in possession of the facts about the drinking pattern. If it continued and caused difficulty, here was concrete evidence on which to base a decision about Antabus.

A second reason for a tentative approach was the hope that the usual concept of the disciplinarian as dogmatic and arbitrary could be undercut if I adopted a less adamant program. If later on it became necessary to crack down, the patient would not be justified in claiming that the new tactics were evidence of a hopelessly closed mind toward drinking.

One patient tried to puncture that stratagem by ferreting out the reason for the delaying tactics and accusing me of waiting until he had hanged himself. Since that was true, I admitted the charge and went on from there. I told him he still had to look at the fact that he had hanged himself. The focus was kept on the drinking problem; that he still had to face.

I The third reason for adopting a non-dogmatic policy was to place myself in the position of being able to discuss the problem of the drinking with the patient directly. Generally with such delaying tactics the patient makes an extra effort at control and as a rule succeeds for a while, after which the condition usually takes its course and the patient gets drunk. At that point, it is possible to review with him his hopes of controlling intake and his consequent disillusionment and renewed awareness of his drinking problem. In this manner, the patient's feeling of need for help is revived and motivation is thereby strengthened. Therapy can thus proceed on a firmer footing.

My third comment opens up a vast area. It has to do with the significance of the direct approach in treating alcoholism or any other condition. The full import of this question can only be hinted, but an effort must be made to point out the far-reaching bearing of the direct approach with its stopping-attribute.

One way to discuss the significance of being direct is to ask the question, "How much of

the handling of people is of the direct or stopping-variety?" To my mind the answer is, "Far more than most of us realize or have ever suspected." As already pointed out, incarceration is a form of direct treatment. It still has its values in certain situations. Its more respectable counterpart, the trip or vacation or residence in a sanitarium, serves much the same purpose, namely that of lifting the individual out of the whirling currents of his everyday existence and depositing him in a setting where he can slow down and stop. One can also wonder at the new therapies. Certainly shock gives the body and mind an awful beating which in some obscure fashion perhaps may serve a disciplinary, hence stopping, function. Again the sleep therapies put the patient in an enforced rest and, for the time being, effectively stop him.

Children are told to "cut that out" and know that they are being stopped. While the routine use of such a phrase is severely to be frowned upon, the teacher or person in authority who cannot use that phrase when necessary is badly handicapped in the performance of his job.

Youngsters in the nursery school or kindergarten reveal the need for stopping. Good practice has periods of free play interspersed with times when the children sit and draw or paint or listen to stories or have rest periods. These quiet times are designed to slow the youngsters down. On occasion, particularly with a new and inexperienced teacher, the class gets too keyed up and, since this kind of excitement is infectious, the class goes "wild." It then must be dismissed for the day. The firm hand of the good teacher was lacking and the children got out of control.

Certainly a lot of preventive mental hygiene is of this same stopping variety. -- We sleep, we play, or take holidays to provide a break or a cut in the monotony of continued plugging. We seek avocation interests to change our life pattern. Part of the undoubted value of church attendance arises from the peace and quiet of the religious ceremonies and the soothing atmosphere of the church surroundings.

The list is long and could be expanded almost indefinitely. Most rule-of-thumb therapy is of this sort. To rule directness out because it is not scientific may hamstring our effectiveness as people. Neither was surgery, which is a "cut-it-out" technique, too scientific at the outset, but its value was never doubted, and as it went on, the skill in its application advanced until its use is now routine, always, of course, where it is indicated. Yet, obviously, surgery only tackles a symptom, a resultant of infection or tissue change. The surgeon's concern with cause does not hinder his taking appropriate action.

Similarly the psychiatrist should not hesitate to cut in. He should not be just a butcher with a knife, but perhaps more than is the custom, the psychiatrist should assume responsibility for things happening to his patient. He must not fall back on the excuse that his patient was uncooperative or poorly motivated; he must do his bit to shift attitudes so that cooperation is obtained. Sometimes a little discipline, artfully applied, works wonders. To discard it entirely may deprive one of a very necessary therapeutic resource.

In Conclusion

Let me repeat what I initially stated, namely that the treatment of the alcoholic must

include direct treatment of the symptom. This does not exclude the value of deep insights; it merely re-channels them into an understanding of why the patient blocks from taking the remedy prescribed. The study of causation is shifted from origins to the causes which obstruct the therapy. As they are uncovered and resolved, not only is sobriety attained but the inner changes necessary to a sober existence can be and are developed.

The truth of this last statement I can only vouch for at this time. In a later paper I shall try to prove the validity of this claim. In the meantime, this paper will have served its purpose if it has alerted the reader to the dangers inherent in the rigid application of the concept of symptomatic behavior and has tempered his antagonisms to disciplinary measures when properly applied. If it has, the effort to prepare it has been worth while.

THE EGO FACTORS IN SURRENDER IN ALCOHOLISM

Harry M. Tiebout, M.D.

Introduction:

In the past 15 years, my understanding of the nature of alcoholism as a disease has been influenced largely by insight into the mechanisms at work in the Alcoholics Anonymous process. Some years ago I stated that A.A., to succeed, must induce a surrender on the -part of the individual I. More recently, I discussed the idea of compliance acting as a barrier to that real acceptance which a surrender produces. On this occasion I propose to extend my observations by discussing (a) what factors in the individual must surrender, and (b) how the surrender reaction changes the inner psychic picture.

The first question, what factors in the individual must surrender received passing attention in the article on compliance. There, relative to the difficulty of surrender, I noted that "the presence of an apparently unconquerable ego became evident. It was this ego which had to become humble." The first part of the present communication will be devoted to an elaboration of the nature of this ego factor.

Use of the word "ego" involves always the possibility of confusion of meaning. For a time, therefore, I considered a substitute term. That idea was set aside because, despite possible misinterpretation, the word ego is current in everyday language in exactly the sense in which it will be employed in this discussion. The expression, "he has an inflated ego," is self-explanatory. It evokes the picture of a pompous, self-important, strutting individual whose inferiorities are masked by a surface assurance. Such a person appears thick-skinned, insensitive, nearly impervious to the existence of others, a completely self-centered individual who plows unthinkingly through life, intent on gathering unto himself all the comforts and satisfactions available. He is generally considered the epitome of selfishness, and there the matter rests.

This popular view of ego, while it may not have scientific foundation, has one decided value: it possesses a meaning and can convey a concept which the average person can grasp. This concept of the inflated ego recognizes the common ancestor of a whole series of traits, namely, that they are all manifestations of an underlying feeling state in which personal considerations are first and foremost.

The existence of this ego has long been recognized, but a difficulty in terminology still remains. Part of the difficulty arises from the use of the word ego, in psychiatric and psychological circles, to designate those elements of the psyche which are supposed to rule psychic life. Freud divided mental life into three major subdivisions: the id, the ego and the superego. The first, he stated, contains the feeling of life on a deep, instinctual level; the third is occupied by the conscience, whose function is to put brakes on the impulses arising within the id. The ego should act as mediator between the demands of the id and the restraints of the superego, which might be over-zealous and bigoted. Freud's own research was concerned mainly with the activities of the id and the superego. The void he left with respect to the ego is one that his followers are endeavoring to fill, but as yet with no generally accepted conclusions.

Ego: By Two Definitions

The word ego, however has been preempted by the psychiatrists and psychologists, although they do not always agree among themselves about the meaning to be attached to it. The resulting confusion is the more lamentable because almost everyone, layman or scientist, would agree on the concept of the inflated ego. It would be helpful if other terms were found for the ego concepts about which there are differing views.

The solution for this dilemma will be to indicate with a capital E the big Ego, and without a capital to identify the personality aspect which Freud had in mind when he placed ego between id and superego.3

With this disposition of the problem of terminology, it is now possible to consider the first issue, namely, the Ego factors in the alcoholic which, through surrender, become humble. The concept of the enlarged Ego, as noted previously, is available to common observation. Those who do not recognize it in themselves can always see it in some member of their family or among friends and acquaintances -- not to mention patients. Everyone knows egotistical people and has a perfectly clear idea of what the word means. Besides egotistical, and the series of words mentioned earlier, adjectives which help to round out the portrait of the egotistical person are prideful, arrogant, pushing, dominating, attention seeking, aggressive, opinionated, headstrong, stubborn, determined and impatient.

All these terms are inadequate, however, because they describe only surface features without conveying any feeling of the inner essence from which the Ego springs. Unless some appreciation for the source of the Ego is gained, the dynamic import is lost and the term may seem merely a form of name calling. It is easy to say someone has a big Ego without awareness of what is really happening in the deep layers of that person's mind, without perception of the Ego. Nor is it a matter of intellect. The need here is to lay hold of the inner feeling elements upon which the activity of the Ego rests. Only when these elements become clear can the fundamental basis of the Ego also be clarified.

It is convenient, for the exposition of this inner functioning, to reverse the usual sequence and to present a conclusion in advance of the evidence on which it is based. This is, briefly, that the Ego is made up of the persisting elements, in the adult psyche, of the original nature of the child.

Certain aspects of the infant's psyche may be usefully examined. There are three factors which should receive mention. The first is, as Freud observed in his priceless phrase "His Majesty the Baby," that the infant is born ruler of all he surveys. He comes from the Nirvana of the womb, where he is usually the sole occupant, and he clings to that omnipotence with an innocence, yet determination, which baffles parent after parent. The second, stemming directly from the monarch within, is that the infant tolerates frustration poorly and lets the world know it readily. The third significant aspect of the child's original psyche is its tendency to do everything in a hurry. Observe youngsters on the beach: they run rather than walk. Observe them coming on a visit: the younger ones tear from the car while their elder siblings adopt a more leisurely pace. The three-year-olds, and more so the twos, cannot engage in play requiring long periods of concentration. Whatever they are doing must be done quickly. As the same children age, they gradually become able to stick to one activity for longer times.

Thus at the start of life the psyche (1) assumes its own omnipotence, (2) cannot accept frustrations and (3) functions at a tempo allegretto with a good deal of staccato and vivace thrown in.

Now the question is, "If the infantile psyche persists into adult life, how will its presence be manifested?"

In general, when infantile traits continue into adulthood, the person is spoken of as immature, a label often applied with little comprehension of the reason for its accuracy. It is necessary to link these three traits from the original psyche with immaturity and, at the same time, show how they affect the adult psyche. If this is done, not only will the correctness of the appellation "immature" be apparent but, moreover, a feeling for the nature of the unconscious underpinnings of the Ego will have been created.

Recognizing Immaturity

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Two steps can aid in recognizing the relationship between immaturity and a continuance of the infantile elements. The first is, by an act of imagination, to set these original traits into an adult unconscious. The validity of this procedure is founded upon modern knowledge of the nature of the forces operating in the unconscious of people of mature age. The second step is to estimate the effect that the prolongation of these infantile qualities will have upon the adult individual.

This attempt should not strain the imagination severely. Take, for instance, the third of the qualities common to the original psychic state, namely, the tendency to act hurriedly. If that tendency prevails in the unconscious, what must the result be? The individual will certainly do everything in a hurry. He will think fast, talk fast and live fast, or he will spend an inordinate amount of time and energy holding his fast-driving proclivities in check.

Often the net result will be an oscillation between periods of speeding ahead followed by periods during which the direction of the force is reversed, the brakes (superego) being applied in equally vigorous fashion. The parallel of this in the behavior of the alcoholic will not be lost on those who have had experience with this class of patients.

Let us take the same trait of doing everything in a hurry and apply it to the word "immature." Few will deny that jumping at conclusions, doing things as speedily as possible, give evidence of immaturity. It is youth that drives fast, thinks fast, feels fast, moves fast, acts hastily in most situations. There can be little question that one of the hallmarks of the immature is the proneness to be under inner pressure for accomplishment. Big plans, big schemes, big hopes abound, unfortunately not matched by an ability to produce. But the effect upon the adult of the persisting infantile quality to do everything in less than sufficient time can now be seen in a clearer light. The adult trait is surely a survival from the original psyche of the infant.

The two other surviving qualities of the infantile psyche similarly contribute to the picture of immaturity and also, indirectly, help to clarify the nature of the Ego with a capital E. The first of these, the feeling of omnipotence, when carried over into adult life, affects the individual in ways easily anticipated. Omnipotence is, of course, associated with royalty, if not divinity. The unconscious result of the persistence of this trait is that its bearer harbors a belief of his own special role and in his own exceptional rights. Such a person finds it well-nigh impossible to function happily on

an ordinary level. Obsessed with divine afflatus, the thought of operating in the lowly and humble areas of life is most distressing to him. The very idea that such a place is all one is capable of occupying is in itself a blow to the Ego, which reacts with a sense of inferiority at its failure to fill a more distinguished position. Moreover, any success becomes merely Ego fodder, boosting the individual's rating of himself to increasingly unrealistic proportions as the king side eagerly drinks in this evidence of special worth.

The ability to administer the affairs of state, both large and small, is taken for granted. The belief that he is a natural executive placed in the wrong job merely confirms his conviction that, at best, he is the victim of lack of appreciation, and at worst, of sabotage by jealous people who set up roadblocks to his progress. The world is inhabited by selfish people, intent only on their own advancement.

The genesis of all this is beyond his perception. To tell him that his reactions spring from the demands of an inner unsatisfied king is to invite incredulity and disbelief, so far from the conscious mind are any such thoughts or feelings. People who openly continue to cling to their claims of divine prerogative usually end up in a world especially constructed for their care. In others, the omnipotence pressures are rather better buried. The individual may admit that, in many ways, he acts like a spoiled brat, but he is scarcely conscious of the extent of the tendency, nor how deeply rooted it may be. He, like most people,

resolutely avoids a careful look because the recognition of any such inner attitudes is highly disturbing. The unconscious credence in one's special prerogatives savors too much of straight selfishness to be anything but unpleasant to contemplate.

And so, for the most part, people remain happily ignorant of the unconscious' drives which push them around. They may wonder why they tend to boil inside and wish they could free themselves from a constant sense of uneasiness and unsettlement. They may recognize that they seem jittery and easily excited and' long for the time when they can meet life more calmly and maturely; they may hate their tendency to become rattled. But their insight into the origin of all this is next to nothing, if not a complete blank. The king lies deep below the surface, far out of sight.

Inability to Accept Frustration

The last trait carried over from infancy is the inability to accept frustration. In an obvious sense, this inability is another aspect of the king within, since one of the prerogatives of royalty is to proceed without interruption. For the king to wait is an

affront to the royal rank, a slap at his majesty. The ramifications of this inability to endure frustration are so widespread, and the significance of much that occurs in the behavior of the alcoholic is so far-reaching, that it seems advisable to discuss this trait under a separate heading.

As already indicated, on the surface the inability of the king to accept frustration is absolutely logical. The wish of the king is the law of the land, and especially in the land of infancy. Any frustration is clearly a direct threat to the status of his majesty, whose whole being is challenged by the untoward interruption.

Even more significant is another aspect of this inner imperiousness. Behind it lies the assumption that the individual should not be stopped. Again, this is logical if one considers how an absolute monarch operates. He simply does not expect to be stopped; as he wills, so will he do. This trait, persisting in the unconscious, furnishes a constant pressure driving the individual forward. It says, in essence, "I am unstoppable!"

The unconscious which cannot be stopped views life entirely from the angle of whether or not a stopping is likely, imminent, or not at all in the picture. When a stopping is likely, there is worry and perhaps depression. When it seems imminent, there is anxiety bordering on panic, and when the threat is removed, there is relief and gaiety. Health is equated with a feeling of buoyancy and smooth sailing ahead, a sense of "I feel wonderful!" Sickness, contrariwise, means lacking vim, vigor and vitality, and is burdened with a sense of "I'm not getting anywhere." The need to "get somewhere" to "be on the go," and the consequent suffering from eternal restlessness, is still another direct effect of an inner inability to be stopped or, expressed otherwise, to accept the fact that one is limited. The king not only cannot accept the normal frustrations of life but, because of his inordinate driving ahead, is constantly creating unnecessary roadblocks by virtue of his own insistence on barging ahead, thus causing added trouble for himself.

Of course, on some occasions, the king gets stopped, and stopped totally. Illness, arrest, sometimes the rules and regulations of life, will halt him. Then he marks time, complies if need be, waiting for the return of freedom, which he celebrates in the time-honored fashion if he is an alcoholic: he gets drunk, initiating a phase when there is no stopping him.

The immaturity of such a person is readily evident. He is impatient of delay, can never let matters

evolve; he must have a blueprint to follow outlining clearly a path through the jungle of life. The wisdom of the ages is merely shackling tradition which should make way for the freshness, the insouciance of youth. The value of staying where one is, and working out one's destiny in the here and now, is not

suspected. The 24-hour principle would be confining for one whose inner life brooks no confinement. The unstoppable person seeks life, fun, adventure, excitement, and discovers he is on a perpetual whirligig which carries him continuously ahead but, of course, in a circle. The unstoppable person has not time for growth. He must always, inwardly, feel immature.

This, then, is how the carry-over of infantile traits affects the adult so encumbered. He is possessed by an inner king who not only must do things in a hurry, but has no capacity for taking frustration in stride. He seeks a life which will not stop him and finds himself in a ceaseless rat race.

All this is part and parcel of the big Ego. The individual has no choice. He cannot select one characteristic and hang on to that, shedding other more obviously undesirable traits. It is all or nothing. For example, the driving person usually has plenty of energy, sparkle, vivacity. He stands out as a most attractive human being. Clinging to that quality, however, merely insures the continuance of excessive drive and Ego, with all the pains attendant upon a life based on those qualities. The sacrifice of the Ego elements must be total, or they will soon regain their ascendancy.

Learning To Live

Those who view the prospect of life without abundant drive as unutterably dull and boring should examine the life of members of Alcoholics Anonymous who have truly adopted the A.A. program. They will see people who have been stopped -- and who, therefore, do not have to go anywhere -- but people who are learning, for the first time in their lives, to live. They are neither dull nor wishy-washy. Quite the contrary, they are alive and interested in the realities about them. They see things in the large,are tolerant, open-minded, not close-minded bulling ahead. They are receptive to the wonders in the world about them, including the presence of a Deity who makes all this possible. They are the ones who are really living. The attainment of such a way of life is no mean accomplishment.

Preliminary to this discussion, the conclusion was offered that the Ego was a residual of the initial feeling life of the infant. It should be evident that the immaturity characteristically found in the make-up of the alcoholic is a persistence of the original state of the child. In connection with the description of the manifestations which denote a large and active Ego, it should be recalled that the presence in the unconscious of such Ego forces may be quite out of reach of conscious observation. Only through the acting and feeling of the individual can their existence be suspected.

Now the answer to the first question raised herein, namely, what part of the alcoholic must surrender, is obvious: it is the Ego element.

Life without Ego is no new conception. Two thousand years ago, Christ preached the necessity of losing one's life in order to find it again. He did not say Ego, but that was what he had in mind. The analysts of our time recognize the same truth; they talk also about ego reduction. Freud saw therapy as a running battle between the original narcissism of the infant (his term for Ego) and the therapist whose task it was to reduce that original state to more manageable proportions. Since Freud could not conceive of life without some measure of Ego, he never resolved the riddle of how contentment is achieved; for him, man to the end was doomed to strife and unhappiness, his dearest desires sure to be frustrated by an unfriendly world.

THE EGO FACTORS IN SURRENDER IN ALCOHOLISM
Harry M. Tiebout, M.D.

In his studies on the addictions, Rado3 more explicitly asserts that the Ego must be reduced. He first portrays the Ego as follows: "Once it was a baby, radiant with self-esteem, full of belief in the omnipotence of its wishes, of its thoughts, gestures and words." Then, on the process of Ego-reduction: "But the child's megalomania melted away under the inexorable pressure of experience. Its sense of its own sovereignty had to make room for a more modest self evaluation. This process, first described by Freud, may be designated the reduction in size of the original ego; it is a painful procedure and one that is possibly never completely carried out."

No Compromise With Ego

Like Freud, Rado thinks only in terms of reduction; the need for the complete elimination of Ego is a stand which they cannot bring themselves to assume. Hence they unwittingly advocate the retention of some infantile traits, with no clear awareness that trading with the devil, the Ego, no matter how carefully safeguarded,' merely keeps him alive and likely at any occasion to erupt full force into action. There can be no successful compromise with Ego, a fact not sufficiently appreciated by many, if not most, therapists.

Thus the dilemma encountered in ego-reduction would be best resolved by recognizing that the old Ego must go and a new one take its place. Then no issue would arise about how much of the earliest elements may be retained. The answer, theoretically, is none. Actually the total banishment of the initial state is difficult to achieve. Man can only grow in the direction of its complete elimination. Its final expulsion is a goal which we can only hope.

The second question raised here is, "How does the surrender reaction change the inner psychic picture?" This question is based on a presupposition, namely that surrender is an emotional step in which the Ego, at least for the time being, acknowledges that it is no longer supreme. This acknowledgment is valueless if limited to consciousness; it must be accompanied by similar feelings in the unconscious. For the alcoholic, surrender is marked by the admission of being powerless over alcohol. His sobriety has that quality of peace and tranquility which makes for a lasting quiet within only if the surrender is effective in the unconscious and permanent as well.

The effects of surrender upon the psyche are extremely logical: The traits listed as~ characteristic of the Ego influence are canceled out. The opposite of king is the commoner. Appropriately, Alcoholics Anonymous stresses humility. The opposite of impatience is the ability to take things in stride, to make an inner reality of the slogan, "Easy does it." The opposite of drive is staying in one position where one can be open-minded, receptive and responsive.

This picture of the non-Ego type of person might be amplified in many directions but to do so would serve no immediate purpose. To have discussed the effect of the Ego upon behavior, and to have pointed out what may happen when the Ego is at least temporarily knocked out of action, is sufficient to, make the point of this communication: It is the Ego which is the arch-enemy of sobriety, and it is the Ego which must be disposed of if the individual is to attain a now way of life

Up to this point, no clinical material has been submitted to confirm the ideas presented. Their validity will be apparent to many therapists. One brief citation from clinical experience will be offered, however, in the hope that it may serve as a concrete illustration of these ideas.

The patient, a man in his late 30's, had a long history of alcoholism with 7 years of futile attempts to

recover through Alcoholics Anonymous, interspersed with countless admissions to "drying out" places. Then, for reasons not totally clear, he decided to take a drastic step. He determined to enter a sanitorium and place himself in the hands of a psychiatrist, a hitherto unheard of venom. We planned to arrange for a limited stay at a sanitarium where he could have regular interviews with me.

From the outset, he was undeniably in earnest, although it was only after the first interview that he really let go and could talk freely about himself and the things that were going on inside him. After the usual preliminaries, the first interview started with a discussion of feelings and how they operate. The patient was questioned about the word Ego as used at A.A. meetings. He confessed his ignorance of its true meaning and listened with interest to brief remarks on how it works. Before long, he was locating in himself some of the Ego forces which hitherto he had been vigorously denying because they savored too much of vanity and selfishness with that recognition, the patient made a revealing remark. He said, in all sincerity, "My goodness, I never knew that. You don't do your thinking up here (pointing to his head), you think down here where you feel" placing his hands on his stomach. He was learning that his feelings had a "mind" of their own and that unless he heeded what they were saying, he could easily get into trouble. He was facing the actuality of his Ego as a feeling element in his life, a step he was able to take because he was no longer going at full steam ahead. His decision to place himself under care, a surrender of a sort, had quieted him and made him receptive, able to observe what was going on in himself. It was the beginning of a real inventory.

The next insight he uncovered was even more startling. He had been requested routinely to report any dreams he would have. Much to his surprise, they appeared regularly during the period of contact. In his fifth dream, the patient found himself locked up in an institution because of his drinking. The interpretation offered, based upon relevant materials, was that the patient equated any kind of stopping with being locked up; that his real difficulty lay in the fact that he could not tolerate being stopped, and abstaining was merely another stopping he could not take. The patient's reaction to the interpretation was most significant. He remained silent for some little time; then he began to talk, saying, "I tell you, Doc, it was like this. I'd get drunk, maybe stay on it 2 or 3 days, then I'd go into one of those drying out places where I'd stay 5 or 6 days and I'd be all over wanting a drink. Then I'd come out and stay sober, maybe a week, 'maybe a month, but pretty soon the thought would come into my mind, I want to drink! Maybe I'd go into a tavern and maybe not, but sooner or later I'd go and I'd order a drink, but I wouldn't drink it right off. I'd put it on the bar and I'd look at it and I'd think and then I'd look and think: King for a day!" The connection between Ego and his own conduct had become explicit, as well as the relationship between not being stopped and Ego. He saw clearly that when he took that drink, he was the boss once more. Any previous reduction of Ego had been only temporary.

In treatment, the problem is to make that reduction permanent. Therapy is centered on the ways and means, first, of bringing the Ego to earth, and second, keeping it there. The discussion of this methodology would be out of place here, but it is relevant to emphasize one point, namely the astonishing capacity of the Ego to pass out of the picture and then reenter it, blithe and intact. A patient's dream neatly depicted this quality. This patient dreamt that he was on the twelfth floor balcony of a New York hotel. He threw a rubber ball to the pavement below and saw it rebound to the level of the balcony. Much to his amazement, the ball again dropped and again rebounded to the same height. This continued for an indefinite period and, as he was watching, a clock in a neighboring church spire struck nine. Like the cat with nine lives, the Ego has a marvelous capacity to scramble back to safety -- a little ruffled, perhaps, but soon operating with all its former aplomb, convinced once more that now it, the Ego, can master all events and push on ahead.

The capacity of the Ego to bypass experience is astounding and would be humorous were it not so tragic in its consequences. Cutting the individual down to size and making the results last is a task never

completely accomplished. The possibility of a return of his Ego must be faced by every alcoholic. If it does return, he may refrain from drinking, but he will surely go on a "dry drunk," with all the old feelings and attitudes once more asserting themselves and making sobriety a shambles of discontent and restlessness. Not until the ego is decisively retired can peace and quiet again prevail. As one sees this struggle in process, the need for the helping hand of a Deity becomes clearer. Mere man alone all too often seems powerless to stay the force of his Ego. He needs assistance and needs it urgently.

Summary

In the process of surrender which the alcoholic necessarily undergoes before his alcoholism can be arrested, the part of the personality which must surrender is the inflated Ego. This aspect of personality was identified as immature traits carried over from infancy into adulthood, specifically, a feeling of omnipotence, inability to tolerate frustration, and excessive drive, exhibited in the need to do all things precipitously. The manner in which surrender affects the Ego was discussed and illustrated briefly from clinical experience. The object of therapy is to permanently replace the old Ego and its activity.

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SURRENDER VERSUS COMPLIANCE IN THERAPY WITH SPECIAL REFERENCE TO ALCOHOLISM

Harry M. Tiebout, M.D.

Introduction:

SINCE BECOMING a side-line observer of Alcoholics Anonymous in 1939, my approach to alcoholism has undergone an almost total reorientation. For the first time I saw what peace of mind means in the achievement of sobriety and I began to consider the emotional factors involved from a very different viewpoint. In A.A. meetings, the role of resentments was a recurrent theme. This seemed significant. Continuing this line of observation, I found that another enemy of sobriety was defiance, which Sillman (1) had already described as "defiant individuality," a major hallmark of the personality of alcoholics.

Another significant emphasis in A.A. was humility and "hitting bottom," completely new points of emphasis for me. It was clear that if the individual remained stiff-necked he would continue to drink, but I could not see why. Finally the presence of an apparently unconquerable ego became evident. It was this ego which had to become humble. Then the role of hitting bottom, which means reaching a feeling of personal helplessness, began to be clear. It was this process that produced in the ego an awareness of vulnerability, initiating the positive phase. In hitting bottom the ego becomes tractable and is ready for humility. The conversion experience (2) has started.

What happens in the unconscious at the time of hitting bottom remained a mystery. The first elucidation came from a patient. Through psychotherapy she was gradually losing the intractable ego structure and finally, for rather obscure reasons, she had a minor conversion experience which brought her relative peace and quiet. During this phase she began attending various churches in town. One Monday morning she entered the office, her eyes shining and said at once, "I know what happened to me. I heard it in a hymn yesterday. I surrendered when I had that experience." Guided by this clue, I realize that "hitting bottom" is ineffectual if not followed by a surrender. Hitting bottom must produce a result, which is surrender.

Most of my ideas along these lines were incorporated in an article3 on "the act of surrender" in relation to the therapeutic process. I now wish to extend these thoughts a step further. The surrender concept has not generally been well received except by some A.A.'s who recognize its validity in their own experiences. One or two psychiatrists have told me they are beginning to see the usefulness of the concept but no one, to my knowledge, has yet come forward with a paper supporting the thesis of surrender out of is own observations.

One reason for this lag is the resistance to the idea of surrender. It seems too completely defeatist. Were I writing that article now I would change it in this respect so as to discuss the term surrender in linkage with other, less to-be-shunned concepts. But those links were discovered only later.

In the article on surrender, I said: "One fact must be kept in mind, namely the need to distinguish between submission and surrender. In submission, an individual accepts reality consciously but not unconsciously. He accepts as a practical fact that he cannot at that moment conquer reality, but lurking in his unconscious is the feeling, 'There'll come a day' -- which implies no real acceptance and demonstrates conclusively that the struggle is still going on. With submission, which at best is a superficial yielding, tension continues. When, on the other hand, the ability to accept reality functions on the unconscious level, there is no residual battle, and relaxation ensues with freedom from strain and conflict. In fact, it is perfectly possible to ascertain to what extent the acceptance of reality is on the unconscious level by the degree of relaxation which develops. The greater the relaxation, the greater is the inner acceptance of reality."

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Understanding Acceptance

In that paragraph the words "accept" and "acceptance" are each used three times. I saw at the time that surrender leads to acceptance. What I failed to see and emphasize was the very important relationship between surrender and the capacity for acceptance.

I propose, therefore, first, to consider acceptance as a human capacity, and second, to discuss the blocks to the development of acceptance. The importance of 61 acceptance" is widely recognized although often only by indirection. Sometimes the necessity for acceptance is bluntly stated, as in Grayson's4 recent article on the role of "acceptance" in physical rehabilitation. Grayson reports his discovery that the individual who needs rehabilitation remains a poor prospect until he finally accepts his need for the rehabilitating procedures. More often the concept of acceptance is dragged in by the heels with little or no recognition that acceptance itself is a major psychological step. Two recent illustrations are worthy of mention. In a summarizing article on Alcoholics Anonymous, in the Connecticut Review on Alcoholism5, the following statements appear: "He does not have to fight against ideas which come from this group, he can accept them." Thus the idea that he is an alcoholic is acceptable when coming from this group. The need to avoid the 'first drink' is 44 accepted." Certainly the need for acceptance is unequivocally stated. And the following statement is from Kubie's6 book: "The man who is normal can accept the guidance of reason, reality and common sense" The word "accept" is scattered throughout the pages of the book but the question of acceptance is never raised-as if it were something that needs no discussion.

The first of the Alcoholics Anonymous twelve steps reads: "We admitted we were powerless over alcohol -- that our lives had become unmanageable." The second word is "admitted," which in many ways is a blood brother of acceptance although many an A.A. meeting has been devoted to quibbling about the difference between admit and accept. Time and again slips are explained on the basis that the one who slips has not truly accepted his alcoholism.

The word "accept", thus, appears quite regularly in speech and writing but never is there much discussion of how acceptance comes about. The usual explanation is that, if the doctor is accepting, the patient will be so too; in case of failure, the therapist is held responsible, just as parents are for their children. To suppose that acceptance is caught by contagion is a pretty thought. It is not, however, likely to stimulate much understanding of individual psychodynamics. It is not enough merely to point the finger elsewhere.

There is need, therefore, to discuss the dynamics of acceptance in the individual. Acceptance appears to be a state of mind in which the individual accepts rather than rejects or resists: he is able to take things in, to go along with, to cooperate, to be receptive. Contrariwise, he is not argumentative, quarrelsome, irritable or contentious. For the time being, at any rate, the hostile, negative, aggressive elements are in abeyance, and we have a much pleasanter human being to deal with. Acceptance as a state of mind has many highly admirable qualities as well as useful ones. Some measure of it is greatly to be desired. Its attainment as an inner state of mind is never easy.

It is necessary to point out that no one can tell himself or force himself wholeheartedly to accept anything. One must have a feeling -conviction -otherwise' the acceptance is not wholehearted but halfhearted with a large element of lip service. There is a string of words which describe halfhearted acceptance: submission, resignation, yielding, compliance, acknowledgment, concession, and so forth. With each of these words there is a feeling of reservation, a tug in the direction of nonacceptance.

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Most people regard nonacceptance as a sign of willful refusal; this bypasses all current knowledge of the unconscious elements in resistance and will power. Others, better informed about those attributes, avoid the use of such a phrase as willful refusal. They know that it is largely unconscious attitudes and feelings that determine the conscious thinking and hence do not suppose that resistance can be given up by an act of will on the part of the conscious mind.

Acceptance: A Step Beyond Recognition

Those who recognize the role of unconscious forces then take a curious next step: They talk about undermining the resistance by uncovering the reasons for the particular series of resistance, as if the unconscious mind must then accept those reasons-a non sequitur. It is one thing to see reasons and quite another thing to behave with corresponding rationality. One patient neatly punctured this assumption. After 8 years of analysis with four therapists of different schools, he began to get some inkling of acceptance as a state of mind which he sadly lacked. Finally, in a burst of awareness, he remarked, "I know all the reasons but I don't know how to be reasonable." That statement aptly summed up his predicament. His logical mind could perceive and believe all the factors underlying his difficulties but he remained cantankerous and unreasonable as far as his feeling life was concerned. In his head, or conscious mind, he could "accept" the explanations but deep inside where the heart, or the unconscious, operates there was no feeling of acceptance. That capacity still had to be developed. Uncovering reasons for behavior, no matter how convincing, does not and cannot insure acceptance of those reasons. Acceptance is a step beyond recognition, a further operation in the process of therapy. Many therapists have failed to discern this two-stage process. The clue was my patient's use of the word "reasonable." He could have said, with accuracy, "reasonable and accepting," because he was beginning to appreciate the fact that one's frame of mind governs one's response to things that are reasonable or, for that matter, unreasonable.

What was not clearly appreciated is the fact that a state of reasonableness or acceptance or receptivity has an emotional origin which rises from exactly the same source as does the resistance and the forces which predominantly contribute to our being willing, namely, the unconscious. Unless the unconscious has within it the capacity to accept, the conscious mind can only tell itself that it should accept but by so doing it cannot bring about acceptance in the unconscious which continues with its own non-accepting and resenting attitudes. The result is a house divided against itself: the conscious mind sees all the reasons for acceptance while the unconscious mind says, "But I won't accept!" Wholehearted acceptance under such conditions is impossible. Experience has proved that in the alcoholic a halfhearted reaction does not maintain sobriety for very long. The inner doubts all too soon take over. The alcoholic who stays "dry" must be wholehearted. Here we meet a complication. People accept the necessity of being wholehearted about alcoholism but not about everything else. They are determined to maintain their capacity for resistance. They fear the fact that if they become total acceptors they will have no ability whatsoever to resist and will become "pushovers," complete "Caspar Milquetoasts."

Such fears of passivity are supported not only by conscious logic but also by deep unconscious sources which cannot be dealt with in the present paper. Powerful forces are aligned against acceptance, producing in the individual extreme conflict which must be resolved if the capacity for acceptance is ever to develop.

Compliance: Partial Surrender

We are thus confronted with the question: What does produce wholehearted acceptance? My answer is, as before, surrender. But surrender is a step not easily taken by human beings. In recent years, because

of my special interest in the phenomenon of surrender, I have become aware of another conscious and unconscious phenomenon, namely compliance -- which is basically partial acceptance or partial surrender, and which often serves as a block to surrender. The remainder of this paper will concern itself with that reaction and how it throws light on the handling of patients, particularly alcoholics.

Compliance needs careful definition. It means agreeing, going along, but in no way implies enthusiastic, wholehearted assent and approval. There is a willingness not to argue or resist but the cooperation is a bit grudging, a little forced; one is not entirely happy about agreeing. Compliance is, therefore, a word which portrays mixed feelings, divided sentiments. There is a willingness to go along but at the same time there are some inner reservations which make that willingness somewhat thin and watery. It does not take much to overthrow this kind of willingness. The existence of this attitude will probably appear as neither strange nor new. Nor is it, until one begins to see how it operates in the unconscious.

One thing must be made absolutely clear: There is a world of difference between' thinking of compliance in conscious terms and in unconscious terms. The following discussion is focused wholly on unconscious reactions and cannot be translated into conscious reactions until the possible effect of the former upon the latter is appreciated. An illustration at this point may be helpful. An alcoholic, at the termination of a long and painful spree, decides that he has had enough. This decision is announced loudly and vehemently to all who will listen. His sincerity cannot be questioned. He means every word of it. Yet he knows, and so do those who hear him, that he will be singing another tune before many weeks have elapsed. For the moment he seems to have accepted his alcoholism but it is only with a skin-deep assurance. He will certainly revert to drinking. What we see here is compliance in action. During the time when his memory of the suffering entailed by a spree is acute and painful he agrees to anything and everything. But deep inside, in his unconscious, the best he can do is to comply -- which means that, when the reality of his drinking

problem becomes undeniable, he no longer argues with incontrovertible facts The fight, so to speak, has been knocked out of him. As time passes and the memory of his suffering weakens, the need for compliance lessens. As the need diminishes, the half of compliance which never really accepted begins to stir once more and soon resumes its way. The need for accepting the illness of alcoholism is ignored because, after all, deep inside he really did not mean it, he had only complied. Of course consciously the victim of all this is completely in the dark. What he gets is messages from below which slowly bring about a change in conscious attitudes. For a while drink was anathema but now he begins to toy with the thought of one drink, and so on, until finally, as the noncooperative element in compliance takes over, he has his first drink. The other half of compliance has won out; the alcoholic is the unwitting victim of his unconscious inclinations.

It is the nature of the word to have this two-faced quality of agreeing and then reneging. It is only by realizing the widespread ramification of the compliance tendency that its far-flung importance can be appreciated.

One of the first things to recognize is the fact that the presence of compliance blocks the capacity for true acceptance. Since compliance is a form of acceptance, every time the individual is faced with the need to accept something he falls back on compliance, which serves for the moment -- the individual consciously believing that he has accepted. But since he has no real capacity to accept, he is soon swinging in the other direction, his seeming acceptance a thing of the past. In other words, the best an inwardly complying person can do toward acceptance is to comply. During treatment the patient regularly is surprised to learn that his previous tendency to agree in order to be agreeable was merely a lot of compliance without any genuine capacity to accept.

This unconscious split in the compliance mechanism has deep psychosomatic reverberations. One patient, who had uncovered a wide streak of compliance, had a dream in which he placed the two components of compliance side by side, disclosing their utter incompatibility. What he saw was that his wish to be cooperative and well liked while yet maintaining his ego intact meant certain conflict, with other people whose very existence was a threat to his own ego. He was torn by the dilemma of being nice and pleasant or being a man and holding his own. His next dream contained a busy ferry-boat plying back and forth across a river. As the patient watched, it went faster and faster and faster, the patient following its motion closely. Soon it seemed as if he were following the flight of a tennis ball while sitting at the net, his head turning more and more rapidly until finally he became giddy and woke up feeling dizzy. When the patient, and physician, saw the connection between this

dream and the dilemma of his preceding dream, he laughed and remarked, "You know, I have been doctoring for many years and have heard all about this psychosomatic business, but I never thought I would learn about it from myself."

Compliance creates other problems for the individual. Since it says "yes" on the surface and "no" inside, it contributes to the sense of guilt. The person who says yes and feels the opposite has an inward realization that he is a two-faced liar; this stirs up his conscience and evokes a feeling of guilt. Compliance also adds mightily to the problems of inferiority. The guilt reaction increases the sense of inferiority but the compliance response engrafts it even more. The unconscious situation can be outlined thus: Compliance is a form of agreeing, of never standing up for one-self. When that response is automatic, routine and unvarying, the individual gets a feeling that he cannot stand up for himself; this inevitably augments his inferiority problems.

Compliance and Alcoholism

It is now possible to link compliance with the problem of alcoholism and also to the theory of surrender. The link between alcoholism and compliance has already been shown in the alcoholic's repeated vows that he would never take another drink, vows which go by the board because of the inner inability to do more than comply. The presence of a strong vein of unconscious compliance in the alcoholic can be demonstrated in other ways. Alcoholics are a notably pleasant and agreeable group with a marked tendency to say yes when approached directly. They claim they want to be well liked -- hence their willingness to promise anything. Yet -- and here the other side of the compliance reaction is manifest -- they balk at the showdown and are' ever likely to renege on their original promises. As another illustration, they are keen to go to a show, buy tickets in advance, and then on the night of the performance wish they had never had the idea. Characteristically, one man always calls up at the last moment for a date, knowing that if he had made the engagement in advance his present wish would later appear as a "must" which he had to live up to. He, like so many of his kind, has to do things on the spur of the moment. Otherwise, the contrary half gets into action and the project is opposed and quashed. A favorite remark, "Let's have some fun," must mean immediately: the desire evaporates if there is any planning to be done. Often alcoholics go downtown merely looking for fun with not a thought of a drink on their minds -- in fact, quite "compliant" to the need for sobriety. When they find the fun, however, the chances are that they will be in trouble before, the night is over. Undoubtedly the initial restlessness which stimulated the need for some fun had its origin in the early rumblings of the noncompliance elements. Much

of the apparent dual personality of alcoholics becomes understandable if their behavior is seen in the light of conflicting trends.

The next point, the relationship between compliance and surrender, has already been intimated in the remark that compliance blocks the capacity to surrender. The inability to surrender may seem a small loss until the matter is studied more thoughtfully.

After an act of surrender, the individual reports a sense of unity, of ended struggles, of no longer divided inner counsel. He knows the meaning of inner wholeness and, what is more, he knows from immediate experience the feeling of being wholehearted about anything. He recognizes for the first time how insincere his previous protestations actually were. If he is a member of Alcoholics Anonymous, he travels around to meetings proclaiming the need for honesty -- usually, at the start of his pilgrimage, with a certain amount of surprise and wonder in his voice. Quite frankly, before he was able to embrace the program, he had no idea he was a liar, dishonest in his thoughts; but now that A.A. is making sense -- that is, he is accepting A.A. wholeheartedly and without reservations -- he sees that previously he had never truly accepted anything. The A.A. speaker does not follow through to state that, formerly, all he had been doing was complying; but if asked, he nods his head in vigorous assent, saying, "That's exactly what I was doing." A more articulate individual, after a little thought, added: "You know, when I think back on it, that was all I knew how to do. I supposed that was the way it was with everybody. I could not conceive of really giving up. The best I could do was comply, which meant I never really wanted to quit drinking, I can see it all now but I certainly couldn't then."

Obviously this speaker is reporting the loss of his compliant tendencies, occurring,' let it be noted, when he gave up, surrendered, and thus was able wholeheartedly to follow the A.A. program. Let it further be noted that this new honesty arises automatically, spontaneously; the individual does not have the slightest inkling that this development is in prospect. It represents a deep unconscious shift in attitude and one certainly for the better.

It is now possible to see the usurping, dog-in-the-manger role of compliance. As long as compliance is functioning, there is halfway but never total surrender. But the halfway surrender and acceptance, serving as it does to quell the fighting temporarily, deceives both the individual and the onlooker, neither of whom is able to detect the unconscious compliance in the reaction of apparent yielding. It is only when a real surrender occurs that compliance is knocked out of the picture, freeing the individual for a series of wholehearted responses -- including, in the alcoholic, his acceptance of his illness and of his need to do something constructive about it.

Enough has been said, it would seem, to show the significance and the importance of understanding the relationship between compliance and the ability to surrender and accept. They are in complete opposition. As long as the former controls reactions, there can be no wholehearted acceptance, only the halfhearted kind which is admittedly not sufficient. Results of real value can only come about when the compliant reactions have been successfully dissipated.

No Easy Road to Understanding

Some will ask how this can be brought about. The answer, insofar as I have been able to formulate it, is long, involved and rather hazy. Experience shows that through psychotherapy the dominance of compliance over the unconscious can slowly be superseded, and that through the A.A. experience compliance can be temporarily and sometimes permanently blotted out. There does not appear to be any easy road to real understanding of this problem.

The preceding materials can now be summed up. It was pointed out that in an earlier article on the

phenomenon of surrender, the tie of surrender to acceptance had not been sufficiently stressed. It was also pointed out that the concept of acceptance is freely talked about but rarely if ever made an object of study. Some observations regarding the nature of acceptance were reported and it was shown to contain two possible reactions which we called wholehearted acceptance and halfhearted. It was then demonstrated how halfheartedness and compliance were closely allied. The nature of compliance was next discussed and, lastly, the antipathetic relationship between compliance on the one hand and surrender and acceptance on the other.

This is a long and rather circuitous route to the point of this paper, namely, that surrender is essential to wholehearted acceptance and that unconscious compliance, which is a halfway surrender, can be a vital block to genuine surrender. It was then pointed out that alcoholics frequently show marked unconscious compliant trends which not only help to explain some puzzling aspects of their behavior but also account for their frequent inability to respond meaningfully to treatment. Since the presence of these trends has been more clearly recognized, the response of many patients to therapy has been considerably more satisfactory. These considerations have been presented in the hope that others also may find that a recognition of the processes of surrender, acceptance and compliance can be a source of help in tackling the alcoholic psychotherapeutically.

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