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In 1974 I attended the annual meeting of the Alcohol and Drug Problems Association of North America. I heard a presentation at that meeting by John Wallace that stunned me in terms of the deep clinical intuition from which it was derived and the clarity of the presentation. Wallace argued that alcoholics develop a preferred defense structure (PDS) (e.g., denial, minimization, projection of blame, intellectualization) that allows them to sustain their drinking and escape the consequences of that drinking. That starting position was not a new idea to me in 1974, but Wallace went on to say that the same PDS that supports drinking may be used to get through the early stages of recovery and that prematurely confronting this brittle PDS could actually trigger relapse. His idea that denial and minimization (of the problems facing the just-sobered), black-white thinking (e.g., “all of my problems are related to my drinking”; “all I have to do is not drink and everything will be fine”), and other defense mechanisms were actually an ally in the recovery process was a striking concept to me, pregnant with clinical implications. But then Wallace laid out the third paradox of recovery: the same PDS that supported alcoholism and that was reframed to support early recovery must later be abandoned in late stages of recovery. Wallace’s presentation forever changed the way I looked at the treatment and recovery processes. I am delighted to have Dr. Wallace’s permission to post this early paper.

William White

Tactical and Strategic Use of the PREFERRED DEFENSE STRUCTURE Of The Recovering Alcoholic

By JOHN WALLACE, Ph.D.

ABSTRACT

A SYSTEMATIC THEORY of psychotherapy specific to the disease of alcoholism has

never been formulated. At present, psychotherapies with the alcoholic consist of derivations of techniques and ideologies drawn from parent theories that were formulated for different types of patients, different treatment contexts, and different therapeutic problems. These derivative psychotherapies have not proven effective in helping the alcoholic achieve abstinence.

The purpose of this paper is indeed an ambitious one. It attempts to outline a theory of psychotherapy developed from the perspective of the *alcoholic* client. It argues that a preferred defense structure exists in the alcoholic client. This preferred defense structure can be described conceptually at the moment if not operationally. Most importantly, the preferred defense structure of the recovering alcoholic can be used effectively to produce initial abstinence. The seeming paradox of utilizing the same defense structure that kept the alcoholic drinking in order to get him abstinent is resolved if one takes into account the characteristics of the alcoholic client, the nature of his situation, and the time dependent nature of the therapeutic process. In essence, the preferred defense structure of the recovering alcoholic should not be confronted and modified except in matters pertaining directly to drinking and the direct negative consequences of drinking. In most other matters, the therapist should support, reinforce, and encourage the preferred defense structure, skillfully switching these mechanisms from maintaining continued drinking to achieving abstinence. Since most psychotherapies are incompatible with this ideological stance, one can expect considerable resistance to the notion that anything at all can be gained from reinforcing and supporting defenses rather than confronting them and removing them. However, as non-obvious and counter-intuitive the therapeutic strategy outlined here may seem, it is clearly the method of choice in achieving initial abstinence.

DESPITE the increasing concentration of effort upon rehabilitation of alcoholic drinkers, a systematic and specific theory of alcoholism therapy remains to be formulated. Alcoholism therapy today seems largely a grab bag of tricks, slogans, techniques, assumptions, and ideological stances derived from common sense, implicit theories of personality, and formal theories of behavior developed for other purposes. Although seemingly reasonable, these generalizations of therapeutic principles developed for other purposes in other contexts are in fact proving unreasonable and, in many cases, detrimental to the progress of the alcoholic client.

Traditional insight-oriented, psychodynamic psychotherapies have not been shown to be particularly effective in producing abstinence. And much the same kind of statement can be made about transactional analysis, substitute drug therapies, chemical deterrents of various kinds, encounter groups, bioenergetics, and general psychological eclecticism. Therapies supposedly drawn from and based upon modern learning theories, although the present darlings of the academic community, also do not hold up under careful scrutiny. Despite the seeming "rigor" of such things as behavior modification, manipulation of response-reinforcement contingencies, and aversive conditioning, these therapies are in need of a sound empirical data base in the treatment of alcoholism. In fact, these therapies are equally in need of a sound theoretical base since their derivation from modern learning theory remains tenuous, incomplete, and ambiguous. For example, whatever aversion therapy may prove to be ultimately, it is presently clear that it is not classical conditioning. And for anyone to argue seriously that behavioral training methods are of demonstrated effectiveness in producing "controlled drinking" in alcoholics is, at the moment, so

premature as to constitute blind faith rather than scientific conclusion.

But is it any wonder that these approaches to alcoholism therapy have left much to be desired? The majority of them have been developed for purposes other than alcoholism. Few, if any, have been developed from the perspective of the alcoholic client. None have taken into account the attributes, characteristics, and common situational elements of the alcoholic and the alcoholic career. And most importantly, none have recognized the fact that intelligent treatment of the recovering alcoholic is a *time dependent process*. That is, alcoholism therapy must be viewed in terms of a long time span. A particular therapeutic intervention for a recently drinking alcoholic may be entirely inappropriate for one who has managed to achieve several years of sobriety and vice versa.

The purpose of this paper is indeed an ambitious one. It is my aim here to develop a theory of therapy specific to alcoholism, a theory that takes into account the nature of the disease, the characteristics of the client, and the time dependent nature of intelligent therapeutic intervention.

In the following pages, my arguments will include the following major ideas:

1. Alcoholics can be described in terms of a preferred defense structure. This preferred defense structure (PDS) need not be cast in negative terms. In fact, it need not be construed at all in terms of the classical language of defense mechanisms. The alcoholic PDS can be thought of as a collection of skills or abilities -- tactics and strategies if you will -- for achieving one's ends.

2. Therapy with alcoholics as it is presently practiced too often attempts to remove the alcoholic PDS when it should be utilizing it effectively to facilitate the achievement of abstinence. Therapeutic efforts that confront the alcoholic PDS prematurely and too heavily will increase the probability of further drinking rather than reduce it.

3. Recovery programs successful in producing abstinence, such as Alcoholics Anonymous, partially owe their success to the intuitive recognition of the fact that the alcoholic PDS is to be protected and capitalized upon rather than confronted and radically altered.

4. Paradoxically, the very same defenses that the alcoholic used to maintain his drinking can be used effectively to achieve abstinence.

5. Equally paradoxically, the very same defenses that enabled the alcoholic to drink, as well as achieve abstinence, must ultimately be removed if long-term sobriety is to be maintained. However, in many cases such growth must take place over periods of time ranging from two to five years of abstinence.

The Preferred Defense Structure (PDS) of the Recovering Alcoholic

Enough controversy has been generated around the question of the existence of something called an "alcoholic personality" to caution me not to engage that particular battle. However, it is curious to note that the strength of belief in something called "the alcoholic personality" is a direct function of degree of actual involvement with alcoholics on a sustained and continuing basis. Thus, in the fellowship of Alcoholics Anonymous, the reification is so intense as to fix the concept in concrete. Persons are said to be "alcoholic in personality long before the first drink," they are alcoholic in personality and behavior "whether they are drinking or not," and the alcoholic personality can return at any time for no apparent reason in the form of the "dry drunk." But of course, these and other exotic beliefs that abound in A.A. are not without enormous therapeutic value. Their actual truth-value is, in the final analysis, irrelevant. Any idea that can keep a drunk sober is valuable regardless of its status in the scientific community.

On the other hand, the concept of an alcoholic personality has not fared well at all among

those whose acquaintance with alcoholics is merely passing and whose knowledge about them flows from their own and other persons' research laboratories.

Hence, the data of experience and of folk wisdom urge us in one direction while the data of the research laboratory caution us to choose a different one. The situation is not unusual. In truth, both accounts of reality are biased. "The sober member of A.A. *needs* his ideological base. He can ill afford the dispassionate, disinterested, and, indeed, almost casual play upon words and ideas of the inquiring academic intellectual. He recognizes intuitively that he needs a stable and enduring *belief system* if he is to stay sober." And in many cases, the whole ball of string may come undone if somebody pulls just one loose thread.

The academician's equally biased view of reality is often more difficult to discern. Hidden neatly beneath the rhetoric of science and "scientism" are the actualities of dreadfully inadequate personality measuring instruments, inappropriate sampling procedures, inadequate measuring operations, improper choice of variables for study, grossly violated statistical assumptions, data gathering, recording, and analyzing errors, and so on and so forth. Is it any wonder then that the most outstanding quality of most academic research is "now you see it, now you don't?" And are we really amazed to find sober alcoholics clinging to their belief systems like drowning poets to their metaphors in a sea of uncertainty?

For my purposes, I shall simply *assume* that an alcoholic PDS exists and that it can be described meaningfully at a conceptual level, if not at an operational level at present. In the following, I do not mean to suggest a single, unvarying profile - one that is characteristic of each and every alcoholic drinker. However, I am assuming that *some* of these are found in *some* combinatorial pattern in virtually every alcoholic drinker at *some* point in his drinking and recovery from alcoholism.

Denial

Enough has been written about denial as a major defense in alcoholism as to require little in the way of further elaboration here. What has *not* been observed, however, is that aside from the obvious destructive nature of denial in matters concerned with drinking, denial is not without merit. Tactical denial or, if you will, *deliberate* denial of certain life difficulties or problems is a useful and extremely valuable temporary adjustive and coping device. In the case of the alcoholic well-practiced in such behavior, denial as a general tactical mechanism should not be discarded totally. That would be rather like throwing out the baby with the bath water.

But, of course, the recovering alcoholic must stop denying the impact of alcohol upon his major life concerns. That is an obvious truism in alcoholism therapy that need not be altered. However, simply because that statement is true, it does not follow that the recovering alcoholic need immediately, thoroughly, and completely root out all evidence of denial generally in his personality and behavior. First of all, he can't. Secondly, he rather likes the tactic of denial - he should, he's leaned heavily upon it for years. Thirdly, at some level or another, he recognizes that tactical denial is a coping strategy he simply can't do without. Whatever else do sober A.A.'s mean when they say, "turn it over?" Despite the spiritual origins of that phrase, its meaning is more commonly understood in practice as "don't worry about it," "let it go," "don't think about it," "don't talk about it," "don't focus on it because you really can't do anything about it anyway." For many A.A.'s God is a worry wart or, for that matter, a garbage can for all sorts of human woes, miseries, and predicaments. "Give it to God, you can't handle it." "Let Him worry about it," and so on and so forth. These and many other phrases as well indicate clearly that "spirituality" more often than not has its roots deeply into denial during the early stages of

abstinence from alcohol.

But in any case, the important point is as follows: Alcoholism may very well be referred to aptly as "the Merry-go-round of Denial." However, if my analysis is correct, with regard to denial generally, the alcoholic is going to keep going round and round, *long after his drinking stops*. And the very worst thing a therapist could ever possibly do is try to jam the mechanism and block the use of tactical denial entirely.

Projection

While much has been written about disowning projection (the tendency to attribute unwanted and unacceptable aspects of self to others), there has been very little appreciation of other types of projection in the field of alcoholism. This is most surprising since assimilative projection is perhaps the most outstanding characteristic of both drinking and sober alcoholics. Assimilative projection is the tendency to assume that others are very much like oneself and to perceive them as such. Negative or socially unacceptable impulses and traits need not be seen in others. In fact, much of assimilative projection involves many desirable and socially admirable characteristics. As we shall see, the tendency toward assimilative projection has great significance, both for the illusion and substance of identification and also for the understanding of therapeutic communities.

All or None Thinking

It is often the case that the alcoholic will exhibit a strong preference for certainty. Judgments of people, events, and situations are often extreme. Decision-making does not often seem to take into account the realistically probable. Decision rules are often inflexible, narrow in scope, and simplistic. Perceived alternatives are few, consisting largely of yes-no, go-no go, black-white, dichotomized categories. It is in this sense that the thinking is said to be "all or none" in character. This aspect of the alcoholic PDS has obvious implications for the nature of persuasive communications in therapy as well as the manner in which information is structured and presented.

In general, it is my experience with alcoholics in a variety of therapeutic contexts that they prefer large amounts of structure. While the drinking alcoholic may certainly appear to prefer uncertainty and unpredictability bordering on chaos, the recovering alcoholic seems to like things to move along in a fairly predictable and structured manner. Meetings of A.A., for example, are certainly among the most structured of social encounters. True, the setting is informal and non-bureaucratic, but the actual content of an A.A. meeting is most predictable. In Southern California, for example, virtually every meeting begins with a reading of Chapter 5 of the book, *Alcoholics Anonymous*. Hence, for example, an alcoholic from Anaheim, sober for ten years attending three meetings of A.A. a week, has heard the same thing read 1,560 times! I know that it is important that the alcoholic never forget where he has come from, but that kind of reminding seems to border once again on the wretchedly excessive!

In any case, the qualities of all or none thinking, preference for highly certain communications, simple decision rules, restricted choices, and highly structured social encounters all have obvious implications for the conduct of therapy and the structuring of therapeutic environments.

Conflict Minimization and Avoidance

Although their behavior while drinking may suggest otherwise, alcoholics do not like

interpersonal conflict, nor do they handle it well. Nor do they thrive in competitive relationships. As others have suggested, alcoholics do best in relationships characterized by complementarity rather than competition. Complementary relationships are those based upon satisfaction of reciprocally balanced needs. For example, a dominant person and submissive person would comprise a complementary relationship. These attributes concerning conflict minimization and conflict avoidance have obvious implications for both the nature and depth of therapeutic confrontation with the alcoholic. Confrontation tactics should be used by only the most skillful of therapists and only at carefully selected times in the therapeutic process. Angry and hostile confrontation with the alcoholic client is rarely, if ever, appropriate. Moreover, the group therapist working with alcoholics should exercise extreme caution in utilizing the resources of the group to confront a resistant member.

Rationalization

As anybody with only passing acquaintance with alcoholism can testify readily, alcoholics are often masters of rationalization. Many have developed the art and science of wishful thinking to its ultimate form of expression. They have had to. Anybody who can continue to drink in the face of the steadily accumulating disastrous consequences of active alcoholism must surely have learned a trick or two in order to make his drinking appear perfectly reasonable to himself and to others. But, as we have already seen with denial, rationalization can be a useful tactic in dealing with otherwise difficult situations, anxiety-laden happenings and guilt-provoking personal actions. Perhaps the most extreme example of naked rationalization known to mankind is apparent in the phrase, "Well, what the hell, at least I'm sober today!"

After years of making the procuring and drinking of alcohol his number one priority, the alcoholic understands very well how ultimate priorities can be maintained. Paradoxically, it is a relatively straightforward shift from rationalizing drinking to rationalizing other less than desirable behaviors *with sobriety*. That is, in the early stages of abstinence, the recovering alcoholic may quickly discover that while drinking was a crutch, sobriety is an even better one! "Why I can't do that, I might get drunk!" "I had to have an affair - my sobriety was in jeopardy." "I had to choose between her and my sobriety." In essence, the recovering alcoholic may discover that he has a freedom of personal action that few others can enjoy. But such rationalization can be an invaluable tactic in avoiding the reexperiencing of painful emotional cues that previously served as triggers to drinking, e.g., guilt, remorse, anxiety, resentment, and anger. Eventually, of course, the recovering alcoholic must face up to his *sober* rationalizations. However, the word to be stressed in that sentence is *eventually*. What the alcoholic very definitely does not need early in his sobriety is a therapist dedicated to immediate rigorous honesty - especially one devoted to immediate rigorous honesty in *others*, or even what he imagines rigorous honesty to be in others. More than anything, therapists working with alcoholics need to learn how to "bite their tongues" whenever they feel they've simply got to tell the guy the truth and nothing but the truth as they see it. Working with an alcoholic in therapy is rather like playing a big, fat albacore way out from the boat. You give him lots of line and let him lope around out there until even he gets sick and tired of all that honest self-deception. On certain issues, you sit and wait patiently before you reel him in. On some matters, you let him off the hook. On others, you set it ever so gently.

At times the therapist may find himself becoming more adept at rationalization than his alcoholic client. On more than one occasion I had to giggle madly when I found myself saying, "I suppose I should have opened that up more deeply than I did - but what the hell, he's sober

today, and that's not nothing!"

Self-centered Selective Attention

Alcoholics, for the most part, tend to look at things from a single perspective – *theirs*. Even in some alcoholics with considerable sobriety, there is often a curious lack of true empathy, a seeming inability to grasp the position of the other. This is not to say that alcoholics are "selfish." The facts are often to the contrary. But an alcoholic can be generous to a fault and still show extreme self-centeredness. As used here the term "self-centered selective attention" refers to the fact that alcoholics tend to be obsessed with self, to perceive the happenings around them largely as they impinge upon self. They attend selectively to information relevant to self, ignore other information not relevant to self, screen out information that is discrepant with their views of themselves, and to distort other information that does not fit their preferred self-image. And I suppose that if you had as negative a self-concept as the alcoholic clients I have worked with, you'd do pretty much the same thing.

In a very real sense, alcoholics are often resistant to feedback from others as well as from their own life experiences. This characteristic "blindness" can prove severely distressing and, in fact, maddening to those whose lives are linked to the alcoholic in important ways. It is often the case that drinking alcoholics (as well as recently sober ones) can maintain views of reality in the face of even massively disconfirming feedback. Faced with these obvious contradictions, the therapist may feel that it is his responsibility to apply immediate corrective feedback. Unfortunately, with the alcoholic client that is surely the very worst thing that the therapist could do. One must never forget that the characteristic blindness of the alcoholic is there for reasons, that it is dynamically linked to chronically low self-esteem, feelings of worthlessness, guilt, fear, and what might otherwise prove to be overwhelming anxiety. It is not that the therapist and his client are uninterested in the "truth," whatever that might be. It is really more a matter of *when* "truths" get revealed and also, *what* "truths" need to be invented and imagined if the client is to get sober.

The imaginative and creative therapist is aware of the simple fact that Reality is often up for grabs, and the fundamental therapeutic task is not one of finding and exposing something that smacks of ultimate reality. Rather, the task is one of inventing or discovering realities with the help of the client that serve specific therapeutic goals. Truth, you see, sometimes has a way of closing off inquiry, and in some cases, of helping people to continue drinking.

Preference for Non-analytical Modes of Thinking and Perceiving

It seems often the case that alcoholics are influenced more by the emotional persuasive appeal than the "rational." Leadership styles that are likely to work with the alcoholic are often charismatic, inspirational, and "spiritual." It is not that alcoholics cannot operate in logical-analytical modes. That would be patently false since alcoholics are as capable as non-alcoholics in approaching matters in a linear, logical, and analytical manner. However, in terms of preference, the alcoholic is more often drawn to the warmth of magic rather than the cold objectivity of science.

Passivity Versus Assertion

Although the intoxicated individual may often appear aggressive, assertive, and even frankly hostile, it is often the case that the alcoholic in the initial stages of abstinence prefers passivity rather than active coping as a general adjustive strategy. Assertion and active coping

tend to bring the person into normal conflict with others. And as we have seen, alcoholics do not thrive in situations characterized by conflict, competition, and win-lose outcomes. In fact, it is precisely in these situations that they tend to pick up a drink.

In actuality then, despite the surface picture, the preferences of the alcoholic are for a general life attitude of passivity rather than active assertion.

Obsessional Focusing

Alcoholics are, for the most part, intense people. And, as nearly everyone knows, they are often obsessed people. Intense obsession is no stranger to the alcoholic. In addition to the obsession with alcohol during periods of active drinking, it is not uncommon to find obsessions with work, money, success, sexuality, and so forth. Contrary to popular stereotype, the alcoholic, sober and drinking, is often so obsessed with work as to fully deserve the label, "work-aholic." And in terms of sheer insanity, no other phenomenon known to mankind is characterized by greater undisciplined energy than the alcoholic love relationship.

In general, the alcoholic seems to prefer a state characterized by a moderate-to-high activation level. Witness the enormous amounts of stimulating drugs, e.g., caffeine and nicotine, consumed by sober alcoholics. It is probably true that more socially acceptable "speed" or "uppers" are consumed in a typical A.A. meeting than in any ten other comparable social gatherings of non-alcoholics. Even the so-called states of "serenity" of many sober alcoholics are intensely focused states of moderate-to-high activation rather than low.

The therapeutic problem in alcoholism therapy is not to alter directly this level of intense obsession, but to *redirect* it. Along these lines, it is interesting to note how the obsession with alcohol, previous drinking, and sobriety continues in the *sober* alcoholic. Recovering alcoholics on A. A., for example, seem often obsessed with their programs, with meetings, and with alcoholism generally. Curiously, this same obsession with the problem is what enables them to remain sober when previously it served to maintain drinking.

In essence then, the problem in alcoholism therapy is not to reduce activation levels, since that is often impossible, but to switch the focus of the obsession. Unfortunately, some number of alcoholics would rather fight than switch.

Tactical and Strategic Use of the PDS

In the preceding material, we described the alcoholic PDS and hinted at how it might be used effectively to help the alcoholic client achieve abstinence. I do not wish to imply that the above is an exhaustive description of the PDS. However, the major features of that structure have now been considered. We are in a position now to restate the central thesis of this paper. An alcoholic preferred defense structure exists. It is not only ineffectual but therapeutically disastrous to confront this structure prematurely. The therapist knowledgeable about alcoholics will turn this structure to the advantage of his client and himself by selectively reinforcing and encouraging the defenses of the alcoholic client. The central problem in therapy with the alcoholic is learning how to swing the PDS into the service of abstinence rather than continued drinking.

Eventually, the alcoholic preferred defense structure must be dealt with directly if real changes in personality are to be achieved. However, when and how much such changes should be attempted is dependent upon characteristics of individual alcoholics as well as upon years of continuous sobriety. In my opinion, in the majority of recovering alcoholics, such changes should not be attempted until several years of sobriety have been achieved.

However, the therapeutic task in alcoholism therapy at the early stages of abstinence differs radically from that of other psychotherapies. The role of the therapist is not to expose, confront, and modify the defenses of the alcoholic client. Rather, the role of the therapist is to teach the alcoholic client how to use these very defenses to achieve and maintain abstinence. Denial, rationalization, projection, and so forth have for too long been construed in moralistic terms by psychotherapists. In actuality, such mechanisms are perfectly acceptable tactics when used deliberately and selectively for particular purposes. In the case of the alcoholic, these mechanisms have become part of a preferred defense structure throughout years of alcoholic drinking. For a therapist to try to remove these is equivalent to trying to force water to flow uphill.

It requires little therapeutic imagination to see how tactics such as denial and rationalization can be used effectively with the recovering alcoholic. Once the denial and rationalization associated with drinking have been confronted and dealt with, the recovering alcoholic typically is faced with many very real and difficult life problems. A list of these may serve to remind us of the intolerable internal and external stressors the recovering alcoholic may be required to face. He may have to deal with very serious malfunctions of physical health. His marital situation may remain complicated for many years after his last drink. His finances are often in alarmingly poor condition. He may have alienated everybody that ever meant anything to him in life. He may be facing non-trivial legal and criminal proceedings, unemployment, disturbed interpersonal relationships, parent-child complexities of unbearable proportions, personal emotion problems of serious dimensions, and so on and so forth. What can we do for the person in not one serious life crisis, but a host of them all at once? It is precisely here that variants of denial and rationalization become important. Through direct tuition, we can help the alcoholic to the position that things will work out if he just will stay sober, that even though his life is complicated at the moment, at least he is sober, that sobriety is his number one priority, and so on and so forth. In other words, we as therapists are appealing to his preferred use of denial and rationalization to give him a toehold on abstinence.

Similarly, by appealing to the alcoholic's preference for assimilative projection, we can get him to identify with other persons whose problems seem to center around something called "alcoholism." If the alcoholic comes to construe himself in these terms, then all of the benefits that can flow from such a self-attribution are his. The label, "alcoholic" or "alcoholism," provides the person with a convenient explanatory system for much of his behavior. Moreover, by listening to the experiences of others who make the same self-attribution and who also conveniently explain their behavior by this attribution, the person has a ready source of social reinforcement for his changing belief system. Moreover, he is now open to considerable positive social influence. And he has been given the key to dealing with otherwise overwhelming anxiety, remorse, guilt, and confusion. In addition, by fixing his lifeline in terms of two clearly demarcated points, i.e., when you were drinking and now that you are sober, we have provided the client with reference points for a belief system that includes the possibility of dealing with the negativity of previous behavior and the possibility of hope for desired future behaviors.

In a very real sense, helping the client to achieve a self-attribution of "alcoholism" and, hence, an explanatory system for his behaviors, is a central role of the therapist. It should not be done directly. In fact, the guiding principle of work at this phase of therapy should be, "as little external force as necessary for the attribution to be made." If the therapist literally tries to force the attribution upon the client, one of two things will happen. The client will become defiant and reject the therapist's attribution, or the client will publicly acquiesce but privately disagree.

In truth, psychotherapy with the client at this point is very much the teaching of an "exotic belief." The often heard phrase, "your life was a mess because you were drinking, you weren't drinking because your life was a mess" and the many variants of this phrase are, in actuality, efforts to teach the client the convenient fiction that all of his problems are or were attributable to alcoholism. The truth value of this assertion is irrelevant. If it enables the client to 1) explain his past behavior in a way that gives him hope for the future, 2) cope with his guilt, anxiety, remorse, and confusion, and 3) provide him with a specific behavior (staying sober) that will change his life in a desired direction, then the assertion is valuable despite its questionable truth value. The therapist must remember that the recovering alcoholic has a lifetime of sobriety in which to gradually recognize the fact that not all of his personal and social difficulties can be attributed to alcoholism. In the meantime, the intelligent therapist will make very good use of assertions that have their basis solidly in denial and rationalization. In effect, the therapeutic task is one of helping the client to construct a belief system. And the fact that this belief system may at the beginning of sobriety contain strong elements of denial and rationalization should not trouble us. One must remember that the recovering alcoholic in initial stages of sobriety is faced with so many serious life problems that he will need a healthy dose of denial and rationalization if he is to survive at all.

Nor should the therapist be troubled about the intelligent use of any of the other preferred defenses of the alcoholic. The preference for all or none thinking can clearly be brought into the service of sobriety. Phrases such as "one drink will eventually get you drunk" are naturals despite recent dismay on the part of academic psychologists about the continued belief in the "myth of the first drink" among recovering alcoholics. Alcoholics need strongly-worded persuasive appeals. Probabilistic statements such as, "you have one chance out of twelve in getting drunk after a first drink," never got anybody sober. Much the same thing can be said about any of the black and white, dichotomous statements that are so evident in an organization such as Alcoholics Anonymous. What the academic psychologists can't seem to get straight is simply that the recovering alcoholic isn't interested in a belief system that is socially acceptable in a graduate student research seminar. The recovering alcoholic wants a belief system that will work, one that will keep him sober.

Summary and Conclusions

Throughout this paper, I have argued for the existence of a preferred defense structure in the alcoholic client. I have further maintained that traditional and even contemporary psychotherapies are largely inappropriate for the recovering alcoholic precisely because they have failed to recognize the *value* of the alcoholic preferred defense structure. Therapeutic ideologies that consist largely of disguised moralistic stances concerning certain behaviors called "defenses" are likely to do more harm than good in alcoholism therapy.

The central problem in alcoholism psychotherapy is not one of exposing, uncovering, and modifying the alcoholic PDS. The central problem is one of discovering further ways of swinging it into the service of achieving and maintaining sobriety.

Finally, psychotherapists must recognize that alcoholism therapy is a time dependent process. We must begin to see the obvious fact that entirely different therapeutic behaviors are called for in various stages of the long recovery period from active alcoholism.*

*Further questions concerning this article should be addressed to the author in care of The

National Council on Alcoholism.