Similarity of Personality Constellations of Alcoholics and Other Selected Hospitalized Groups

by

Patricia Pell, Diane Cromwell, Doris Spalsbury, and Aldene Crockett

ABSTRACT

The purpose of this study was to determine the similarity of a personality constellation in alcoholics and other selected groups: manic depressives, manic type; psychoneurotic depressives; and schizophrenics, paranoid type. It was hypothesized that we would find a common personality constellation occurring in the alcoholics and members of the other groups.

A sample of one-hundred cases, representing the four diagnostic groups, was obtained from Ypsilanti State Hospital, Ypsilanti, Michigan. The data was gathered through an inventory of personality traits appearing in the cases, and the statistical method of pattern analysis was utilized to process the data. The pattern analysis included one-hundred observations, fifty-two variables, six response categories, and four criteria categories. The minimum discrimination level was set at .60 and the minimum significance level was set at .0001.

Cur hypothesis was not supported, in that, a core personality was not found in the alcoholic. In contrast, the other criterion groups provided specific classic personality patterns. Patterns elicited for the alcoholics were clusters of items discriminating the absence of traits.

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by
Patricia Pell
Diane Cromwell
Doris Spalsbury
Aldene Crockett

A RESEARCH REPORT

Submitted to
Michigan State University
in partial fulfillment of the requirements
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INTRODUCTION

The increasing presence of alcoholism in our society has evolved into a problem of major concern. During the past twenty years, various disciplines, including physiology, sociology, anthropology, psychology, and psychiatry have attempted to deal with the problem. To date, a clearly defined etiology does not exist. (15, 16, 28) Although there is no known cure for the addictive state, it is agreed by all investigators that total abstinence is required to arrest the progressively disintegrative psychological and physical processes. (1-34)

It is estimated that there are 4,589,000 individuals in an addictive state labelled alcoholism. (34) The complexity of the impact of the problem of alcoholism presents the greatest difficulty in studying the subject. Preliminary reading from diversified disciplines provided no conclusions as to the etiology, effective prevention, or significantly effective treatment. We felt that the psychodynamic theories provide the most comprehensive and feasible approach to the problem.

It is not felt that an extensive review of this literature is necessary here. However, we would like to call attention to the article "Alcoholic Addiction and Personality" by Zwerling and Rosenbaum (34), which provides the most complete review of the interdisciplinary studies, as well as providing a tentative formulation concerning personality and alcohol addiction. This may be summarized as follows:

> Disruption of the mother-child relationship in the period of dependency sets into motion a series of developmental trends evolving into sequences of 1. distrustful withdrawal with attendant experiences of isolation and estrangement in addition to persistence of atypical, magical thinking processes, 2. persistent passive-dependent longings, with resultant distortions in object relationships; 3. inevitable frustration in the insatiable omnipotence and dependency demands with resultant impulsive grasping behavior and chronic rage; 4. conflicted, ambivalent dependency relationships which must be frequently ruptured, repeatedly establishing the setting for depressive reactions; and 5. conflicted, ambivalent sexual role-playing with immature modes of sexual behavior. (34)

Zwerling and Rosenbaum suggest that their formulation represents a core personality among alcoholics around which multiple characterological configurations may form. We believe, however, that this personality is present not only among alcoholics, but also among non-alcoholics in other clinical categories.

It is our aim to identify the described personality constellation in alcoholics and compare it to that found in three other diagnostic groups. We hypothesize that we will find a common personality configuration occurring in all four groups.

METHCD

Instrument Development:

It was determined that reading a sample of clinical records in a state mental hospital would provide evidence of personality traits. It was felt that data taken from these histories could be analyzed to identify a personality constellation occurring in alcoholics, which could be compared to other emotionally ill patients. It was further decided to compare the alcoholic patient to three other clinical diagnostic categories, including: psychoneurotic depressive; schizophrenia-paranoid type; and manic-depressive, manic type.

In order to devise an instrument with which to identify a personality matrix in the alcoholic, the Zwerling and Rosenbaum personality formulation was factored into specific symptoms, which we assumed to be typical of the alcoholic personality. These were operationally defined as follows:

Dependency - A passive expectation for gratification of physical and emotional needs from others.

Depression - A reaction to loss or threatened loss, to failure, discouragement or disillusionment appearing as a mood disturbance expressed in the form of dejection and self-depreciation, somatic disturbance and repetitive complaints of feeling inferior, hopeless and worthless.

Schzoid - A tendency toward emotional withdrawal due to an inability to form meaningful relationships, used as a defense against depression.

Hostility - An overt or covert expression of suppressed and introjected hate to a frustrating coersive experience.

Sexually immature - A pre-oedipal fixation: the prevalent psychosexual development has not progressed beyond the early anal phase and is reflected in sexual practices and object relationships.

Based on the above definitions, the following inventory was developed to collect significant data from case records of both alcoholic patients, and the three clinical diagnostic categories mentioned above. For each of the five symptoms, we identified ten representative indices which we deemed pathological. Since there was no method by which to determine the degree of intensity of a pathological trait, we assumed that if evidence was found in the case records of any representative item on the inventory, it was of sufficient concern to present a problem area to the psychiatrists and therefore could be classified as a pathological symptom.

Inventory:

Dependency

1. Repeated hospitalization or reliance on external agents for care and security. (jail, AA, etc.)
2. Excessive and constant demands for affection and attention.
3. Financial dependence on spouse if man, or parents if either man or woman.
4. Fear of being alone or abandoned. (jealousy)
5. Prolonged relation with parent of opposite sex, ie. living at home after age 30.
6. Excessive and constant demands for gratification. (alcohol, obesity, smoking)
7. Impulsive behavior - irrational spending, frequent job change, temper tantrum.
8. Immature, childlike, clinging behavior.
9. Preoccupation with death of loved object.
10. Poor identification

Depression

11. Attempted or threats of suicide.
12. Self depreciation - expression of inferiority, worthlessness, and hopelessness.
13. Lack of interest and initiative (people, job, events, self).
14. Somatic complaints.
15. Grandiosity, elation, mood swings.
16. Excessive fatigue.
17. Insomnia.
18. Apathy, indifference.
19. Guilt - not living up to expectations over past, guilt over past or present behavior.
20. Constant and repeated need for reassurance.

Schizoid

21. Use of sleep as a defense.
22. Withdrawal from family, social life and community responsibilities.
23. Flight from all anxiety arousing experiences.
24. Inability to evaluate reality situation (fabricate).
25. Hallucination, delusions.
26. Depersonalization, estrangement.
27. Seclusion - impulse to or actual flight.
28. Frequent disruption of intimate close relationships.
29. Lack of appropriate affect.
30. Inability to form meaningful relationships.

Hostility

31. Defensiveness - unjustified reaction to real or unreal criticism.
32. Homicidal attempts or threats.
33. Ambivalence toward loved objects.
34. Highly authoratative, takes advantage of people.
35. Rebellious acting out -- inappropriate behavior.
36. Resentment of dependency and hatred of object dependent upon.
37. Use of abusive language and vulgarity.
38. Passive aggressive behavior (overt compliance with covert resentment).
39. Low frustration tolerance - temper tantrum.
40. Conscious rigidity, withholding.

Sexually Immature

41. Masturbation.
42. Inability to have children with absence of physical reason.
43. Sexual deviant; homosexual, transvestite, etc.
44. Inability to perform intercourse except with certain type of individual, ie. prostitute.
45. Promiscuity.
46. Pathological reaction to childbirth.
47. Extended periods of sexual abstinence.
48. Excessive demands for sexual intercourse.
49. Voluntary sterilization.
50. Seductive behavior.

Sample:

In cooperation with Alexander P. DuKay, M.D., Medical Superintendent, and Hans von Brauchitasch, M.D., Director, Division of Research, of Ypsilanti State Hospital, Ypsilanti, Michigan, one hundred case records were processed, utilizing the above inventory.

The sample of cases were obtained in the following manner. Dr. von Brauchitasch made available to the committee a list of cases drawn from the hospital census from January 1, 1966, through December 31, 1966, which had been coded according to diagnostic categories. From this list, one hundred cases were drawn at random. Of these, twenty-five cases represented alcoholics; twenty-five, psychoneurotic depressives; twenty-five, schizophrenia-paranoid type; and twenty-five, manic-depressive, manic type. For the purposes of this study, there was no discrimination made with respect to age, sex, race, length of stay in the hospital, socio-economic or cultural background. The alcoholic

group was taken from the diagnostic category of personality trait disturbance with alcoholism. These patients were hospitalized in a separate alcoholic ward. In the other diagnostic categories, cases with alcoholism were excluded from the study.

The total number of cases for this study was arranged according to their primary diagnoses in the following order: Criterion I, Alcoholics; Criterion II, Manic-depressive, manic type; Criterion III, Psychoneurotic depressive; Criterion IV, Schizophrenia, paranoid type. They were serially numbered from one to one hundred, and the respective case records were pulled from the hospital files, from which the clinical information was obtained. The records were surveyed for evidence of the items listed on the above inventory. If an item was found to be present in the record of a patient, it was recorded. If the item was not present, the specific category was left blank.

DATA ANALYSIS AND RESULTS

Due to the fact that we were seeking to identify patterns of character traits and not dimensions, we utilized the statistical method of pattern analysis. The information was transferred to IBM cards and was processed on the CDC 3600 Computer at Michigan State University.

Our intent was to determine if patterns existed which would discriminate the differences between the alcoholic and the other diagnostic categories. Therefore, the minimum discrimination level was set at sixty per cent. This allowed any pattern to be identified if sixty per cent of the numbers of the total set of cases falling into the pattern were in a given criterion group. If a cluster of traits met this requirement, it qualified as a pattern. It was assumed that if there was a common core personality among our diagnostic groups, there would be no differentiating patterns elicited ie. no patterns will be identified for any criterion groups. It is further assumed that if the alcoholic personality corresponds to any of the four diagnostic categories, we will elicit patterns for the three pathological groups in which the alcoholic cases will be absorbed.

As a matter of fact, patterns were elicited from the alcoholic group, Criterion I, but these provided no evidence of a personality constellation common to the alcoholics. The eight patterns which evolved discriminating the alcoholic from the other criterion groups dealt with the absence of

personality traits. (See table I)

The most frequent reason found was the absence of constant and repeated needs for reassurance. This occurred in four of the eight patterns. Lack of appropriate affect and of hallucinations and delusions occurred in three of the eight patterns. In five of the patterns, two traits occur simultaneously. The maximum number of items occurring in any pattern was three. (See Table I)

There were twenty-nine alcoholic cases which fell into the patterns for psychoneurotic depressive (Criterion 3). Seven occurred in the pattern showing the presence of self depreciation in combination with the absence of flight in anxiety arousing experiences. Seven occurred in the pattern with the presence of lack of initiative and the absence of flight from anxiety arousing experiences. Five cases appeared with the presence of somatic complaints and the presence of low frustration tolerance.

Six cases were found in manic-depressive, manic type (Criterion 2). This pattern included the presence of grandiosity, elation and mood swings.

There was only one pattern within the schizophrenia, paranoid type criterion in which alcoholic cases appeared. This pattern was the absence of excessive and constant demands.

In constrast to the alcoholics, the other three criterion groups provided specific patterns commonly associated with their diagnostic

categories. In the manic-depressive group, two patterns were distinguished; the presence of grandiosity, elation and mood swings occurred in sixty-seven per cent of the cases; the absence of hallucinations and delusions, and the presence of lack of appropriate affect were found to occur simultaneously in seventy-eight per cent of the cases. (See Tables I and II)

The psychoneurotic depressive type, Criterion 3, provided the greatest number of patterns, as well as the greatest variety of patterns (See Table I). The discrimination range was from sixty-six to ninty-two per cent within the respective patterns. (See Table II) The pattern of the presence of poor identification, appearing with the absence of the constant and repeated need for reassurance, had the highest level of discrimination; whereas, the presence of attempted or threat of suicide combined with the absence of flight from anxiety arousing experiences, was at the discrimination level of sixty-six per cent. Two patterns appeared in twenty-five cases of this criterion. These patterns showed the presence of self depreciation, expressions of inferiority, worthlessness and hopelessness, and the presence of low frustration tolerance; and the presence of grandiosity, elation, mood swings, combined with the absence of hallucinations and delusions. The patterns in this criterion involved the largest number of cases in the respective patterns, including 309 observations, with an average of 31 observations to a pattern.

In the schizophrenic group, there were six patterns with discrimination

ranging from sixty-three to eighty-four per cent (See Table I and II). Only one characteristic, the presence of hallucinations and delusions, appeared in more than one pattern. This was observed in a single pattern, involving twenty-two cases, and was combined with the absence of attempted or threat of suicide in twenty-one cases.

DISCUSSION OF RESULTS

The above data confirms the complexity of the alcoholic etiology. This study does not identify a symptomatology in alcoholics common to the other diagnostic groups as hypothesized by Zwerling and Rosenbaum (34). Our objective, to elicit a matrix of personality traits, was also not fulfilled. Therefore, we have been unable to compare such a matrix with the other diagnostic categories.

It is, however, pertinent to note that at the .001 significance level, the production of approximately 31 patterns for the alcoholic group were consistent in the absence of responses mentioned above. These patterns were reversed from our original hypothesis concerning the alcoholic group. In contrast to the presence of a personality matrix, an absence of the traits formed the patterns elicited. The percentiles of discrimination show such internal consistency within the alcoholic group that it is felt that serious thought must be given to the variables discriminated, as well as the variables which failed to be included in the patterns. This is, however, beyond the scope of this study.

It is recognized that the absence of a specific pattern of symptomatology for all alcoholics does not preclude a variety of subpatterns, and, or a pathology concurrently present in many individuals, labelled "alcoholics". This is suggested by the frequency in which the alcoholic cases appeared

in the psychoneurotic depressive type patterns.

It is not known to what degree the above sample is biased. The sampling method used did not consider such factors as length of hospitalization and socio-economic or cultural backgrounds. Another possible bias within the sampling may have been due to the exclusion of alcoholics with any gross pathology, and the exclusion of other diagnostic categories in which alcohol was a secondary factor.

As the majority of the information was taken from the preliminary history, it is not known to what degree the impact of hospitalization temporarily mobilized the ego defenses, and therefore, tended to contaminate the responses of the patients.

The patients of this study were all hospitalized, and their respective need for, and acceptance of, hospitalization is a variable which is not evaluated in terms of symptomatology. Our patterns of absence of traits tend to support the Sherfey conclusion: ". . . that alcoholism is not a single entity or disease, but a symptom associated with several illnesses or syndromes." (24) It is noted, however, that the Sherfey study also drew the sample from hospitalized patients in a mental institution. It would seem that this common factor has implications for further analysis into the type of personality utilizing these facilities, and why this method of treatment was chosen.

From a clinical standpoint, we question the pertinence of the patterns

elicited. For example, one pattern included the following items: 11--an absence of attempted or threat of suicide; 15--an absence of grandiosity, elation and mood swings; 25--an absence of hallucinations and delusions. Clincally, the absence of hallucinations indicates the stage of alcoholism. Delirium tremens may be anticipated as a progressed stage of alcoholism. Grandiosity, elation and mood swings are evident in the active drinking phase and not in the period of abstinence while hospitalized. Likewise, threats of suicide are more commonly found in later phases (11). This is further supported by empirical observations of the research team.

CONCLUSIONS

The analysis of the data did not support our hypothesis. Evidence of a core personality was not found in the alcoholic. In contrast, the other criterion groups evidenced specific classical personality patterns in each of their respective categories. Specific patterns were elicited for the alcoholic group. These represented clusters of absent traits. Therefore, we cannot conclude that there is a specific personality constellation or symptomatology for the alcoholic.

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TABLE I

PATTERNS ELICITED

	Characterization
Criterion Group I (N 25) 8 Patterns	Absence of immature, childlike clinging behavior (2 patterns) Absence of poor identification (1 pattern) Absence of attempted or threat of suicide (2 patterns) Absence of grandiosity, elation and mood swings (2 patterns) Absence of need for constant and repeated reassurance (4 patterns) Absence of hallucinations and delusions (3 patterns) Absence of lack of appropriate affect (3 patterns)
Criterion Group II (N 25) 2 Patterns	Presence of grandiosity, elation and mood swings (1 pattern) Absence of hallucinations and delusions (1 pattern) Presence of lack of appropriate affect (1 pattern)
Criterion Group III (N 25) 10 Patterns	Presence of attempted or threat of suicide (2 patterns) Presence of self depreciation, expression of inferiority, worthlessness and helplessness (3 patterns) Presence of lack of interest and self initiative (1 pattern) Presence of somatic complaints (1 pattern) Presence of constant and repeated need for reassurance (1 pattern) Absence of withdrawal from family life, social life and community and responsibilities (3 patterns) Absence of flight from anxiety arousing experiences (5 patterns) Absence of inability to form meaningful relationships (1 pattern) Presence of low frustration tolerance and temper tantrums (1 pattern)

TABLE I (Continued)

PATTERNS ELICITED

	Characterization
Criterion Group IV (N 25) 6 Patterns	Absence of excessive and constant demands for affection and attention (1 pattern) Absence of excessive demands for gratification (1 pattern) Absence of attempted or threat of suicide (1 pattern) Absence of grandiosity, elation and mood swings (1 pattern) Presence of hallucinations and delusions (2 patterns) Presence of lack of appropriate affect (1 pattern) Presence of masturbation (1 pattern)

TABLE II

DISCRIMINATION CAPACITY OF PATTERNS ELICITED BY CRITERION GROUPS

Pattern Number And Criterion Group	Cases in Pattern			
	Within Criterion		Outside Criterion	
	N	%	N	%
Criterion Group I				
Pattern 1	11	73	4	27
2	20	80	5	20
3	21	75	7	25
4	23	82	5	18
5	23	64	13	36
6	23	89	3	11
7	19	91	3	9
8	18	95	1	5
Criterion Group II				
Pattern 1	25	68	12	32
2	18	78	5	22
Criterion Group III				
Pattern 1	24	67	12	43
2	24	92	2	8
3	22	71	9	29
4	25	71	10	29
5	20	65	11	35
6	22	69	10	31
7	25	69	11	31
8	23	89	3	11
9	22	76	7	24
10	22	82	5	28
Criterion Group IV				
Pattern 1	14	64	8	36
2	11	69	5	31
3	22	63	13	37
4	16	64	9	36
5	21	84	4	16
6	16	80	4	20