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Abstract of

BECOMING "ALCOHOLIC:"

A STUDY OF SOCIAL TRANSFORMATION

by

ODIS E. BIGUS

DISSERTATION

Submitted in partial satisfaction of
the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

SOCIOLOGY

in the

GRADUATE DIVISION
(San Francisco)

of the

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This dissertation consists of an analysis of the process by which persons who come to be labeled "alcoholic" have the conditions of "normal" (i.e. non-alcoholic) life supplanted by the conditions of "alcoholic" life. This process is conceptualized as the "supplanting process." The process is analyzed from the point at which drinkers "disengage" from participation in "normal social networks" (i.e. family, occupation, etc.) to the point at which they enter the rehabilitation milieu and eventually get locked into an "alcoholic career."

The major phases of the supplanting process occur as follows: Drinkers are "eased out" of participation in normal social networks, usually, but not always, as a consequence of drinking behavior which important others define as in excess of ordinary. As they are eased out, "limits on behavior" afforded by participation in normal social networks begin to erode. This prompts increased drinking behavior, which accelerates the "easing out" process. When complete disengagement occurs, drinkers may come to live their lives within an alcoholic milueu.

As time passes, experiences occur which may prompt a drinker to enter the alcoholic rehabilitation milieu. Receptivity to rehabilitation services, however, may occur before or after entry into the rehabilitation milieu. A drinker may initially enter in search of resources (food, a bed, money, etc.), without a commitment to rehabilitation, and later become receptive to rehabilitation services. Or, he may enter initially <u>because</u> he has become receptive to rehabilitation services (he may also, of course, never become receptive). Frequently, but not always, acceptance of the self-identity of "alcoholic" occurs at about the time a drinker becomes receptive to rehabilitation services.

Receptivity to rehabilitation services is occasioned by what are referred to as "realizing experiences" (moments at which a drinker comes to have major revelations regarding the implications and/or meaning of his drinking behavior). Realizing experiences are prompted by one or more of what are referred to as "self-control failure history" (a history of failure at self-control attempts), "crisis or crises buildup" (a crisis or series of crises which are perceived by the drinker as related to excessive drinking), "comparing experiences" (experiences during which drinkers compare themselves and their drinking behavior with other drinkers), and exposure to therapeutic rhetorics (the word "rhetoric" is used descriptively, not evaluatively).

Once drinkers become committed to rehabilitation they begin to "work" on their drinking problem. Many feel a compulsion to find an "explanation" for their having become "alcoholic," which they ordinarily find in one or more of the rhetorics available in the rehabilitation milieu. Maintaining sobriety, however, is the paramount problem at this time. This is accomplished (or at least attempted) through self-controls (which are usually more sophisticated than those attempted earlier) and through the controls inherent in residence in the rehabilitation milieu (organized activities, time and task requirements, etc.).

Once sobriety is successfully maintained for a relatively long period of time, drinkers ordinarily begin to devise a "recovery plan," for eventual reentry into normal social networks. However, for a number of reasons (e.g. lack of resources. rusty social and occupational skills, etc.), such plans are ordinarily doomed to failure, whereupon drinkers get locked into an "alcoholic career."

The research upon which this analysis is based was conducted using the techniques of intensive interviewing and participant observation. The concepts were "discovered" through inductive coding of the data, whereupon they were integrated into a "grounded" substantive theory of the "supplanting process." The implications of this research and analysis for further theoretical development within this framework, for research in the area of "alcoholism," and for practical application in the area of alcoholic rehabilitation are discussed in the closing chapter.

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CHAPTER I

METHODOLOGY

The research presented in this monograph was conducted using the techniques of what Glaser and Strauss (1967) refer to as "grounded theory." The techniques of grounded theory have been elaborated upon since their original publication (although they have not yet been updated in publication). This research was conducted in light of grounded theory's present state of development.

A short discussion of grounded theory is appropriate as a preface to this analysis. Such a discussion will enable the reader to place this research within the larger context of social research in general, and clarify what it does and does not purport to accomplish. Only a very rudimentary sketch of grounded theory will be given. For a detailed discussion, see Glaser and Strauss (1967).

Fundamentally, grounded theory is an inductive model of research. Its general procedure is to elicit codes from raw data through detailed analysis,[1] using these codes to direct further data collection, from which the codes are further developed (i.e. elaborated) in respect to their properties and dimensions, and then integrating the codes in their elaborated form into a theory. Glaser and Strauss refer to this as "theoretical sampling."

> Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is <u>controlled</u> by the emerging theory, whether substantive or formal. The initial decisions for theoretical collection of data are based only on a general sociological perspective and on a general subject or problem area

> (such as how confidence men handle prospective marks or how policemen act toward Negroes or what happens to students in medical school that turns them into doctors). The initial decisions are not based on a preconceived theoretical framework. (Glaser and Strauss, 1967: 45).

The grounded theory model of research is a "discovery" model, as opposed to a "verification model." In a discovery model codes and concepts are developed in direct response (i.e. as a product of) data, whereas, in a verification model, data is collected to verify a preformulated or preconceived hypothesis or set of hypotheses.[2]

A more recent and as yet unpublished development of grounded theory which is pertinent to this analysis is a generic theoretical construct,[3] created by Barney Glaser, termed "basic social process."[4] Related to this is a distinction between "process" and "unit" analysis.[5]

Basic social processes are patterns basic to the organization of social behavior as it occurs over time. Important properties of basic social processes are that they account for change over time, they may occur under differing specific conditions in regards to time, context and substantive area, and they account for the most variation in regards to the specific sociological problem at hand.

As an example for illustration, one basic social process characteristic of American culture is what might be referred to as "upgrading." Upgrading is the process wherein persons, whenever possible and appropriate, "move up" or graduate to something "bigger and better," so to speak. Americans have become notorious, for instance, for their propensity to upgrade in regards to material goods -- from a Chevrolet to a Buick, from a $30,000 house to a $40,000 house, from a black and white television set to a color television set, and so on. Furthermore, the

American concept of occupational "career" includes the notion of a gradual and regulated progression from one step to another, each step being successively "higher" in regards to status, responsibility, and income.

It is apparent, then, that the process of "upgrading" occurs over time, occurs under differing conditions in different substantive areas (from purchasing habits to career patterns), and accounts for much variation in regards to specific sociological problems (how Americans make choices in regards to the purchase of certain material goods, for instance).

The focus of analysis in a process (i.e. basic social process) analysis is the process itself. The aim of a process analysis is to develop the dimensions, properties, conditions, and so forth of the particular process under scrutiny, within the particular context(s) within which the research is being conducted. In this manner, process analysis is distinguishable from "unit" analysis. The focus of a unit analysis is a particular unit, whether it be a population unit, cultural unit (e.g. skid row), or defined social unit (e.g. alcoholics). The aim of a unit analysis is to develop a description of the particular unit under scrutiny, through qualitative description, the construction of statistical rates, or whatever. Ordinarily, the unit which has been studied is considered to be representative of larger units with supposedly similar characteristics (ergo the development of techniques with which to draw random samples, etc.). Thus, the results of a unit analysis are usually generalized to a larger unit. In contrast, the results of a process analysis are not generalized to a unit, but to the generic process itself. Thus, if one were to conduct a study of upgrading in reference to

home purchases in America, the results of that study could be generalized to the generic process of upgrading. The properties and so forth of upgrading which were discovered are just that, properties of the process of upgrading, not properties of a unit. Therefore, the notion of generalization to a unit is simply not applicable. Questions regarding to what extent and in what characteristic ways the upgrading process and its various properties are found in particular units are entirely separate from the discovery and theoretical development of the process. Such questions can only be posed after the development of the process theory, using entirely different research methods.

A grounded, basic social process theory is presented in this monograph. The general sociological problem with which the research originated is the question of how drinkers come to center their lives within the alcoholic milieu. After spending several days in that milieu, I became curious as to how it was that drinkers ended up there, and furthermore how it was that they seated their lives in that context for long periods of time. The basic social process which was "discovered" in researching this problem is what I shall refer to as the "supplanting process" (a rather clumsy term, but the only one which adequately fits the substance of the process). The supplanting process is the process by which drinkers come to have their "normal" (i.e. non-alcoholic) lives supplanted by life in the alcoholic rehabilitation milieu.

In accordance to the previous discussion of grounded theory and basic social process theory, my unit of analysis is the "supplanting process," not the defined social unit of "alcoholics," or any other unit. The process and its properties were generated from data collected from specific units, but are not meant to be representative of any particular

unit. As I stated above, the question as to which units (what types of alcoholics in what locations, etc.) my findings apply is a separate question, requiring an entirely different research model than used in this study. In short, I am talking about the supplanting process and its properties as they occur in the context of alcoholism, not about alcoholics or alcoholic rehabilitation institutions per se. The supplanting process could be studied in other contexts (e.g. the development of chronic illness, or mental illness), the data from the various contexts could be analyzed for their similar and dissimilar properties, and a more formal theory of the supplanting process could be developed. However, I shall limit its development here to a purely substantive level.

In light of the above discussion of grounded theory, I might add at this point that the concepts and variables developed in this analysis are grounded, having been generated from inductive codification. Therefore, variables such as age, sex, race, religious affiliation, social class, etc. which are routinely included in many analyses will not be included here. The reason is simple. Such variables were not discovered to be properties of the process under scrutiny. This, of course, is not to say that they are not related to alcoholism. One might construct a survey, for instance, to determine which sex, age group, social class, etc. the phenomena discussed in this analysis pertain to. Such information cannot be ascertained using the research model utilized in this study, but may nonetheless be ascertained to be related to the subject matter.

Before I proceed with substantive and theoretical matters, I shall briefly describe the persons and places from which the data for this analysis were collected, as well as the way in which this collection

occurred. The descriptions of persons and places are offered, not as part of the analysis, but merely to orient the reader regarding where and to whom the supplanting process may occur.

The data from which this analysis draws came primarily from two sources. First of all, I collected data, in the form of both observations (unstructured) and interviews (also unstructured) at various intervals over a period of one year, from February 1972 to February 1973. These data were collected within the City and County of San Francisco Department of Public Health Community Mental Health Services system. I spent most of my time in one large institution within this system, which offered inpatient, day care, and outpatient (in the evening) services. Inpatients remained in residence for twenty-one days, with the possibility of a seven-day extension under certain circumstances. The day care program lasted eight weeks, and the outpatient program had no duration limits. In addition to these programs patients themselves had organized an association of "alumni" which consisted of persons who were either current or past clients of the institution. They performed various tasks to aid the staff and their fellow clients.

I did not focus my attention on the institution per se, but used it as a source of respondents. I did attend staff meetings and talk with staff persons, but I did not concentrate on the organization of their activities.

Some of the respondents whom I interviewed in this institution resided in other live-in institutions while participating in programs within this institution. Thus, I received information about these settings indirectly. I made visits to several other institutions, not to find respondents, but merely to get a feeling for their operation.

The second set of data utilized in this analysis was collected and generously made available to me by Warren Breed, his associate Lester Cohen, and their assistants.[6] These data consist of extraordinarily intensive interviews, which were tape recorded and transcribed. These interviews were open-ended, with specific as well as spontaneous topics being covered. The respondents were selected from various rehabilitation institutions, including "half-way houses," in the San Francisco Bay Area. The respondents were chosen by asking for volunteers in each of the various institutions included. They were interviewed at different times from several, up to eight times each. Each interview lasted approximately two hours. Thus, a respondent who had been interviewed six times, for instance, would have engaged in approximately twelve hours of intensive interviewing.

Wherever possible I use excerpts from these interviews for illustration. Most of the interviews which I conducted myself were not tape recorded. None of them were transcribed. However, all of these interviews were directly transcribed, thus they serve much better as illustrations. Most of the codes generated from my analysis were originally "discovered" in the data I collected. This additional data was very helpful in elaboration of codes and as informal verification of my findings. In any event, it was invaluable to my analysis, and saved me a tremendous amount of time in the field. In all, I coded eighty-nine of these interviews, which had been conducted with nineteen respondents.

Combining the two data sets, the respondents ranged in age from the middle twenties to the late fifties. The approximate modal age was in the late forties.[7] All but several of the respondents were male. They were with several exceptions Caucasion (the exceptions being Negro and Latin

American). Most respondents had formerly worked at blue collar and white collar occupations, again with several exceptions. The respondents whom I interviewed myself appeared to be typical of persons availing themselves of the services of that institution. They were not selected for any particular characteristics with regularity, although several times I selected particular respondents because they were female or young. I also selected several respondents because (according to the staff) they were fairly advanced in the rehabilitation process. I made these selections for reasons of theoretical sampling (Glaser and Strauss, 1967: 45-77), as discussed previously. In short, I wanted to ascertain whether or not significant variation would be found within these categories of drinkers.

The process by which I collected my data progressed, generally, as follows: I spent my first several days in the field acquainting myself with the milieu within which I would be conducting my research.[8] I did this not so much to gather codeable data as to ascertain what I was up against regarding data collection, as well as to select a researchable problem (not having entered the research with a particular problem in mind).

After several days in the field, questions began to arise in my mind. I chose one particular question to focus on. I became curious as to how it was that persons ended up entering and seating their lives for long periods of time in the alcoholic rehabilitation milieu. In short, "How did these people get here, and what keeps them here?" This question appealed to me because it contained no preconceptions regarding the phenomenon which is ordinarily referred to as "alcoholism," yet seemed to be very important both sociologically and practically.

During these first several days I was interested also in finding the best locations and times in which to observe and converse with "patients" (as they were called) in the institution. I found it most rewarding to locate myself in a large room sometimes referred to as the "day room." This room contained a pool table, coffee urn, several couches, tables and chairs. Patients spent much of their unscheduled time in this room playing pool, conversing with one another, drinking coffee, playing cards, reading, and so forth. I discovered that most of them welcomed the opportunity to talk with me at length. The activities which went on in this room were merely time filling activities which could easily be interrupted. Therefore, I spent considerable time in this setting.

In this early stage of the research I spent most of my time in this room listening to conversations and engaging in rather casual discussions with patients. I tried to project the image of an "interested party" or casual "friend,"[9] although my identity as a researcher was made known from the beginning. I was treated with deference for several days, after which my presence appeared to be taken for granted. By then I had become "part of the scene."

The data collection could best be characterized as participant observation and unstructured, intensive interviewing.[10] I received much valuable information from overhearing discussions between patients and observing their interaction with one another. Information gained in these manners was fed back into my interviews for elaboration and confirmation.

It is impossible to even guess at the number of interviews I conducted. I started with short conversations, which as I developed rapport and became a taken for granted feature of the setting, became longer and

more formal. It is difficult to ascertain just where the line between "conversation" and "interview" falls.[11] Does one call a two minute encounter which elicits useful information an "interview?" Often such conversations do not even get recorded in field notes. However, later during analysis, they may be recalled and found to be important.[12] The later interviews I collected were very intensive, and ordinarily lasted from two to four hours. These were, of course, more easily identifiable as interviews.

As is routine with grounded research, I began analyzing data shortly after I began collecting it. The codes which I generated from the data were used to direct the course of further data collection, which was then analyzed, and so on. Accordingly, the topics covered and questions asked changed over time. I began developing a list of topics (not specific questions) which I used to guide the interviews. As new topics arose, I added them to my interview guide. The list eventually amounted to ninety-five topics, each of which elicited a number of questions.

Particularly in the early stages, I left the course of the interviews up to the respondents, as much as possible. I took momentary control only when the discussion generated onto topics obviously unrelated to the subject of the research. This seldom occurred, as the respondents talked about what was important, relevant, and interesting to them, which at the time was their drinking and related problems.[13]

Once I began to perceive the process which I eventually came to conceptualize as the "supplanting process," I began collecting data specifically to develop the properties of this process. The data which were made available to me by Warren Breed and Lester Cohen covered such

a broad range of topics in such detail and depth that a great amount of it related to my research. It was therefore very helpful in my analysis, despite the fact that its collection was conducted separately.

As I analyzed the data for codes, I began writing memos regarding the supplanting process and related codes. These memos were eventually sorted into a first, rough draft of the monograph which follows.

To summarize: This research was conducted using an inductive "discovery" research model. The variables and concepts were generated from close inductive coding of the data. As these codes were developed, they were used to direct the ongoing data collection, in a manner which Glaser and Strauss (1967: 45-77) refer to as "theoretical sampling." The unit, or focus, of analysis is a process, referred to as the "supplanting process." The findings of the research are therefore meant to be generalized to this generic process. Questions regarding the extent to which and the characteristic ways in which the supplanting process occurs in particular contexts and populations are a separate matter for further research using entirely different methods than those used here.

This analysis, furthermore, shall concern itself with theoretical, as opposed to descriptive coverage. That is, it shall concern itself with the densification of codes discovered in the data, and integration of these codes into a theory. In short, this is a theory about a process, not a theory about a particular population or other analytic unit.

CHAPTER I NOTES

1. For detailed discussions of how this type of analysis is conducted, see Glaser (1965) and Hadden (1973). Glaser refers to such analysis as the "constant comparative method of qualitative analysis."

2. It is appropriate to note here that concerns over "replicability" inherent in verification research are not inherent in discovery research. A follow up study to a discovery study would logically be conducted using a verification model (there is no need to "rediscover" something). Thus exact replication would not be of concern.

3. Similar in genus to Max Weber's "ideal type," for instance.

4. It is important to note that a basic social process theory is not the only type of theory which can be constructed using grounded theory techniques. For empirical examples of basic social process theories, see Bigus (1972), Glaser (1972), and Hadden (1973). For a formal basic social process theory, see Glaser and Strauss (1971).

5. There are many advantages to process analysis in comparison to unit analysis. However, they are much too complex to adequately discuss here.

6. Breed's and Cohen's research is financed by the National Institute of Alcohol Abuse and Alcoholism (AA00184), and is entitled, Coping with Alcoholism in Mid-Career."

7. The figure is not exact because, once age was ascertained not to be an important property of the supplanting process, concise statistics regarding age were not collected. Age usually came up spontaneously in the course of a conversation or interview, whereupon it was recorded.

8. For a discussion of the researcher's first several days in the field, see Geer (1964). For discussions of gaining entree into research settings, see Dean, Eichhorn and Dean (1967), Kahn and Mann (1952), Lofland (1971), and Schatzman and Strauss (1973).

9. Projecting this somewhat less than straightforward image engendered in me a nagging sense of uneasiness. Although I had a tremendous amount of sympathy and empathy for the respondents, I could not as a researcher give them suggestions, advice and so forth as a friend would -- even if the suggestions and advice were simple and obvious. I felt as if I were playing the role of "friendly researcher," whereas they were playing the role of "friend" in my interaction with them. Olesen and Whittaker (1968: 39-41) refer to this sort of phenomenon as the "friendship dilemma." Davis (1961a) also discusses the guilt researchers might feel regarding their relationships with subjects. My uneasiness was lessened somewhat by the fact that virtually all the respondents enthusiastically thanked me for providing them with an opportunity to talk freely about their problems -- and for listening. Apparently my interviews had some "therapeutic" benefit.

10. For discussions of the general techniques of data collection used in this research, see Denzin (1971), Doby (1967), Filstead (1970), Gordon (1969), Lofland (1971), McCall and Simmons (1969), Richardson, Snell and Klein (1965), Schatzman and Strauss (1973), and Strauss, et. al. (1964).

11. Zelditch (1962) includes the type of interviewing which I conducted under the category of participant observation. For a discussion of the different roles a researcher may play in field observation, see Gold (1958).

12. Lofland (1971: 105) makes a similar observation.

13. For a discussion of "alcohol-related problems" and the uses of the term, see Cahalan (1970: Chapter II).

CHAPTER II

INTRODUCTION

Each of us is subject to a general set of rather stable conditions, elicited by our particular station in life. One's life is greatly affected by whether or not one is married, has children, is female or male, receives a large or small income, resides in a large city or a small town, is a member of one social group or another, is healthy or unhealthy, or is a housewife or a lawyer. Inherent in such statuses are sets of conditions which shape everyday life. If these statuses are altered through what Strauss (1959) and Glaser and Strauss (1971) refer to as "status passages," one's life may be substantially altered. Changes in such conditions may occur gradually, through such occurrences as the advancement of age or progress through an occupational career structure. Or, they may occur more quickly, through such occurrences as conviction for a felony or the onset of an incapacitating illness. When such status changes occur, the conditions of one way of life are supplanted by the conditions of another.

One circumstance under which this exchange of conditions -- which I have referred to as the "supplanting process" -- may occur is through the acquisition of a deviant status, such as "alcoholic." This monograph shall consist of an analysis of the supplanting process as it occurs in one type of deviant career (Becker, 1963: 25-39), which I shall refer to as the "alcoholic career."[1]

My use of the term "alcoholic career" is not unique.[2] However, I use the term in a somewhat specific rather than general sense. The alcoholis career as I shall use it refers to a set of structural and

social psychological conditions and processes which are experienced by and shape the lives of persons to whom the label "alcoholic" is applied. Interaction between the drinker and the world he[3] lives in are important to this conceptualization. It is not just the drinker's behavior, but also the response of others, and his response to their response -- much in the sense of what Lemert (1951 and 1967) refers to as "secondary deviation" -- which are important.

The alcoholic career is a process set in motion and sustained by the interaction between drinkers, the evolution of their "alcoholism," and society.[4] It encompasses a greater range of phenomena than the properties of drinkers and their drinking behavior. Thus, it is more than what Jellinek (1952), for example, refers to as "phases of alcohol addiction." The primary determining variable in Jellinek's model is drinking behavior. The conceptualization of the alcoholic career includes many determining variables, in addition to drinking behavior per se.

It should be noted that progress in the alcoholic career is not directly related to progress in "alcoholism." Phenomena such as amount and frequency of alcohol consumption, and physical and mental symptoms, which from a clinical or medical viewpoint are considered to be properties of "alcoholism," are merely variables in the alcoholic career which vary independently with progress in the career.[5] For instance, experiencing a case of "the shakes" may prod one drinker to seek professional help regarding his drinking, whereas it may have little effect on another. In short, "alcoholism" (in its clinical or medical sense) is merely one of many variables in the alcoholic career, not by itself a determiner.

It is not uncommon to find persons within the alcoholic career who have abstained from drinking alcohol for long periods of time, sometimes years, yet remain active participants in the career (through contact with rehabilitation agencies, maintaining an "alcoholic" self-identity, and so forth). They may have gained control over their drinking -- in a clinical or medical sense, they may have been "cured" of their "alcoholism" -- yet they remain "alcoholics" in terms of their position in the social world. This point will become more clear later. But, for the present, it should be pointed out that one can remain an "alcoholic" in one's own eyes or in the eyes of others after the cessation of drinking. This identity may be either detrimental or beneficial in a therapeutic sense.[6]

On the other side of the coin, some persons drink large amounts of alcohol chronically for many years, experience the physiological symptoms ordinarily associated with alcoholism, yet make little progress within the structure of the alcoholic career. They manage to control the consequences of excessive drinking to the extent that the basic conditions of "normal" (i.e. non-alcoholic) life are not supplanted by the conditions of alcoholic life. Thus, despite the fact that their "alcoholism" may have progressed substantially, they live out their lives essentially within normal social networks.

The alcoholic career can be conceived of as trajectory. It seems generally to be conceived by the general public and rehabilitators as a downward pattern of social, economic, physical and mental deterioration.[7] This conception typically has it that once the career is entered, it leads almost inevitably downward, with little variation in course or

consequence -- a one way ticket to hell, so to speak.[8] This conception is rather overdetermined. The alcoholic career has strong downward potential, however considerable variation occurs.

The alcoholic career begins when a drinker begins to entertain suspicions concerning the possibility that his drinking behavior may be producing deleterious effects, or when persons who are significant in his life (family members, employers, friends) begin to perceive his drinking as being in excess of ordinary in its frequency, intensity and/or consequences. In essence, the career begins at the approximate time that a person's drinking behavior is set aside for special notice and concern. The career ends either at death, or when a person resumes a non-alcoholic (or ex-alcoholic) identity and resumes full participation in non-alcoholic life.

Alcoholic careers ordinarily take place in four general settings, which I shall refer to as normal social networks,[9] skid row,[10] the alcoholic rehabilitation milieu (alcoholism related agencies and institutions), and other alcoholic milieus (a sort of geographically non-specific catch-all category which includes bars, the fringes of skid row areas, inexpensive hotels, or wherever else alcoholics conduct their daily lives). Individual drinkers process out their own personal alcoholic careers within these settings.

Movement between these settings commonly occurs. Such movement varies directionally. In general, movement away from normal social networks, once they have been departed, is restricted. Movement from skid row to normal social networks is effectively non-existent (Wiseman, 1970: 217-238). Movement from the rehabilitation milieu to normal social

networks is greatly impeded (to be discussed in detail later). Movement from other alcoholic milieus to normal social networks is sometimes less impeded, being contingent upon particular circumstances (duration of absence from normal social networks, willingness of relatives and friends to accept a return, etc. -- what Wiseman (1970: 223-226) refers to as "social margin").

Movement from normal social networks, the rehabilitation milieu, and other alcoholic milieus to skid row is impeded primarily by the knowledge and skills necessary to "make it" in that setting,[11] and by the personal "self-respect thresholds"[12] of individual drinkers. Movement from the skid row milieu to the rehabilitation milieu is restricted primarily by gate keeping devices set up by rehabilitation agencies, as well as requisite knowledge and skills for "gate crashing." The permeability of gate keeping devices varies from institution to institution, and frequently at different times within any given institution (to be discussed in detail later). Movement from other alcoholic milieus to the rehabilitation mileu is less restricted than from skid row. Persons coming from non-skid row, milieus are generally seen as more "rehabilitatable" than those from skid row, thus their entry into rehabilitation settings is viewed more positively. Movement from normal social networks to the rehabilitation milieu is largely unrestricted from the rehabilitator's point of view. Gate keeping devices are ordinarily designed in such a way that movement in this direction is encouraged. Clients coming from normal social networks are seen as those who are most rehabilitatable, not having yet "slipped too far." From the drinker's point of view, reluctance to enter the rehabilitation milieu is engendered

by individual self-respect thresholds and aversion to the "alcoholic" label. Reluctance to enter the rehabilitation milieu is often manifested because of what such entry implies about one's character. Cahalan (1970: 6) and Reinert (1968: 23) point out that certain rhetorics frighten potential clients away from rehabilitation services(particularly the dictum which asserts, "once an alcoholic, always an alcoholic").

Movement from normal social networks to alcoholic milieus (other than skid row and the rehabilitation milieu) is generally unimpeded. Many of the respondents in this study moved in this direction as they disengaged from active participation in normal social networks. Movement from the rehabilitation milieu to alcoholic milieus is quite routine as drinkers go through the "revolving door," in and out of rehabilitation institutions. Movement from skid row to other alcoholic milieus generally consists of drinkers who make temporary sojourns to skid row, then return to their ordinary settings.

The nature of individual alcoholic careers as they are performed within these separate milieus are quite different, as they are shaped and affected by the separate sets of conditions present in each individual milieu. The day-to-day existence of careerists[13] in these milieus, accordingly, differs substantially. The priorities, concerns, beliefs about drinking and attitudes and perceptions towards one's own drinking also differ appreciably.

This analysis will focus its attention primarily upon events which take place in normal social networks and the rehabilitation milieu. I shall focus upon the process through which movement from normal social networks to the rehabilitation milieu occurs -- i.e. the "supplanting process" by which a drinker's life in normal social networks is supplanted

by life in the rehabilitation milieu. The analysis shall include discussions of the general phases of the supplanting process as it occurs in the alcoholic career. The major phases of the process include drinkers disengaging from participation in normal social networks, then entering the rehabilitation milieu and becoming receptive to rehabilitation services (for many reasons, to be discussed later), whereupon the priorities of their lives shift from those of a drinking career to those of working at rehabilitation. A major consequence of efforts at rehabilitation is that they come to seat their lives within the rehabilitation milieu. Eventually they begin to make plans to return to normal society, but for reasons to be discussed later, such plans are usually doomed to failure, whereupon drinkers get locked into their alcoholic careers, despite their best efforts to get out.

The supplanting process as it occurs in the alcoholic career has both major structural and social psychological properties (which themselves form sub-process). A careerist's progress in the career may be conceived of both in terms of what set of exterior conditions he is encountering and what internal experiences he is undergoing, as well as the interaction between these external and internal phenomena.

In short, this monograph will address itself to the question of how drinkers get from one place to another, both physically and mentally, and what happens when they get there. It will focus on the grounded structural and social psychological variables responsible for this process. A major aim of the analysis will be to transcend description and develop a substantive theory (i.e. a set of integrated, grounded concepts) which will afford an understanding of the subject matter.

The analysis will not focus on the question as to "why" (in a psychological sense) careerists engage in what are clinically considered pathological drinking behaviors. Psychological propensity to drink will be assumed. Given the assumption of this propensity, the question remains as to what happens to drinkers such that they get labeled "alcoholic," and eventually end up as clients of rehabilitation agencies.

Before I advance to a discussion of the early phases of the supplanting process -- in particular, the process by which drinkers are disengaged from normal social networks (through being eased out and the erosion of limits on behavior) -- it is appropriate to indicate my working definition of the term "alcoholic" (and its variants such as "problem drinker"). I shall not enter into the debate regarding what constitutes a proper "scientific" or clinical definition, apart from the way the term is used in the everyday world.[14] When I use the term I shall regard it as a common sense social category,[15] which when applied to individuals has consequences for their lives. The term as I shall use it implies no fixed properties. In short, for this analysis, as Wittgenstein might have it, an alcoholic is what people say an alcoholic is.

CHAPTER II NOTES

1. For other uses of the "career" concept in sociology (aside from the substantive study of occupational careers), see Goffman (1961) and Weinberg (1966). The following statement from Goffman (1961: 127) aptly describes the advantages of its use:

> Traditionally the term career has been reserved for those who expect to enjoy the rises laid out within a respectable profession. The term is coming to be used, however, in a broadened sense to refer to any social strand of any person's course through life. The perspective of natural history is taken: unique outcomes are neglected in favor of such changes over time as are basic and common to the members of a social category, although occurring independently to each of them. Such a career is not a thing that can be brilliant or disappointing; it can no more be a success than a failure....One value of the concept of career is its two-sideness. One side is linked to internal matters held dearly and closely, such as image of self and felt identity; the other side concerns official position, jural relations, and style of complex. The concept of career, then allows one to move between the self and its significant society, without having to rely overly for data upon what the person says he thinks he imagines himself to be.

2. The term is used specifically, for instance, by Warren Breed in his National Institute of Alcohol Abuse and Alcoholism research project (data from which was used in this analysis), "Coping With Alcoholism in Mid-Career" (AA 00184).

3. I shall, for simplicity's sake, refer to the subjects of this analysis in the male gender unless I am referring to a specific female respondent. The vast majority of the respondents were male, although several of them were female. I found no substantial differences between the alcoholic careers of the men and women respondents. However, the fact that most of the respondents were male, by virtue of there having been very few females in the institutions in which data were collected, indicates that differences must exist. It appears that males are more prone to the supplanting process than females.

4. This is, of course, the general substantive area of what has come to be called the "labeling perspective." Lofland (1969), Matza (1969), and Schur (1971), amongst others, provide congent expressions of the labeling position.

5. Goffman (1961: 134) makes a similar note regarding mental patients.

6. For general statements on this position, see Lofland (1969) passim and Goffman (1963) passim.

7. As will become evident in the following chapters, the alcoholic career appears to be a major mode of downward mobility in American culture.

8. This belief which seems to be general amongst rehabilitators might easily be confirmed by the fact that their clients are often those persons who have "hit bottom" -- i.e. their sample is loaded with the "failures."

9. The term "normal social networks" refers to family, occupational, friendship networks, and the like -- the networks within which most working class and middle class Americans live out their lives. This is in contrast to social networks which are alcohol oriented, such as those one might find in a bar subculture, in a rehabilitation institution, or on skid row.

10. Many excellent studies of skid row have been accomplished. Among those most pertinent to this analysis are Bogue (1963), Spradley (1970), Wallace (1965), and Wiseman (1970).

11. For a pertinent discussion of knowledge and skills and their relationship to deviance, see Lofland (1969: 82-84 and 199-202).

12. The concept "self-respect threshold" refers to the point at which a drinker "draws the line" in regards to what behaviors he will engage in. He considers behaviors beyond that "line" to be "beneath" him, to the extent that if he were to engage in them his self-respect would suffer extensively.

13. I use the term "careerist" here to refer to persons who are experiencing an alcoholic career, not those engaging in an occupational career.

14. For discussions of the various definitions and usages of the term "alcoholic" (or "alcoholism"), see Bowman and Jellinek (1941), Cahalan (1970), Keller and Seeley (1958), and Marconi (1959).

15. An emphasis on social (common sense) meanings is, of course, a major foundation of symbolic interaction and phenomenology in the traditions of George Herbert Mead (1934 and 1938) and Alfred Schutz (1962 and 1964).

CHAPTER III

DISENGAGING

The process through which drinkers are disengaged from active participation in normal social networks consists of an interaction between two variables, "being eased out" and "erosion of limits on behavior." These two variables are themselves processual in nature. Although they interact empirically, it is necessary to distinguish them analytically so as to be able to scrutinize their respective properties and how they interact with one another.

The term "being eased out" refers to a process in which the tolerance particular social networks have regarding a careerist's drinking behavior and its consequences gradually diminishes. The drinker is more and more excluded from participation in ongoing affairs of the network, and eventually (as in the case of the respondents) possibly terminated from participation altogether.

The easing out process occurs over months or years. Its duration varies according to the extent to which individual drinkers' social networks tolerate excessive drinking behavior and its consequences. Probable consequences of being eased out are occupational and residential downward mobility.

The term "erosion of limits on behavior" refers to a process in which controls, or limits, on a careerist's drinking behavior gradually disintegrate. Such limits are imposed from within (by self-respect thresholds, for example), as well as from without (normal social networks provide outside limits on behavior such that one is not free to drink heavily without consequence). As the eroding process progresses, limits

on behavior diminish.

The eroding process is ordinarily initiated as a consequence of the easing out process. However, once they are both operating they interact with one another in an accelerating pattern in which one promotes the other.

In this chapter, I shall discuss the process of being eased out, the downward mobility which ordinarily results, and the erosion of both outside and self-limits on behavior.

BEING EASED OUT

The easing out process is ordinarily initiated by violations of prescriptive or proscriptive expectations -- more specifically, by not meeting up to the requirements of full participation in a particular social network or by engaging in drinking related behaviors which are perceived as reprehensible.

Membership in a social network carries with it certain responsibilities, tasks, obligations, and so forth. If these are not fulfilled "adequately," according to the general expectations of other members of the network, thoughts about expulsion may be aroused. Such thoughts are particularly likely to occur if the violator's behavior is disruptive to the ongoing activities of the network. For example, heavy drinkers who develop a history of tardiness, absenteeism, or mistakes on their jobs often eventually lose them. In the same light, heavy drinkers whose expected amount of "family time" (i.e. time required by family obligations and responsibilities) is usurped by frequent drinking and drunkenness often find themselves in the midst of marital discord and eventual separation from the family.[1] The more time a heavy drinker spends engaging in drinking activities, the less time he has available to engage in family oriented activities.[2] It is evident, then, that what might be regarded as "inadequate" behavior may kindle the easing out process.

Behavior defined as "improper" may also initiate the process by which a drinker's membership in a network comes to be terminated. This may occur in the form of a buildup of displeasing incidents and behaviors, or as a consequence of one particularly reprehensible act. Incidents and behaviors commonly mentioned by respondents include beating one's

wife or children while drunk, being arrested (for drunk driving, participating in a "barroom brawl," etc.), acting belligerent or "making a fool of one's self" during social occasions, upsetting the family budget by spending excessive amounts of money on drinking activities, breaking promises to cut down on drinking, drinking on the job, and berating fellow employees or supervisors while under the influence of alcohol. Such behaviors may be embarrassing, uncomfortable, and even costly to those who witness them and are affected by them.

In the early phases of the easing out process, a drinker's behavior may be disapproved of, yet generally tolerated. A social network's outside limits on behavior may be stretched to more closely match the drinker's behavior. This may be done, not so much to accommodate the drinker, as to maintain a semblance of harmony.[3] Also, a promise or actual attempt at self control may forestall action against him.

As the drinker's contribution to the network decreases, adjustments may be made. For instance, his wife may begin to assume more responsibility for providing family income and other of his former tasks.[4] Or, his employer may reduce the amount of work expected of him or shift him to a less "responsible" position. One respondent reported that his employer went so far as to arrange a less demanding job with another company for him. His performance had degenerated to a point at which it had become too costly, so, as he related it:

> My boss called me in and said, "John, I think you better take a lighter job." A lot of things had built up because of my drinking -- lack of ability -- my ability was going downhill. He said, "I suggest that you go over and work for Art Johnson," who had a big firm, "They might like to have you do some work for them. They are a smaller firm and the load won't be so large on you, and you can get into a

> little retail selling over there....It would involve your taking a cut in salary, but you know everybody over there, they are fine people."

His employer had already arranged for his reemployment in the new position (which he eventually lost, as well).

If a drinker's "reprehensible" behavior continues, tolerance for his presence may gradually decrease. He may increasingly come to be referred to with such terms as "drinker" or "alky." His drinking reputation may grow. As this reputation grows, it becomes more and more likely that he will be excluded from affairs of his normal social networks. He may, for instance, find it increasingly difficult to hold or find employment.[5] As one respondent related it:

> ....within two years I'd gone from having a pretty good reputation as a bartender to having a pretty bad reputation. I was having trouble getting jobs, I was doing more drinking while I was working 'cause I didn't give a damn about the job. I used to have pride of my work behind the bar. I used to think, "Well, being a bartender isn't much, but I'm going to be a good one if I'm going to be one." And I was. I worked in good houses -- could work anyplace. And, the people that were in the county, it'd be in a small county and everybody gets to know you after awhile. I could do the job so there was no trouble getting a job. But, it gradually got so I couldn't get jobs. I'd go around working in bars that I hadn't even drank in. The last one, I had never been in the door until I went to work there. Wouldn't go in the place -- was a real dive. And, I got fired from there, so I just about worked my way out of the county.

Eventually a drinker may be relegated to the position of being an occupant, but not a participant in his normal social networks. He may, for instance, be allowed to remain in the family home, sleeping on the couch and eating meals if he happens to be home when they are served. At the same time, he may be excluded from decision making and active

participation in the daily affairs of family life. His family may, in effect, live their lives without him, despite his physical presence.

When important others begin to perceive the drinker's behavior as part of an irreversible pattern, or grow weary of the problems generated by his behavior, he may be completely excluded from participation in his normal social networks. At this point, he essentially has no family and few, if any, non-alcoholic friends. He may remain employed, but, if so, in a job requiring few skills, little responsibility, and little pay. For him, the easing out process is complete.

Initially, being eased out of normal social networks may not be particularly displeasing to a drinker. The negative reactions of others to his drinking behavior may, however, be quite displeasing. Being eased out may provide relief from "nagging" wives, "preaching" relatives, and "complaining" employers. At this time, immoderate drinking may not be particularly problematic. The drinker may in fact welcome the opportunity to drink and/or visit bars with minimal restraint. The negative aspects of exclusion from normal social networks may become apparent only later in the career.

Some respondents reported having withdrawn from normal social networks on their own initiative. Some did this to avoid the "nagging," "preaching" and so forth which had become characteristic of their contacts with these networks. Others, however, withdrew because they felt "ashamed" of their behavior or regretted the effect it was having on others. They wanted to avoid embarrassing themselves and others, or placing others in the awkward position of having to react negatively to their drinking behavior. It is apparent, then, that disengaging may not

always be initiated involuntarily. The drinker, as well as those around him, may be agreeable to his withdrawal.[6]

Individual social networks vary according to the extent to which they tolerate drinking behavior and its consequences. Thus, a particular drinker may be eased out of his family, for instance, long before he is eased out of his networks for infractions which are mild compared to those of another drinker who does not get eased out. It is evident, then, that a major reason one drinker may become subject to the supplanting process whereas another may not, is that their respective normal social networks have differing degrees of tolerance regarding excessive drinking behavior and its consequences.[7] Those who end up having their normal life styles supplanted by an alcoholic life style may, then, not necessarily be those with the most abusive levels of drinking behavior, but those whose normal social networks have lower tolerance levels for drinking behavior.[8] Some drinkers may act out their entire alcoholic careers and live out their entire lives within normal social networks which stretch their outside limits on behavior such that the drinker's behavior is begrudgingly tolerated. Other drinkers who may engage in rather moderate drinking in comparison, may be eased out of their networks with dispatch.

It need also be mentioned that problematic drinking behavior may be a <u>consequence</u> of being eased out of normal social networks for reasons unrelated to drinking.[9] Several respondents, for instance, reported not having had problems with drinking until their wives initiated divorce proceedings against them for reasons largely unrelated to drinking. According to them, this triggered substantial increases in their drinking behavior, to the extent that it became problematic. The divorce not only

increased their inclination to drink, but also resulted in elimination of the controls which marriage had over their behavior, including their drinking behavior. They thus became subject to the same process of erosion of limits on behavior as other drinkers, regardless of the origins of their problematic drinking behavior.

Downward Mobility

One of the immediate consequences of being eased out of one's normal social networks may be downward mobility, both occupational and residential. After a drinker has been fired from jobs in his normal occupation several times and has begun to acquire a "poor" job history, he may be unable to cover up his employment history, even if he is able to cover up his drinking history.[10] Some respondents reported not seeking employment in their usual occupations to avoid acquiring an irreversible poor reputation and foreclosing the prospect of being reemployed in the future when they "get themselves straightened out."

Once a drinker is unemployable or chooses not to attempt employment in his normal occupation, he must seek it elsewhere (if he finds it necessary or desirable to remain employed). This is ordinarily done by fabricating an employment history which leaves out one's undesirable record of absenteeism, tardiness and poor performance, and searching for a job which involves minimal responsibility and skills (and consequently a low salary). Such jobs are fairly easy to acquire, as they do not ordinarily require consistent employment histories which may be checked out. Low skill jobs also offer minimal hindrance to one's drinking, and enough of a salary to keep one in "drinking money" and the basic necessities of living.

As a drinker progresses on a downward trajectory occupationally, his resources begin to shrink such that he may find it necessary to find inexpensive housing. He may progress from living at home with his family, to living temporarily with a relative, to renting an apartment, to renting a "sleazy" hotel room, and possibly even to "out on the street."[11]

Occupational and residential downward mobility often results in a drinker moving near or into a skid row area, because of the suitability of such areas for an alcoholic life style. This may or may not include participation in the loop (Wiseman, 1970) (few of the respondents had participated fully in the loop).

Living in or near a skid row area serves several functions for the drinker who has been eased out of his normal social networks. Firstly, housing is relatively inexpensive -- commensurate with the drinker's now diminished resources. Secondly, housing can be easily rented on a short term basis, which allows for mobility, spontaneity, and few obligations -- compatible with the drinker's sometimes impulsive behavior while drinking. Thirdly, drunkenness is tolerated to a large extent. Outside limits on drinking behavior are minimal. They are ordinarily limited to whatever limits are imposed by the context in which one drinks. For instance, if one drinks in a bar one may be expected not to engage in loud or aggressive behavior, or to appear "too drunk." In the public regions of skid row (sidewalks, doorways, etc.), a drinker is subject to what Bittner (1967) refers to as "peace keeping activities" of the police. According to Rubington (1968a and 1968b), even drinking in "bottle-gangs" entails controls over behavior. However, outside limits on behavior in the skid row milieu are lax enough that some respondents reported having made sojourns to skid row areas, lasting several days or weeks, so as to be able to drink uninterrupted without interference from family or non-alcoholic friends.

Fourthly, employment compatible with heavy drinking behavior is generally available in skid row areas. Respondents reported being employed as janitors, dishwashers, telephone solicitors, and the like.

Employers in skid row areas often use alcoholics as a pool of inexpensive labor, particularly for jobs which can tolerate high turnover rates. If an employee fails to show up, another can easily be hired. One respondent reported having worked as a telephone solicotor. If an employee neglected to show up for work, his employer simply hired another. If the previously absent employee showed up several days later, he would hire him again with no qualms. The respondent reported that he worked for this employer several months in succession. Over this short period of time, he became a senior employee (in terms of time seniority) and was given the job of supervisor. He eventually went on a drinking binge and neglected to show up for work for an extended period of time. He returned and was rehired.

In short, housing and employment in the skid row milieu is, to a large extent, tailored to fit persons (including alcoholics) who are unattached to normal social networks. Alcoholics are provided housing and employment compatible with their drinking behavior, in exchange for comparatively meager amounts of money and their (cheap) labor).[12]

EROSION OF LIMITS ON BEHAVIOR

Outside Limits

Normal social networks play a fundamental governing role in our lives, in that they provide sets of outside limits on our behavior.[13] They provide prescriptive and proscriptive behaviors in the form of daily routines, demands, obligations, goals, activities, attachments, responsibilities, tasks, and so forth. In regards to the family, a person is expected to be home at certain times, spend time with children, participate in certain festive occasions (birthdays, Christmas, etc.), perform maintenance activities in the home, etc. In regards to employment, a person is expected to show up regularly, arrive and leave at specific times, perform work tasks competently, etc.

In essence, normal social networks provide behavioral boundaries, within which one is expected to behave in certain fashions, and beyond which one may not traverse without risking negative consequences. To be sure, these boundaries are not always clear and are often rather flexible. But, they nonetheless exist in the minds of members. A drinker may be aware, for instance, that if he arrives home drunk and late for dinner his wife will "nag" at him and possibly impose more severe sanctions, such as withholding sex.

So long as we remain active in normal social networks, their outside limits will have substantial influence over our behavior. A very large percentage of working and middle class persons' time and activities are spent in family and occupational networks. For persons in these categories, these two social networks constitute probably the most fundamental limits on behavior on a day-to-day basis. In this regard, a wife or employer

may exert more control over one's behavior than those we ordinarily refer to as agents of social control (i.e. policemen, judges, etc.).

Outside limits on behavior provided by family and occupational networks, rather obviously, serve as moderating influences over drinking behavior. As one respondent put it:

> I think, whether I was aware of it or not, certain obligations do put controls in our drinking. We control it better when we have these obligations.

In addition to general requirements, obligations, and so forth, normal social networks define limits in regards to drinking per se. It is expected that one will refrain from certain behaviors in regards to drinking. One is expected not to arrive for work drunk or with a hangover severe enough to affect job performance. One may be expected not to drink heavily around the house or in front of children. Or, one may be expected to limit drinking to "special" occasions or time periods, such as parties, holidays, or weekends. Although drinking may be encouraged by others in a network (businessman's lunch, "one more for the road," etc.), it is nonetheless expected to be kept within certain limits. As I mentioned previously, these limits vary according to the tolerance of specific networks. One drinker's family, for instance, may tolerate, or even encourage heavy drinking,[14] whereas another's may attempt to forbid it altogether.

As a drinker is eased out of his normal social networks, his behavior becomes less and less constrained by their outside limits. If a wife begins to plan meals around her drinking husband, it becomes less important that he show up for them. Thus, failing to show up begins to have fewer consequences. This may result in the drinker more

frequently saying to himself, "Oh what the hell, just one more drink," and arriving home late, or not at all, for a meal. Thus, the moderating effect which meal time (or whatever) had on his drinking behavior begins to erode.

Once this process of interaction between being eased out and erosion of limits on behavior is set in motion, it becomes self-feeding. A drinker is required or allowed less and less to participate in the on-going affairs of his normal social networks. As this occurs, the limits which these networks afford over his drinking behavior begin to erode. As they erode, his drinking behavior will likely increase (or at least become more blatant). This may result in his being further eased out, which will result in fewer limits on his behavior, and so on, in an accelerating cycle.

Furthermore, the erosion of limits on behavior of one social network may affect another network in such a way that a drinker may begin to be eased out of the second network as well. This occurs because various social networks have interdependencies. For example, family networks rely upon occupational networks for economic support. Thus, if a person is eased out of his occupational network, his family network will be affected. Conversely, if not for the economic needs of family networks, participation in occupational networks may be regarded as less than necessary. A drinker who has been eased out of his family network may find little reason to work steadily.

It follows, then, that the erosion of limits on behavior of one social network may lead to an increase in drinking behavior, and consequently to being eased out of other networks and loss of the controls which these networks afford.

> Well, yeah, it's rather simple. Say when I got off work at six in the evening, I'd stop in some bar and have a few drinks, and then I'd go home, cause I was supposed to go home. Having a home and supposed to go there did keep a certain amount of control over me. But once I was on my own and I went in a bar and had a few drinks, I didn't have to go home at any particular time. I mean there wasn't anybody that really cared whether I went home or not, so I started sitting around drinking more and associating with people that didn't have to go home either, or didn't have any particular home to go to. Same thing if I woke up in the morning and had a little hangover. I'd woke up mornings and had hangovers for years, you know, but I got up and went to work. My wife went to work. But I thought, "Oh to hell with it, I don't want to go to work." So, I'd take three, four, five days off and I'd lose my job. It didn't seem to bother me. I'd get another job. I was only responsible to myself, you know, for a couple of years. And, if you're drinking and only responsible to yourself, you don't have as much desire to put out as much. You know what I mean? Maybe some people like to acquire things just for themselves, but me I didn't seem to have much interest in it. I had enough money, I had a place, and the pattern just evolved around working to get enough money to drink. And, it was just a gradual downhill -- I'd do more drinking and less working.

A drinker may, himself, remove outside limits on his behavior, simply by choosing to disregard them and the consequences of violating them. A number of respondents reported reaching a critical point at which they decided, "to hell with it," and simply began not to care what wives, employers, co-workers, friends, neighbors, etc. thought or did regarding their drinking behavior. At this point they began drinking much more openly (many up to this point had attempted to hide their drinking), increased job tardiness and absenteeism, began frequently missing meals, and so forth, pretty much without regard to consequence.

In any event, once a drinker is disengaged from active participation in his normal social networks, and thus loses the limits on behavior

provided by them, the door is wide open for rapid acceleration of his drinking behavior. At this point, major obstacles to increased drinking are removed. He no longer has to be in particular places at particular times to do particular things. He is free of time and activity requirements of family and occupation. To a great extent he has nobody to answer to but himself. Thus, he may follow his impulses freely.[15]

The most fundamental outside limits on behavior for a drinker, assuming he wants only to drink, are alcohol supply and physical endurance. Many respondents reported ending drinking binges only when their bodies could no longer endure further drinking, or when their money ran out.

For those with the skills and knowledge, getting a drink when money was depleted was rather easy.

> That's one thing you can get in this town. You can get a drink where you can't get a cup of coffee. You go downtown there around Sixth Street, Fourth Street, or something. Guys in there are soft. They got a bottle, they think you want a drink, they'll offer it to you. You don't have to ask them. You gang up and somebody else will come along with another one.

The most ultimate outside limit on drinking is physical endurance. In short, the human body can only accept a certain amount of alcohol or endure a limited period of time of inadequate rest and nutrition. Beyond these limits, illness, or even death, may result. For some, it may be only at these points that drinking is stopped.

Self-Limits

In addition to limits imposed from without, each of us has certain internal, or self, limits which we impose upon ourselves. Self-limits are individualized, and therefore apt to be quite different from one

individual to another. They may also be contextual. That is, one may refuse to engage in a particular behavior in one context, but have few reservations regarding the same behavior in other contexts. For instance, a man may refuse to utter particular "swear" words in the presence of women, yet utter them profusely in all-male situations. Similarly, a heavy drinker may refrain from appearing drunk in front of his children, but have few reservations about appearing drunk in front of his wife.

The strongest self-limit a drinker may have regarding drinking behavior is what I have referred to as "self-respect thresholds." Many drinkers refuse on principle to engage in certain behaviors. Engaging in these behaviors may have severely determental consequences for their self-respect. Behaviors frequently mentioned by respondents include "bumming," stealing, drinking fortified wine, drinking with "winos," drinking on the job, and drinking in front of children.

Self-respect thresholds may remain undefined or below the level of awareness up until the time at which they are reached. A drinker may do something or have something happen to him which may act as the proverbial "last straw". He could not have predicted beforehand that this occurrance would constitute his self-respect threshold. Self-respect thresholds may also, of course, be very conscious limits.

Although they are generally unmalleable, self-respect thresholds may gradually change over time with any given drinker as his alcoholic career progresses. They may become more consciously discriminating, such that a drinker may say to himself, "I may have done that at one time, but I won't stoop to that level again."[16]

Self-respect thresholds may also gradually erode over time. As a drinker gets farther away from active participation in his normal social networks, behavior which he at one time felt to be beneath his dignity may come to be acceptable (even though possibly distasteful). One behavior which frequently gets redefined is drinking fortified wine. When resources begin to dwindle, it may become necessary to drink less expensive alcohol. Previous reluctance regarding drinking fortified wine may then begin to fade.

Some respondents reported reaching a point at which they effectively had no self-limits on their behavior at all. They simply did not care what they did or what happened to them.

CHAPTER III NOTES

1. For a detailed discussion of the process by which families of male alcoholics adjust to the problems generated by alcoholic husbands and fathers, see Jackson (1954).

2. This phenomenon of "unavailability" was first pointed out to me by Mary Ogles and Richard Ogles in personal conversation.

3. Sampson, Messinger and Towne (1962) report a similar phenomenon in regards to mental patients and their families.

4. For a detailed discussion of this phenomenon, see Jackson (1954).

5. For a discussion of the job behavior of heavy drinkers and the ways in which occupational type influences the way alcoholism is expressed, see Trice (1962).

6. Similar patterns of behavior are reported as general reactions amongst other "social pariah." See, for example, Goffman (1963) Ray (1961), and Rubington (1964).

7. Some drinkers may also have sufficient power within a particular social network to successfully resist being eased out. However, power is a variable unmentioned by the respondents in this study. Most of them had been blue collar and white collar workers, and did not wield such power. Those persons with enough power to resist being eased out would likely be able to seek private counsel, if necessary, and avoid public institutions.

8. Mulford (1964: 646) notes that "whether an individual's drinking leads to trouble depends as much or more upon the reactions of others as it does upon his own actions."

9. Similarly, personality characteristics commonly assumed to be causal variables in alcoholism, may in fact be consequences, inasmuch as they change over the evolution of a drinking problem (Blume and Sheppard, 1967).

10. Women respondents reported having few problems with employment histories. They were able much more easily to cover up poor employment records. Men in American culture are expected to maintain steady employment (particularly in the middle class), except during legitimate crises such as illness. Alcoholism is seldom considered a legitimate crisis as far as employment goes. Women are not expected to maintain employment with regularity. Thus, gaps in employment histories and poor employment histories can easily be covered up by claiming one was "a housewife." Furthermore it is generally easier for women to qualify for various forms of public assistance (particularly if they have children). This may be one of the variables which partially accounts for the disparate

ratio between men and women regarding patronage of alcoholic rehabilitation agencies. It may simply be more necessary for men to patronize them and accept the "alcoholic" label inherent in this patronage in order to acquire the resources which these agencies offer.

11. For discussions of the various sleeping places on skid row, see Spradley (1970: Chapter IV) and Wallace (1965: Chapter III).

12. This is not to say that this exchange is necessarily "just." Respondents reported feeling that the exchange constituted "exploitation" on the part of employers. As one respondent related it:

> I mean, no matter if they've been here for years, their big thing is, which they are in their own heart and I guess in ours too, is that like a grab bag they don't know what they're getting, and they always think that they are helping you. They work your butt right to the ground, but it isn't -- they're looking at it as "I'm doing something to help you" -- so consequently you should do twice as much for your stinking two dollars.

13. For general treatments of the controlling roles enacted by one's social networks, see Gerth and Mills (1953) and Shibutani (1961).

14. For discussions of the effects which others may have upon one's drinking behavior, see Haer (1955), Price (1945), Trice (1956), and Wellman (1955).

15. Furthermore, the loss of one's job and disintegration of one's marriage may lead to depression, guilt feelings, boredom, and the like. These responses may act as "triggers" for more frequent drinking episodes, which at this point can occur without being impeded by the outside limits on behavior imposed by family and occupational networks. Thereby a self-feeding process is set in motion in which problems trigger drinking, which occasions further problems, which trigger more drinking, and so on (Expert Committee on Mental Health, 1952).

16. Self-respect thresholds may also function as a drinker's last vestige of self-respect. He may say to himself, "I may have done some terrible things, but at least I haven't done that."

CHAPTER IV

ENTRY AND RECEPTIVITY

Up to now, I have discussed the variables which comprise the first phase of the supplanting process as it exists in the alcoholic career -- namely those structural variables involved in drinkers disengaging from active participation in normal social networks. My next major task shall be to discuss the variables involved in the second general phase of the supplanting process, during which drinkers come to enter the rehabilitation milieu and become receptive to the rehabilitation services offered within.

Entry and receptivity need to be separated analytically. Firstly, they may or may not occur simultaneously. Secondly, entry is a physical phenomenon, whereas receptivity is a mental orientation which may occur either in or out of the rehabilitation milieu. Some drinkers enter the rehabilitation milieu <u>because</u> they have become receptive to rehabilitation services. Others first enter for pragmatic reasons, unrelated to long term rehabilitation.

I shall first discuss the phenomenon of pragmatic entry. Following this, I shall discuss the variables which lead up to receptivity to rehabilitation services.

PRAGMATIC ENTRY

The term "pragmatic entry" refers to instances in which drinkers enter the rehabilitation milieu for reasons unrelated to rehabilitation. In addition to being a place where one can find rehabilitation services, the rehabilitation milieu is a place where one can find resources,[1] a place where one may go temporarily to recuperate, a place where one can "lounge" and enjoy the companionship of "people like me," and a place where one may go in lieu of jail (a choice commonly given by judges).

By entering the rehabilitation milieu, a drinker may gain immediate resources, such as food, a bed, or medical care. If he continues contact with the rehabilitation milieu, as an outpatient, he may have these resources available whenever he may need them. One respondent, a woman, disclosed to me that she had not drunk in several years, but maintained enrollment in an outpatient program so as to be able to receive prompt medical care and emergency resources. She was qualified for medical services as a welfare recipient, but claimed welfare services were inadequate and slow. The medical care she received in the alcoholic rehabilitation milieu was prompt and adequate to her satisfaction. She also used the resources of the rehabilitation milieu to supplement her welfare income. Towards the end of the month when money was low, she ate meals in the institution where she had outpatient status.

By maintaining at least periodic contact with the rehabilitation milieu, a drinker may gain monetary reward. In the location where this study was carried out, "alcoholism" was officially defined as a disabling illness. Persons willing and qualified to receive the stigmatizing

"alcoholic" label could receive monthly disability payments. Thus, for some, the alcoholic career may become a "job," for which one receives money in exchange for periodic contact with the rehabilitation milieu.

By residing in an institution for a period of time, a drinker may also be able to save whatever cash he may have (by not having to pay for room and board, etc.), so as to be able to finance an extended drinking episode.

Another function the rehabilitation milieu may serve is as a place to recuperate from a drinking episode. During a stay in the rehabilitation milieu, a drinker may receive necessary medical care, nutrition, and rest to be able to begin his next drinking episode in relatively good health.

Some drinkers use the rehabilitation milieu as a place to "lounge." This setting may provide them with leisure activities, such as art or ceramic work (often called "occupational therapy"), and it may provide them with conversation and companionship. Many respondents related to me that they enjoyed stays in the rehabilitation milieu because it enabled them to be with "people like me."[2]

Institutions which were often used as places to lounge were referred to by the respondents as "country clubs." "Country clubs" are institutions which are easy to gain entry to, where rules are lax, and minimal participation in rehabilitation activities is required. In short, country clubs are institutions where one can lounge with relative freedom.[3]

Another function which the rehabilitation milieu may serve for drinkers uninterested in long term rehabilitation is a place to go in

lieu of going to jail. When drinkers are arrested for a drinking related offense, judges sometimes give them the choice of going to jail or "committing" themselves to rehabilitation by entering a rehabilitation institution. The alternative of going to a rehabilitation institution is generally more appealing than that of going to jail.

Having a need or desire to enter a rehabilitation institution is one thing, gaining entry is another. The staff in rehabilitation institutions are fully aware that many drinkers use or attempt to use their institutions for reasons other than rehabilitation. Thus, "gate keeping" devices are set up, so as to "weed out" "undesirable" candidates. Those persons entering for pragmatic reasons must "crash" the gate keeping devices.

The permeability of gate keeping devices varies from one institution to another. Individual institutions acquire reputations amongst drinkers as to the ease or difficulty of crashing their gate keeping devices.

Further, the permeability of gate keeping devices in any one institution often varies according to time and circumstance. Many institutions, for instance, are funded according to the number of filled patient positions. Vacancies mean lost revenues. Therefore, if a large number of vacancies exists, gate keeping devices may be eased. If a drinker in quest of a place to lounge happens to arrive at such a time, he may easily gain entry.

In practice, gate keeping devices tend to be weaker than they are intended to be. For instance, I observed one institution which had a three stage "screening" process. To gain entry, a prospective patient

had to telephone the institution. He was interviewed over the telephone, and a decision was made as to whether to refer him elsewhere or invite him to the institution for further processing. If the prospective client passed this phase of the screening process, he was interviewed once again at the intake desk. If he "passed" this interview, he was once more interviewed by a counselor to determine what patient status he would receive (inpatient, outpatient, etc.).

Despite the complexities of this process, questionable candidates rather easily crashed the gate. Quite simply, none of the "screeners" wanted to be the one to say "no." The telephone interviewer invited questionable candidates to the institution assuming the person at the intake desk would week them out if he saw fit. The person at the intake desk reasoned that they would not have been invited out if they were not acceptable. The counselor reasoned that the prospective client certainly would not have made it this far if he were not acceptable. Each person's reluctance to be the one to say no was easily solved by allowing the "other guy" to be the one to say it.

A variable which is important in gaining pragmatic entry, maintaining residence once entry has been gained, and acquiring particular resources available in an institution is what drinkers refer to as "conning." The term "conning" (and its various synonyms such as "running a game" and "running a shuck") refers to various types of misrepresentation and manipulation of other people. Conning consists of misrepresenting motives, identities, feelings, etc., and conveying other false impressions, so as to favorably influence one's circumstances.

Gate crashing is a form of conning. The most important requisite to gate crashing is being able to appear to be seriously interested in long term rehabilitation. This is best accomplished by being aware of prevailing rhetorics, and feeding them to the gate keeper in a convincing manner.

To stay in an institution, a drinker may need to "con" the staff into believing that his interest in rehabilitation is alive, and that the various forms of therapy he is receiving are helping him. This is accomplished, again, by feeding back prevailing rhetorics in a convincing manner, or, in short, "telling them what they want to hear," much as students do with their teachers. When done during therapy sessions, this is sometimes referred to as "pseudo confessing."

Another con involves volunteering for rehabilitation services when it is unnecessary to do so. Several respondents, for instance, reported having volunteered to take antabuse (the popular trade name for disulfiram, a drug which, if taken, will result in severe illness whenever alcohol is consumed), as a means of convincing counselors of their "seriousness" regarding rehabilitation. However, they discarded the drug, only pretending to take it.

Drinkers sometimes con for resources available in an institution which are not automatically given as a consequence of residence. For instance, some institutions give bus tokens to residents who appear to have need for them. I observed several instances in which drinkers concocted elaborate stories to convince staff persons of their need for one or more bus tokens. Several persons related to me that the bus tokens (or whatever) were in themselves not particularly valuable to them.

They conned, "just to be conning." This form of conning seemed to represent a game to them.

Staff persons seem generally to be aware of the phenomenon of conning, although they are often unaware of specific conning incidents. Frequently they choose to overlook particular "harmless" instances of conning, as it appears easier and less disruptive to let the drinker believe he is successfully pulling off a con. Obvious cons are often viewed humorously by staff persons. The director of one institution, with a mixture of amusement and frustration, told me that when his institution first opened for services, they were swamped with clients "casing" the place to see what it had to offer.

RECEPTIVITY

As I previously mentioned, some drinkers become receptive to rehabilitation services concurrently with entry into the rehabilitation milieu. In such instances, the variables which occasion entry and receptivity are the same. Therefore entry as such need not be discussed separately from receptivity. Having discussed pragmatic entry, I shall now turn my attention to the process by which drinkers come to be receptive to rehabilitation services. The most crucial variable in this process is what I shall refer to as "realizing experiences."[4]

Realizing Experiences

"Realizing experiences" are moments at which a drinker comes to have a major revelation regarding the implications and/or meaning of his drinking behavior. At such moments, past behaviors, incidents, and so forth are ordinarily reevaluated in the light of the present revelation. Thus, the past as well as the present comes to acquire new meaning.

Realizing experiences are particularly important in the supplanting process as it occurs in the alcoholic career, because they function as the facilitant to receptivity to rehabilitation services, which in turn leads to drinkers' lives becoming increasingly centered in the rehabilitation milieu.

Drinkers may undergo one or more of at least three types of realizing experiences -- the realization that their drinking is detrimental to their lives to the extent that they should stop or cut down, the realization that their drinking is out of their personal control and they are in need of outside help, and the realization that they are "alcoholic" (to be discussed separately, in Chapter V).

The realization that one needs outside help and/or that one is alcoholic often, but not always, prompts immediate entry into the rehabilitation milieu and receptivity to the services offered therein. For some, it takes a succession of realizing experiences, each subsequent one being more cogent, to occasion entry and receptivity. For instance, a drinker may undergo a realizing experience which brings him to realize his drinking is out of his personal control, but this realization may not be sufficient to prompt him to seek outside help. It may take further prompting, such as a "crises buildup" (to be discussed later), to generate realization that outside help is imperative.

The experience of entering the rehabilitation milieu may, itself, negate the immediate effects of a realizing experience. Many respondents reported finding their first contact with an alcohol related agency or institution to be very distasteful. This occurred most often with Alcoholics Anonymous, probably because it is the agency with which a large number of drinkers first come in contact. Many respondents reported finding Alcoholics Anonymous, its "philosophy," and its members to be "offensive," "stupid," "self righteous," and the like, to the extent that they left with the intent of never returning. However, after experiencing more cogent realizing experiences (particularly those generated by crises), many returned. Others later reevaluated their initial repulsion of Alcoholics Anonymous or other agencies as having been a property of themselves, or their "illness," rather than a property of the agencies.

A realizing experience may also nurture a despondent belief that one is trapped in an irreversible trajectory (one of the common rhetorics concerning alcoholism), and therefore may just as well "give up." Thus, even though a drinker may come to realize the damaging effect drinking is having on his life, hopelessness may prevent him, at least initially, from becoming receptive to rehabilitation services.

Drinkers enter the rehabilitation milieu and become receptive to its services in two distinguishable patterns, which I shall refer to as the "early receptive pattern," and the "late receptive pattern." These two patterns of receptivity are distinguished primarily by the time at which the realizing experience which occasions receptivity occurs in relation to entry. The early receptive pattern is distinguished by the occurrence of the facilitating realizing experience prior to or simultaneous to entry into the rehabilitation milieu. The late receptive pattern is distinguished by the occurrence of the facilitating realizing experience subsequent to entry into the rehabilitation milieu.

These patterns are also distinguished by the types of behavior engaged in within the rehabilitation milieu. Those acting out the early receptive pattern enter and begin promptly and seriously to attempt rehabilitation. Those acting out the late receptive pattern engage in conning behavior without reservation. They also have yet to undergo the types of realizing experiences which prompted those acting out the early receptive pattern to become receptive to rehabilitation services. Thus, events within the rehabilitation milieu may contribute to the generation of such experiences.

There are at least four distinct phenomena which generate realizing experiences which may lead to receptivity -- the development of a "self-control failure history," a drinking related crisis or "crises buildup," the occurrence of "comparing experiences," and exposure to explanatory and/or therapeutic rhetorics. Each of these phenomena may play causal or confirmatory roles in either of the two patterns of receptivity. By "causal" I mean the realizing experience is a direct consequence of the particular phenomenon. By "confirmatory" I mean the realizing experience is confirmed, reinforced or strengthened by the particular phenomenon.

Self-control failure history and/or crisis or crises buildup play a causal role in the early receptive pattern. Comparing experiences and exposure to rhetoric may play a confirmatory role. Any of these four variables may play a causal or a confirmatory role in the late receptive pattern.

A typical representation of the early receptive pattern is: A drinker experiences a severe drinking related crisis or crises buildup, attempts self-control and fails. This generates a realizing experience of sufficient cogency to promote entry into the rehabilitation milieu and receptivity to its rehabilitation services. Once in the rehabilitation milieu, comparing experiences and rhetorics may confirm, reinforce or strengthen the initial realizing experience.

A typical representation of the late receptive pattern is: A drinker enters the rehabilitation milieu to temporarily "dry out," with minimal

intent at long-term rehabilitation. He undergoes comparing experiences and is exposed to rhetorics in the rehabilitation setting which act as "food for thought." With the comparing experiences and rhetoric in mind, he begins to reflect upon his drinking behavior and its consequences in a serious manner. This may or may not be sufficient to prompt receptivity to rehabilitation services. He may leave the rehabilitation setting, experience a crisis or fail at self-control, and then undergo a realizing experience of sufficient strength to prompt receptivity. In such instances the "food for thought" that a drinker acquires in the rehabilitation milieu acts to increase the chance that a self-control failure or a crisis will be cogent enough to bring about a realizing experience which prompts receptivity.

These representations are only typical, and by no means depict the only variations of the two basic patterns. There are more variations of the late receptive pattern than the early receptive pattern, however. The possible variations are much too numerous to mention.

In the following sections, I shall discuss the variables which generate realizing experiences of sufficient cogency to occasion receptivity to rehabilitation services. I shall discuss them in the following order: Self-control failure history; crisis and crises buildup; comparing experiences; and introduction to and acceptance of rhetorics.

Self-Control Failure History

The term "self-control failure history" refers, quite simply, to a phenomenon in which a drinker, without institutional or professional assistance, makes several or many attempts to control his drinking, without success. As this occurs he may come to perceive his pattern of failures as a serious matter, deserving of attention. This awareness may constitute a realizing experience of sufficient cogency to prompt entry into the rehabilitation milieu and receptivity to its services.

> Well something deep down tells you that this isn't right, that's all there was to it. It's something in the back of your head tells you this is no way to live. You gotta do something about it. You try on your own and you don't have the will power or something to do it, and you figure, well, you need some sort of medication or treatment to come off it. Otherwise you're just going to keep going down and down. At least that's the way I feel about it.

Such cases represent instances of the early receptive pattern, as the facilitating realizing experience occurs prior to, and in fact is the source of, entry and receptivity.

Self-control failure histories may also play a part in the late receptive pattern, although usually in more of a confirmatory (as opposed to causal) role. For instance, a drinker who has entered the rehabilitation milieu for pragmatic reasons and undergone a realizing experience through having been exposed to rhetorics, may believe he can control his drinking pretty much alone, without serious and detailed attention to rehabilitation services. After failing several times at self-control, he may undergo a more cogent realizing experience which confirms and strengthens his original realization that his drinking needs to be controlled. He may then become strongly receptive to rehabilitation services.

Self-control attempts may be made at various times in the alcoholic career. Many respondents reported having made attempts early in their careers, before entry into the rehabilitation milieu. In retrospect, they perceived these attempts as being rather superficial. I shall, for the moment, confine my discussion to these early attempts. Later attempts are much more sophisticated, as the buildup of experience brought about by progress through the alcoholic career serves as substance for more careful planning. These attempts will be discussed more appropriately later.

Early self-control attempts are prompted in two general ways -- through self-recognition of the problematic aspects of one's drinking, and through the influence of others. The first mode represents a realizing experience. Such a realizing experience may be brought about, for instance, by a crisis which the drinker perceives as being related to excessive drinking. The second mode may consist of a drinker making a self-control attempt at the urging of others, or to "please" others. Or, it may consist of an ultimatum presented by others which asserts that, unless a self-control attempt is made, distasteful measures (such as losing one's job) will ensue.

Self-control attempts are aimed at both complete and partial abstinence. Partial abstinence (i.e. "cutting down") is ordinarily attempted in one or both of two ways -- limiting the time periods during which one drinks, and limiting oneself to drinking a specific number of drinks within a given time period. In the first instance, a drinker may limit his drinking to weekends only, or to evenings only. In the second instance, a drinker may limit his drinking to two drinks per session, or a fifth of whiskey per week, or whatever.

Complete abstinence is ordinarily attempted in one of three ways -- "cold turkey," "tapering off," and "pledging." The term "cold turkey" refers to attempts to suddenly and completely refrain from drinking alcohol. "Tapering off" consists of a resolution to begin slowly decreasing frequency and amount of drinking, with the intent of eventually stopping completely.

"Pledging" consists of a drinker vowing to refrain from drinking for a given length of time, usually a month or several months. Pledges are often formally administered by such persons as priests or ministers, or under the auspices of Alcoholics Anonymous. They may also take the form of informal "promises" or "vows" to oneself or others to refrain from drinking for a given period of time.

All of the respondents failed at early self-control attempts (lest they would not have become respondents). Failure came about in a number of ways, some specific to particular types of attempts and others more general.

Pledges are frequently successful for their duration, but resumption of previous levels of drinking often recurs immediately upon completion of the pledge. As one respondent reported:

> I'm a Catholic. I'd go and I'd say, "Father, I'm gonna take the pledge for three months." And I'd keep them. I would keep them. The last one I went on was six months about five years ago -- about five years ago. And, I kept them. A month would go by and I'd say, "Jesus, that's one month that I haven't drank; two months I haven't drank; three months I haven't drank; five months I haven't drank; six months -- pretty near six months. Oh, I got one more week to go. Oh, that's fine." The week is over, I say, "goddam it, I stayed six months sober, now I can get drunk again." So, the pledge didn't really do me. It did me good for that six months, but that's as far as it ever went.

Failure to stop cold turkey may come about rather quickly for those whose drinking careers are well advanced. Drinkers who attempt to stop suddenly at this late time may experience illness, anxiety, "the shakes," and other such discomforts. Several drinks ordinarily stop such immediate discomforts. However, to stop them one must violate one's resolution to stop drinking.

One way in which self-control attempts in general fail is through a phenomenon which I shall refer to as "fading." Fading consists of a gradual diminishing of the cognizance, significance, and potency, and therefore the effect, of a particular experience.[5] As the reasons for making a self-control attempt pass further into time, they begin gradually to fade. Good intentions melt particularly easily when one is under the influence of alcohol. Thus, for those who are attempting only partial abstinence or tapering off to complete abstinence, fading occurs most easily.

Ironically, one avenue of failure comes about through temporary success. A drinker may decide to "test" his ability to cut down or abstain from drinking to demonstrate to himself or others that his drinking is under his control ("I can quit any time I want to"). He may be temporarily successful. This success may function as an indicator that he has his drinking under control. Thus, resumption of drinking is viewed as non-problematic, and his career continues.

A period of successful abstinence may serve to give drinkers perspective on their drinking. After having gone from non-abstinence (or partial abstinence) one or several times, comparison between the two states may be made. Some drinkers discover they feel better, feel

happier, are able to begin repairing the problematic areas of their lives, are treated better by others, and so forth during control periods. As one respondent related it:

> When I'm sober and not drinking I tend to go to church. When I start to drink I tend to stay away. Now, whether its a guilt complex, or when it comes to getting up Sunday and going, I'm not feeling well or whether -- I tend to get awful nervous in crowds when I'm drinking for one thing. You know, the sweats, nervous. But, when I get off the booze I can carry out a fairly normal life, be a family man and stuff like that. But, when I'm drinking, its something else again.

During periods of control, the responses of others may also serve to give one perspective:

> He was so fucking surprised to see what good shape I was, what good health I was, and how healthy I looked, that he could not believe it was me. Now, of course, this is very flattering, and this also made me aware, you know, I could see what booze does to a person.

However, other respondents reported quite different results from comparing drinking and sober periods. Their self-control attempts seemed to have few rewards, so they resumed drinking. As one respondent put it:

> What's the use of being good. Nothing happens to me when I'm good. So, I might as well be bad. In other words, I might as well drink.

A drinker may find that he receives little attention of any sort during sober periods, but receives considerable attention during heavy drinking periods. During drinking periods his behavior is problematic to others, so it draws special attention. For instance, he may receive money when he is drinking -- "to get rid of him" -- but nothing when he is sober.

> The only time that they give a shit about me is when I'm drinking. Then I get a lot of attention, oh yeah, I get a lot of attention. They're gonna do this, or, you know, you better snap out of it. I get a lot of attention. And, I figure well, when everything's going smooth like it is now, nobody phones me. I haven't had a phone call since I been here.

Such experiences may lead a drinker to simply give up on the notion of controlling his drinking behavior.

Another mode of self-control failure is best described as simple impulse, with no visible structural or social psychological account (except possibly "fading"). Respondents reported thinking, "to hell with it," and resuming drinking "for no good reason."[6]

In general, early self-control attempts fail easily because drinking constitutes such a central part of the everyday lives of heavy drinkers. Quite often their friends are heavy drinkers. Drinking may be important in their leisure time activities. Or, it may fulfill important psychological functions, such as allowing them to interact with others with confidence, alleviating loneliness, boredom or guilt, and the like (these are variables commonly mentioned by respondents). Thus, the elimination of drinking from one's life may constitute an unanticipated crisis. A drinker may find that he cannot function "normally" without drinking, thus even though he may be aware of the problematic aspects of drinking, he may put off further control attempts until the consequences of his drinking are defined as unbearable. By that time, he may be unable to control his drinking without professional help.

Crisis and Crises Buildup

In this context, I refer to the term "crisis" as a moment or situation of particular urgency or distress, which from the viewpoint of a drinker is related to excessive drinking. The fact of crisis is not a property inherent in a particular event, but is rather a definition conferred upon an event. Therefore, a particular type of event which may constitute a crisis for one drinker may have little effect upon another. Similarly, a particular type of event may constitute a crisis for a given drinker at one time, but not at another. For instance, a drinker's first arrest for a drinking related offense may be quite traumatic, whereas later arrests may become "routine."

For some drinkers, a crisis may occasion a realizing experience which prompts immediate entry into the rehabilitation milieu and receptivity to rehabilitation services. For others, a series of crises may be necessary to generate a realizing experience of sufficient cogency to prompt entry and receptivity. I shall refer to this phenomenon as a "crises buildup."

A "crises buildup" is a process which involves a set of variables, interacting in such a way as to promote a cycle of recurring crises. This process may culminate with a realizing experience of sufficient strength to prompt entry and receptivity. The crises buildup process progresses in this manner: A drinker experiences a crisis which prompts him to attempt to control his drinking; the experience of the crisis fades; a "drinking trigger" is encountered; drinking is resumed; and so on, in a cyclical fashion.

The phenomenon of "fading" fills the same function in this instance as it does with self-control failure. As the initial experience recedes into the past, the impact and control function it served begins to fade, finally reaching a point at which it no longer serves as a control mechanism. As related by one respondent:

> I lived over a bar on Mission, and I went into the bar and said, "Give me a Calso and water." And, he said, "Been at the A.A. meeting?" And, Jesus Christ, that scared the living hell out of me, you know. I never had a drink for two weeks. I said to myself, Jesus, I hate to end up that way. But, it faded.

The term "drinking trigger" (which I shall henceforth refer to simply as "trigger"), as used above, refers to phenomena which initiate a drinking reaction. A trigger is a mental phenomenon brought about by external events. Triggers vary from person to person. They are ordinarily consistent with any given person, although the kinds of external events which engender them may change. Over time, a drinker may come to recognize his triggers, and thus may learn to try to control them, so as to be able to control drinking. Triggers frequently mentioned by respondents include feelings of loneliness, boredom, inadequacy, guilt and anger.

As reflective of the early receptive pattern, a crisis or crises buildup may occur as a prelude to entry and receptivity. This may occur either before or after the drinker is disengaged from normal social networks, although it appears to occur most often after disengagement.

A crisis or crises buildup may also play a role in the late receptive pattern, either in a confirmatory manner (as with self-control failure histories) or in a more causal manner. Crises may play a causal role with drinkers who enter, leave, and reenter several times, for

pragmatic reasons, then experience a crisis or crises buildup which occasions receptivity to the rehabilitation services they had previously ignored (or even scorned).

A number of different phenomena may generate a crisis state of sufficient cogency to prompt receptivity to rehabilitation services. A common crises-generating phenomenon consists of a drinker being arrested for a drinking related offense, such as drunk driving, participating in a barroom brawl, or vagrancy. The following excerpt typifies an arrest crisis:

> One time I had gone out and picked cotton awhile and come back in and spent a couple of hours having a, oh well, four, five or six beers in a bar, and I got picked up by the police. And I think it's the only time I got picked up by, and eventually charged with being drunk, which oddly enough, I wasn't . In any event, it was, that kind of shook me up, that drunk arrest and the whole...I think that what happened was that they wound up dismissing the charge, and I don't know because I left town, but I think the charge was taken off the books. It would have been dismissed anyway. But, in any event, it wouldn't have happened had I not been drinking in a bar. The whole thing wouldn't have happened, and that was one of the things that, uh, made me realize that, you know, brought it home that I ought to do something about the drinking. And it was very shortly after that, anyway, a few days after that, about a week after that, that I went back to Sacramento. And, when I came back to Sacramento the first thing I did, I decided, well, I was gonna, was gonna quit drinking. So, within a few days I got into, about a week I guess, I got into this group.

Another common crisis-generating phenomenon occurs when a drinker's resources to live and to drink are completely depleted. The drinker finds he has no place to go nor nothing to do, but seek help. As one respondent related:

> I had no job, had no money, had no place to go. Somebody told me about a place run under the Bureau of Alcoholism called Themis House. I came down here and looked the place over and was interviewed and accepted.

Reaching or violating one's self-respect threshold may also constitute a crisis of sufficient proportion to prompt receptivity.

> Now I'm beginning to drink in the room, and I worked for this friend of mine taking care of his mother -- she's eighty-three years old. He gave me twenty five dollars a week. Twenty dollars I paid for my room, and five dollars for myself, so I had no money to drink whiskey, so I started on the wine, and that's all I drank was wine. And, it was getting so every night, every night, I'd get a bottle of wine. And then I'd go up in the park and I met some, I guess you'd call them winos. That's what I would call them. Maybe I was a wino myself at that time. And I'm right there. If a guy's got a bottle, I'm right there. If I got some money I'll buy a bottle for him and I. Finally, I woke up to the deal one morning and I said to myself, "What in the hell, now I'm drinking in the goddam park now. And pretty soon I'm gonna be like they are," because I know that they did go out and bum dimes here and dimes there. And then I'm thinking of that skid row business. I said, "Shit, first thing I'm going right down skid row that I hear so much about." That's when I phoned Father here....The next thing I'm gonna be out on the street either bumming money or I'm gonna be down in skid row. So, before I get that far I better get into this house, and that's where I been ever since.

Deteriorating health or illness may generate a crisis state sufficient to prompt entry and receptivity. A drinker may develop an ulcer, diabetes or some other illness which a doctor tells him is related to his drinking. This news may itself not be sufficient to constitute a crisis, but if not a severe episode of the particular illness may be.

> There was nothing but booze there so I decided, well I started getting pains down in here in my stomach, severe. And one or two days that I got them, in the morning I get them when I first start out and after the first couple of drinks I took, they seemed to, you know, I forgot about them. They didn't bother me no more. But, I think it was the third morning, I got them real bad and drink or nothing wouldn't stop them. So I went to see a friend of mine over in the A.A. club and went in there and I'd already drank some, you know, trying to settle myself down plus kill that pain, and ah it wouldn't work. So I told them that and he said, Jesus, you'd better go to the hopsital. He said, you don't know what it is. So he got somebody to drive me over to General. They got me in there and they run all kinds of tests on me....They claimed I had gastritis. So They kept me in there I think about twenty-four hours or something like that. More than that, because the guy took me over there in the morning around ten or something, and they let me go out about three the next day. And this fellow that got the guy to drive me over, he said, "When you get out come back around here but try not to drink nothing because we don't want you in the club if you're drinking. Come around here and sit around and take it easy." And, so I did, but I was nervous as hell, you know. But, I didn't think anything, so then I get thinking, "Well, if I could get into a half-way house." I'd heard of this and met guys that had been in here, you know, and they seemed to be doing all right, so I called up for an appointment and it so happened that they had a vacancy that I, when I called, got interviewed. They told me I could move in the next day.

Several respondents reported having entered a hospital with a health crisis, and being referred to public alcoholic rehabilitation institutions when their immediate crisis was alleviated.

A number of respondents reported acquiring a distaste for food during drinking episodes.

> Yeah, that's it, and it seems like it gets worse each day cause you haven't been eating. I mean a lot of times there's plenty of food around, but you just couldn't look at it. I wouldn't care if somebody offered to prepare it for me, even. It makes you sick, the thought of it.

The consequences of such poor nutrition may be sufficient to generate a health crisis.

Other, often quite severe, crises may be brought on by the physiological and psychological consequences of heavy drinking over long periods of time. Crises may be generated by the experience of such phenomena as "the shakes" (acute tremulousness), "d.t.'s" (delirium tremens), "blackouts" (a form of amnesia),[7] and severe anxiety feelings.

The term "shakes" refers to a state of nervousness, during which the hands shake uncontrollably. The term "d.t.'s" refers to a state of extreme anxiety which includes hallucinations, disorientation, and other extremely uncomfortable symptoms. According to Kessel and Walton (1969), the shakes and d.t.'s are forms of withdrawal symptoms. The shakes occur quite soon after alcohol consumption has ceased (sometimes even before). D.t.'s occur several hours to several days after consumption has ceased. These phenomena ordinarily do not occur until after a number of years of heavy drinking. When they do occur they are most capable of producing a crisis of sufficient proportion to prompt receptivity. The symptoms may be quite severe.

> You suffer like a son-of-a-gun for a couple of days. You got the sweats and you're shaking and you're hot and cold. You could just come out of the shower there and take a good shower, and five minutes later you'd be soaking wet. Then you'll have the chills, feel like you've got a fever. And your nerves are just shot. And that's where three or four drinks, the only trouble you won't stop with three or four drinks, will calm you right down. And you get over all that

sweats, and even the dry heaves if you got them.

A particularly frightening experience was reported by one respondent:

> He just kept talking for several hours after I had already run out of beer. For some reason, after we quit drinking he gave me a cup of coffee. We had a cup of coffee around two o'clock or so, and he quit talking and went to his room, and I started to go into the kitchen and fix something to eat, and I just became disoriented, completely disoriented. I started walking back and forth and getting very excited. I guess, you know, I was stimulated and got over-stimulated somehow and became completely disoriented. I would be going back and forth picking something up, putting it down, picking up an egg and putting it down, and going to the kitchen, then back to my room and then to the kitchen. And the thought got into my mind that maybe he had, among other things, the guy had been mentioning LSD and other drugs, and it got into my mind that maybe he had put some LSD in my coffee. And this built up and I went into an hysteria over this, and eventually it got so, I had fixed some eggs, 'cause I hadn't eaten for maybe twenty-four hours or, you know, since the previous night and this was two o'clock, twenty-four or twenty-six hours later, or something like that. And, it got so I was so hysterical with this idea that something had been slipped in my coffee, that I was losing my mind, I really was, I was losing, I just couldn't put my mind on anything. I got to a point where I couldn't eat, I couldn't do it, and my throat was all tightened up. And, in short, I just went into hysteria. I thought, well, I better go find some help somewhere. I'd better go find, the idea was to go down the street and see if I passed any cops or anything, and have somebody check and see if I had taken or been given some LSD. And I would up at the Crisis Clinic at Mt. Zion Hospital....and they got me sufficiently calmed down to go back home and breathe a little bit. By no means calm, but when I got home, realizing, I knew what had happened, and I was in filthy clothes and my room was filthy and beer cans, and bags of beer cans all over the place, because alcoholics eventually run to the point where they're ashamed to be seen dumping cans and all. So, I just looked at the mess I was in -- the hysteria and the whole mess I was in, and I saw that the drinking was a part of it. Unless I wanted that to happen again, things were going to have to change. That was it!

"Blackouts" are blank periods in one's memory incurred during heavy drinking episodes. After an episode, the drinker finds he cannot remember large segments of time.

> Nothing is clear. You get blackouts. You and I might be somewheres, say this evening, drinking, and you'd see me three or four days later, and maybe you didn't know me that well, you knew I drank, and drank quite a bit, but you didn't know I had that big a problem. I probably was making fairly good sense to you, and you'd say, "How'd you make out the other night?" or "How'd you do after I left you?" I'd say, "I didn't see you." You'd say, "We were at such and such a bar," "We were down at McCarthy's," or "We were at this place or that." "Don't you remember, we had several drinks back and forth?" And you might have had to leave or I might have had to go someplace else. I wouldn't remember a thing about it. I just figure the guy wouldn't be telling me this only for it must be so. I mean you just can't, you try to think back and you can't.

Such blackouts may frighten a drinker to the extent that he becomes receptive to rehabilitation services.

The experience of a severe crisis appears to be more capable than any other phenomena of bringing about swift, even if only temporary, receptivity to rehabilitation services. Other variables which prompt receptivity often function for a period of time as "food for thought" before gaining enough impetus to prompt receptivity.[8] Crises are immediate and pressing, and therefore much more likely to impel remedial action.

Comparing Experiences[9]

Once a drinker enters the rehabilitation milieu, he may undergo various types of "comparing experiences." The term "comparing experience" refers to a phenomenon in which drinkers compare themselves, their

behavior, their situation, their progress within the alcoholic career and the like, with other drinkers. Comparisons may be made directly with specific persons, or with vague typifications of drinkers in general. A drinker may undergo a comparing experience through direct conversation or observation, or through "testimonies" and "confessions" given by other drinkers in group conversations and therapy sessions.[10]

Comparing experiences may occur before entry into the rehabilitation milieu, but ordinarily with less impact than they do after entry. Previous to entry, a drinker may have infrequent contact with drinkers in various stages of the alcoholic career. Thus, he may have little opportunity to place himself within a spectrum of other drinkers. Furthermore, if he does not view his drinking as particularly problematic, he may have little reason to compare himself with other drinkers.

However, when he enters the rehabilitation milieu he is confronted with a wide range of drinkers, possibly at a time when his drinking has come to be regarded as problematic. Under these conditions, most drinkers exhibit a strong tendency to compare themselves with their peers.

For many, this is a very strong objectifying experience. Through viewing other drinkers at various stages in their "alcoholism" and alcoholic careers, drinkers may begin to see mirror images of themselves.[11]

> Well, they're telling their little stories, see 'bout how they drank and how this and how that -- you know, troubles at home and, uh, how they're getting worse instead of better and, uh, how they ditch bottles and all of this kinda stuff, see. So I'm learning my own self through that....I found out that a lot of fellows who come in here tell the same story, "I been drunk for fourteen days, or a month," "I never ate nothing." I figure, well, I'm getting too like that guy, because I could see myself that, that I wasn't eating.

Comparing experiences may prompt a drinker to engage in reflection concerning where he has been, where he is at present, and where his future is headed in relation to other drinkers. For some, a product of these reflections may be a realizing experience of sufficient impact to occasion receptivity to rehabilitation services.

Introduction to Rhetoric

Upon entering the rehabilitation milieu, a drinker is exposed to various explanatory (i.e. purporting to explain "alcoholism") and therapeutic (i.e. suggestive of solutions) rhetorics. Such rhetorics may exist in formalized sets, such as "A.A. philosophy" (the rhetoric set proferred by Alcoholics Anonymous), or may be more general and unattached to any particular set.

A drinker cannot help but be exposed to rhetoric in the rehabilitation milieu. Both formal and informal rhetorics are constantly discussed and espoused in therapy sessions and in conversation between drinkers. Some respondents reported having done reading on their own, usually in a quest for the sources of their "problem." They were thus exposed to rhetorics which they may not otherwise have encountered.

Some drinkers come to subscribe quite strongly to particular rhetoric sets, which they regard as almost God-given. Others assume a "what ever works for you" attitude. These persons accept and reject aspects of various rhetorics to meet their own circumstance and preference.

I shall not analyze the specific content of particular rhetorics or rhetoric sets apart from the ways in which drinkers appear to understand them. One general comment is appropriate, however. For the most part, the rhetorics encountered in this research conveyed the same

message -- that of personal responsibility. These rhetorics almost invariably asserted that the responsibility for the development of a serious drinking problem lies entirely with the drinker. Furthermore, "alcoholism" is a "disease" which some persons "have" and others don't. Similarly, these rhetorics asserted that the responsibility for rehabilitation lies with the drinker -- the assumption being that if rehabilitation fails, it is the drinker's fault.

Judging from my observations and from the understandings of the drinkers I talked with, the variables commonly asserted by staff persons to be related to problem drinking are self-centeredness, inability to communicate and interact with others, inability or refusal to express oneself openly, and inappropriate emotional response (particularly anger). These are all variables which imply individual responsibility and pathology. Seldom are conditions outside the drinker's personal psychology given serious mention. Interaction between individual psychologies and the social conditions within which they operate is infrequently given reference.[12] Furthermore, it is assumed that problems of emotion, communication, and so forth are properties of the drinkers' psychologies. It is seldom conceded that a drinker's anger, for instance, may be quite appropriate to the context within which it is expressed.[13]

The variables most often mentioned by drinkers themselves as being responsible for their excessive drinking are loneliness, boredom, inadequacy, guilt and anger. In addition to these, they frequently mentioned quite simply that they liked the taste of alcohol, enjoyed the "high" which they derived from it, and felt relaxed when they drank.

These are all variables which may have foundation in the external conditions within which drinkers' lives are carried out. They are also variables which do not necessarily imply psychological pathology. Many of the above-mentioned variables are considered by staff persons to be consequences, rather than sources, of drinking. They are also commonly asserted to be "excuses" rather than potentially explanatory variables.[14]

Initial exposure to rhetorics may generate a realizing experience sufficient to occasion receptivity to rehabilitation services. However, this appears to be rare. Most often, drinkers are reluctant to accept rhetorics initially, unless, as would be the case with the early receptive pattern, they have already become receptive. In fact, often acceptence of rhetoric is a consequence of receptivity. In such cases, rhetoric functions in a confirmatory manner. Seldom does rhetoric alone generate receptivity. It does, however, commonly serve as "food for thought," which may play a role in future receptivity.

Early rejection of rhetoric seems to stem from two sources -- the discrepancy between the variables regarded by staff persons and drinkers to be related to heavy drinking, and the general offensiveness and lack of understandability of staff rhetorics. The variables proferred by staff persons simply do not meet the experiences of drinkers, as these experiences are understood prior to receptivity to rehabilitation services. Such variables "blame" the drinker, no matter what the circumstance.

Furthermore, staff rhetorics are ordinarily couched in psychological, quasi-psychological, or quasi-religious jargon, which is frequently unintelligible, annoying, offensive, and sometimes even humorous to

drinkers who are first exposed to them. It is difficult, for instance, for drinkers ambivalent about their identity and course of action regarding rehabilitation to accept such terms as "weak ego," "character defect," and"self-centeredness." Likewise it is difficult for former truck drivers, laborers, electricians, and the like to understand, less relate to, the jargon characteristic of such things as "behavior modification" and "Gestalt therapy." Many respondents mentioned that they preferred staff persons who were themselves once alcoholic, because they "spoke the same language." With these persons it was not necessary for the drinker to stumble through what might be regarded as offensive, unintelligible or annoying jargon.

After the experience of a crises buildup, self-control failure history, or other such phenomena, rhetorics generally become more acceptable.

> In A.A., as I said in that meeting, I'm new at A.A., which is I said, I was here for a year and ten months, but I didn't go to any A.A. meetings. Outside the house I never went to one. When I left the house I never went to an A.A. meeting. I didn't went to one. I've gone to more A.A. meetings this week than I did for a year and ten months, because I can see myself this time, to what they are talking about. It's catching up with me, see. You get the point? Drinking the wine, and drinking in the parks, I never like I say, not got down to the gutter, but I'm going that way. That's when I told you, I said to myself, shit, I'm not going to go all the way down, I'm going to snap out of it. That's why I'm listening more at these A.A. meetings.

When a drinker experiences a crises buildup or other cogent experience, it becomes much easier to accept staff rhetorics as authoritative. After all, one's own interpretations have not led one in the proper

direction. Acceptance of staff rhetorics is further facilitated by the common rhetoric which asserts that rehabilitation cannot begin until the drinker admits his "illness" and gives up his interpretation of his problems for those of the therapist.[15]

When this occurs, prior rejection of staff rhetorics ordinarily comes to be defined by both the drinker and staff persons as a "self-con." Usually, at this point receptivity to rehabilitation services is complete.

CHAPTER IV NOTES

1. As Wiseman (1971) points out, the rehabilitation milieu may serve as a branch of the skid row loop.

2. This appears to be a rather general "latent" function of institutions. See, for example, Wallace (1965), Wiseman (1970), and Sternberg (1963). For graphic fictional accounts, see Green (1964) and Plath (1971). For correlate discussions regarding the "functions" of deviant gangs, see Matza (1964) and Short and Strodtbeck (1964).

3. Some drinkers use larger institutions, which offer safety in relative anonymity, as places to lounge, without bothering to register as patients. By so doing, they are able to watch television, sleep, and possibly even con a few meals without having to fake interest in rehabilitation. Such persons are sometimes referred to as "floaters."

4. Realizing experiences and what Maxwell (1962) refers to as "conditions for change" are somewhat similar.

5. A fading experience which most readers who drive automobiles have probably undergone occurs when one witnesses a severe automobile accident. Such an experience is ordinarily unnerving to the extent that one drives very carefully for several hours or days. However, eventually the immediate impact of the experience fades, and previous driving habits are resumed.

6. Wiseman (1970: 219) reports this phenomenon as it occurs to skid row alcoholics "making the rehab route."

7. For a succinct discussion of these phenomena, see Kessel and Walton (1969).

8. In fact, frequently a crisis acts to transform such thoughts into action.

9. I am using the word "comparing" in this context as an adjective.

10. This can be recognized as the analogue to the general Meadian conception of "taking the role of the other" (Mead, 1934 and 1938) passim.

11. This is a phenomenon of concern to symbolic interactionists. See, for instance, Cooley (1964), Mead (1934), and Strauss (1959).

12. Marked increase in drinking, for instance, is ordinarily attributed to psychological variables, ignoring such social phenomena as the erosion of outside limits on behavior, as discussed earlier in this monograph.

13. A similar situation exists with conventional psychological explanations for "paranoia." As Lemert (1962) and Scott and Lyman (1968) point out, those whose behavior is diagnosed as "paranoid" frequently have undergone experiences which would quite reasonably arouse a high degree of suspicion and thoughts about "conspiracy." They may have good reason to be suspicious of other people's motives, etc. Others may, in fact, have talked behind their back, systematically excluded them, and conspired against them. In short, their response may, at least initially, have been quite appropriate. However, this alternative is automatically excluded by the therapist.

14. Similar observations on staff interpretations of patients' "excuses" have been noted by Goffman (1961), Scheff (1966), and Szasa (1964), amongst others. Central to each of their analyses is the role played by staffs' "therapeutic vocabulary" as furnishing an ontological basis for the patient's reality qua patient.

15. As Goffman (1961: 155) succinctly states, in analyzing the career of mental patients: "The patient must "insightfully" come to take or affect to take, the hospital's view of himself." This process is crucial to therapeutic success <u>from the institution's point of view</u>.

CHAPTER V

ACCEPTING THE LABEL

At some point during his alcoholic career, a drinker may undergo a realizing experience which leads him to define himself as "alcoholic."[1] This may occur before, concurrent with, or after entry into the rehabilitation milieu. It appears to occur most frequently at the time of entry or following entry. Although it may occur previous to entry, and even previous to receptivity, I have held off discussion of it up to this point so as to be able simultaneously to discuss all routes to its occurrence (i.e. those which I observed).

The process which leads up to acceptance of the alcoholic label is similar to the process which leads up to receptivity to rehabilitation services. Even though the same variables are involved, they are distinct phenomena. The clearest indication of this is that they do not necessarily occur simultaneously. A drinker may become receptive to rehabilitation services, while maintaining he is not an alcoholic. He may concede that he has a "problem," but he is not a "real" alcoholic. Conversely, a drinker may come to identify himself as an alcoholic, yet not become receptive to rehabilitation services. He may find it beneath his self-respect to enter a rehabilitation institution, for instance. Thus, he may attempt self-control (which of course may fail and lead him eventually to become receptive to rehabilitation services).

Ordinarily the alcoholic label is applied to a drinker by others before he is willing to accept it.[2] When his drinking behavior becomes visibly problematic or extraordinarily intense or frequent, others may

begin to hint to him, and discuss openly away from his presence, that his drinking is pathological. These early hints may be couched in a humorous or lighthearted tone, but nonetheless reflect serious concern. If the drinker's behavior persists unchanged or if he fails at self-control, he may be directly confronted with an alcoholic identity.

The respondents invariably rejected this label early in their careers, depsite the fact that many of them held vague suspicions that their drinking behavior may be out of the ordinary. Denial of the label was ordinarily facilitated by the use of what I shall refer to as "contra-indicators." The term "contra-indicators" refers to criteria used by drinkers to establish either to themselves or to others that they are not alcoholic. Ordinarily this consists of some particular behavior, set of behaviors, or characteristics which they do not engage in or possess, yet which they purport to be peculiar to "real" alcoholics. For instance, they may imagine a vague model of what they consider to be an alcoholic, or refer to particular instances of what they purport to be an alcoholic, compare themselves with these representations, and conclude they are dissimilar to them, and thus are not alcoholic.

> I figured the same way as a lot of the guys that come in here go to the A.A. meeting. They still won't say "I'm an alcoholic," because they figure Third Street is an alcoholic. That's the way I figured in my mind. I never been down Third Street only to walk down the street. I never bummed a dime offa anybody in my life, which I never did yet. I might know you and ask you if I see you to loan me four bits or a dollar, but I never bummed a dime. So I figured, "Well that's an alcoholic there. I'm no alcoholic. I drink a lot -- I'm no alcoholic" -- you know, to myself.

Contra-indicators more easily maintain their viability before a drinker enters the rehabilitation milieu. Previous to entry, a drinker's image of alcoholics may refer to skid row "bums" (Trice and Roman, 1972: 9). Skid row alcoholics are rather visible, living in what is effectively a subculture. Most drinkers, however, seldom come in close contact with a subculture of peers, except maybe in bars, until they enter the rehabilitation milieu. As I discussed previously, once in this milieu, direct comparisons (i.e. comparing experiences) with other drinkers at various stages in their alcoholic careers are difficult to avoid.

However, direct comparing experiences with other drinkers may produce contra-indicators as well as indicators. A drinker may compare himself to other drinkers who have suffered the consequences of many more years of heavy drinking and conclude that he isn't like them, thus he isn't an alcoholic.

Likewise, exposure to rhetoric may function to generate contra-indicators, as well as indicators. Rhetorics ordinarily present models of the alcoholic career which include many phenomena, such as "d.t.'s," cirrhosis of the liver, and the like, which have not yet occurred to a particular drinker. He may thus conclude that, being that such "alcoholic" phenomena have not occurred to him, he is not an alcoholic.

In any event, comparing experiences and rhetorics may function as "food for thought," which may at a later time assist the generation of a realizing experience which occasions acceptance of the alcoholic label (and possibly at the same time receptivity to rehabilitation services).

One further, and important, phenomenon which functions as a barrier to acceptance of the label is self-respect thresholds. Accepting the alcoholic label may be a severe blow to one's dignity, particularly after years or months of public denial. The real and imagined "I told you so's" may be extremely humiliating. Furthermore, the alcoholic label is very stigmatizing. Drinkers to whom this label has been officially and effectively applied soon find themselves being treated as fundamentally different, and inferior, to others. Many respondents reported this to be a severe indignity. Under such conditions, reluctance to accept the alcoholic label is understandable.

It is important to point out that acceptance of the alcoholic label is not a clear yes versus no phenomenon. Something often neglected in the literature on labeling theory is that a label may constitute a range upon which a person may be placed or may place himself. Such is the case with the alcoholic label. Drinkers have perceptions of a range from "heavy drinker" to severe alcoholic. The respondents most often placed themselves towards the "heavy drinker" end of the range.

This appears to serve at least two functions. First of all, it allows a drinker to maintain a distinction between himself and severe skid row alcoholics (this is not to say that all persons on skid row are severe alcoholics). Thus he may escape identification with persons whom he may feel to be "beneath" him (although deserving of pity). In short, he may salvage his self-respect.

Secondly, he may maintain belief that he has not yet reached the point of no return, so to speak. He may hold on to the notion that he is not a "real" alcoholic, but only on the verge of becoming one. This

allows for the hope that if he makes amends now, he may return to normal life.

A particular drinker's self-definition regarding where he fits on the alcoholic spectrum may vary over time. He may undergo a realizing experience which occasions a shift from the "heavy drinker" end of the range towards the "real" alcoholic end. He may even come to see his initial perception of an alcoholic spectrum as being merely a self-con which he employed to avoid accepting the fact that he is "really" an alcoholic. From this point of view, an alcoholic is an alcoholic.

Eventually, a drinker may undergo a realizing experience which occasions a complete, unqualified acceptance of an alcoholic identity.[3] Such realizing experiences may be generated in a number of ways, which are outlined fully in "Diagram A." As noted previously, this process is similar to that leading up to receptivity to rehabilitation services.[4]

Realizing experiences which occasion acceptance of the alcoholic label may be generated by the development of a self-control failure history or the experience of a crisis or crises buildup.

> I drink constantly, and when I really realized I was an alcoholic was when I had to have this little shot in the morning to calm my nerves down....After I'd been drinking for any period of time when I got up in the morning I'd be so nervous or shook that I needed a little touch to straighten me out to come to work.

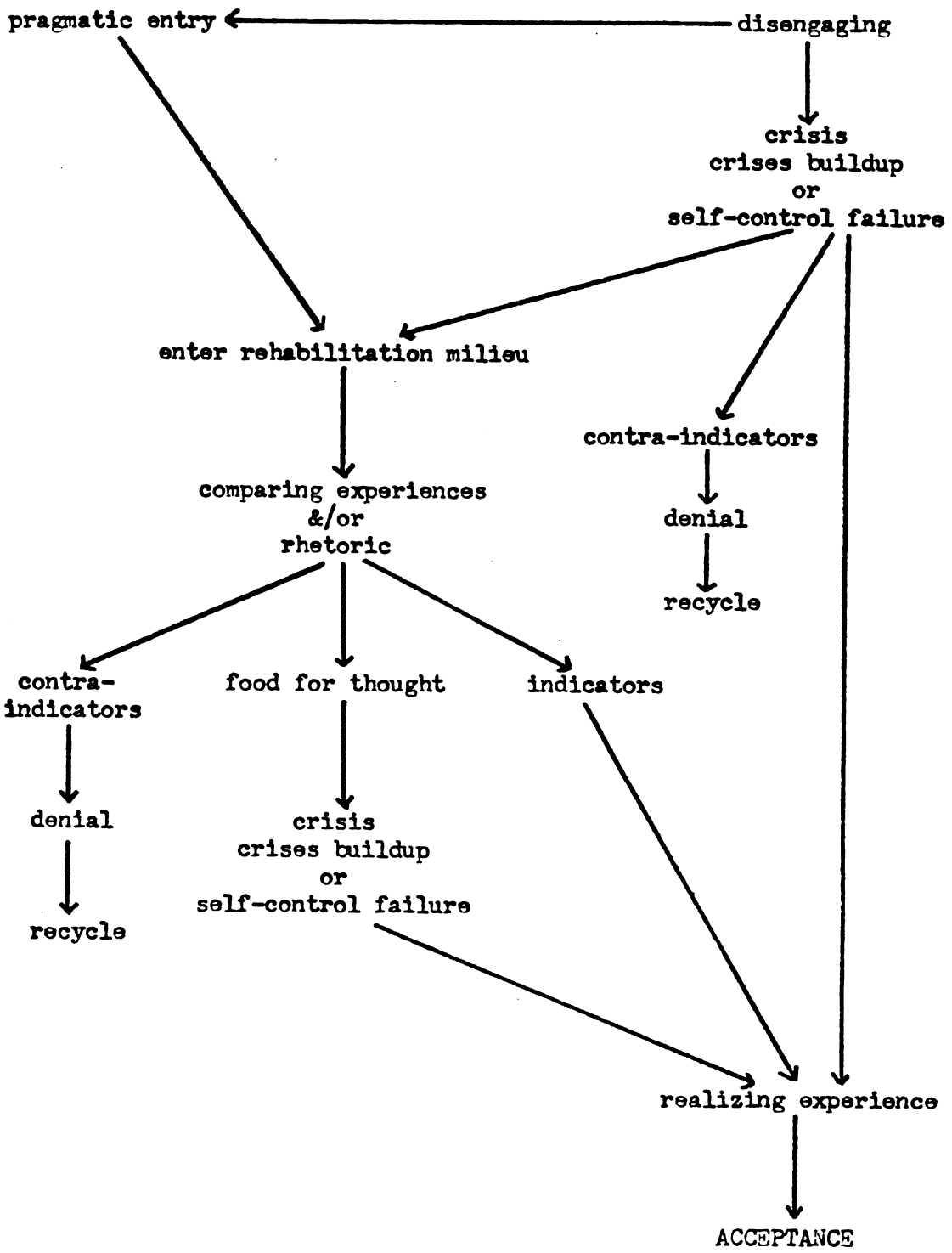
As I mentioned previously, realizing experiences which occasion acceptance of the alcoholic label may also be generated by comparing experiences and exposure to rhetorics, either singly or in interaction with a self-control failure history or crisis. Within the rehabilitation

milieu, a drinker is deluged with experiences and rhetorics which impose the alcoholic label on him. As more time is spent in the presence of other drinkers who may have already come to accept the alcoholic label, the more similarities between oneself and other drinkers are apt to become apparent. Occasionally, those who have already accepted the label directly argue with those who have not that they are conning themselves, and may as well admit what they "really" are. They ordinarily argue that they had also at one time denied their alcoholism, but eventually after prolonged misery, had come to "see clearly" that they were in fact alcoholic, and had been for some time.

While in the rehabilitation milieu, drinkers are also deluged with various rhetorics which urge their acceptance of the alcoholic label. One popular rhetoric (mentioned previously) has it that one cannot begin to solve one's problems until one accepts that one is "sick." Another has it that denial of the alcoholic label is a self-con. Yet another has it that if one were not an alcoholic, one would not be there (i.e. in the rehabilitation milieu).[5] Such rhetorics, particularly in combination with a crisis or self-control failure history, may become persuasive.

DIAGRAM A

ROUTES TO ACCEPTANCE OF ALCOHOLIC SELF-IDENTITY



CHAPTER V NOTES

1. This is essentially a process of identity transformation, in which one identity (i.e. "normal") is dissolved and replaced by another (i.e. "alcoholic"). For more general discussions of this social psychological phenomenon, see Becker and Strauss (1956), Garfinkel (1956), Goffman (1961), Strauss (1959) and Vidich and Stein (1960), amongst others.

2. Although the labeling perspective has offered a fruitful view of deviance, very little empirical work has been done on the acceptance of the label by persons on whom it is conferred. The present research suggests such an acceptance is both problematic and processual. See Gibbs (1966) for a similar statement regarding the labeling approach. For one of the few attempts to empirically delineate the "acceptance" phenomenon, see Williams and Weinberg (1971). Also, see Davis (1961b) for a discussion of the process by which the visibly handicapped "disavow" a deviant label. For a discussion of "self-reaction" to the alcoholic label, see Trice and Roman (1972: 32-37).

3. This may be done while maintaining a distinction between oneself and severe alcoholics by conceiving of alcoholism as a "disease" (a very common rhetoric) which one may have with varying degrees of severity.

4. Given the similarity between the processes which lead up to acceptance of the alcoholic label and receptivity to rehabilitation services, the reader may find it fruitful to view "Diagram A" in regards to its applicability to receptivity.

5. Goffman (1961) makes a similar point in regards to mental patients.

CHAPTER VI

WORKING ON IT

A drinker who has progressed through the supplanting process up to the point to which this analysis has evolved will have disengaged from normal social networks, entered the rehabilitation milieu, become receptive to rehabilitation services, and accepted the self-identity of "alcoholic." Once these are accomplished, drinkers begin to turn their attention to long-term rehabilitation, or as one respondent put it, towards "working on it." In so doing, they gradually come to seat their lives in the rehabilitation milieu. The present chapter will be concerned with these phenomena.

At this point in his alcoholic career, the priorities of a drinker's life shift from those of sustaining a drinking career to those related to long time rehabilitation. Two phenomena which become most important at this time are finding an explanation for one's "alcoholism," and maintaining sobriety. Maintaining sobriety involves both self-controls and institutional controls. I shall discuss these phenomena in the order in which they are mentioned.

FINDING AN EXPLANATION

Once the alcoholic label has been accepted and drinkers become receptive to rehabilitation, many manifest a rather strong urge to find an explanation for their having become "alcoholic." Many respondents mentioned that they felt they could not begin to solve their drinking problem unless they knew what made them drink in the first place. They almost invariably found "explanations" in one or more of the rhetorics to which they were exposed in the rehabilitation milieu.

Rhetorics are a favorable source of answers because they offer packaged explanations which have an aura of authoritativeness. A drinker may avoid having to undergo a painstaking, detailed analysis of his past, his psyche, and the like to piece together an explanation of his own. Once familiar with the explanations offered by particular rhetorics, a drinker may simply scan his past and present behavior for instances which fit the rhetorics towards which he is inclined close enough to verify them in his mind. Thus, his explanation is constructed deductively, rather than inductively. For instance, as I discussed previously, many rhetorics assert certain psychological (and pathological) variables to be related to alcoholism. Those most commonly mentioned in the settings within which this study was carried out are self-centeredness, inability to communicate and interact with others, inability or refusal to express oneself openly, and inappropriate emotional response (particularly anger). A drinker may scan his past for instances in which it could be construed that these characteristics were displayed, and use these instances as confirmation that the rhetoric is the proper explanation for his alcoholism.[1]

A drinker may have little difficulty in finding instances in which the above, and similar, variables might have been involved. If such variables may not originally have been inherent in his personality as sources of his drinking behavior, they certainly could be results. That is, variables which may in fact be consequences of drinking behavior may come to be defined as sources. For instance, as a drinker is going through the experience of being eased out of normal social networks, he may have frequent occasion to become angry. Such anger is a response

to particular events at that particular time. In light of his present identity and rhetorics, this anger may be construed as an intrinsic part of his personality, causally related to his alcoholism.

Whether, in fact, such variables are "really" sources or consequences, is of little matter insofar as the processes being discussed here are concerned. The important fact is that drinkers come to believe they are causal variables, and act accordingly.

Once a drinker accepts particular rhetorics as an explanation for his alcoholism, previous definitions and understandings of his drinking behavior are reinterpreted in light of the rhetoric and his new identity.[2] For instance, he may begin to fault[3] himself for events, such as the destruction of his marriage, conflicts with friends or employers, and the like, for which he previously denied blame. He may for the first time see these events as having been related to his drinking. Similarly, previous drinking behavior may come to be redefined. Previously, he may have described his drinking with such phrases as, "Sure I like to drink, but doesn't everyone?" or "After all, everyone goes on a good drunk now and then." From the present perspective, such previous definitions and behavior are seen as a self-con, and as the early stages of his alcoholism.

MAINTAINING SOBRIETY

Once a drinker becomes receptive to the notion of long term-rehabilitation, the problem of maintaining sobriety becomes foremost. Long-term rehabilitation is viewed not as a matter of merely cutting down on one's drinking, but as a matter of stopping completely and forever. Maintaining sobriety is a social psychological problem. That is, it is a matter of the drinker possessing a mental orientation conducive to maintaining sobriety, yet having to place himself in the world in such a way as to bring it about. Furthermore, although a drinker may place himself in a setting which offers structural controls, such as a rehabilitation institution, sobriety is primarily a problem of self-control. If his mental orientation towards rehabilitation fades, as it often does, he may merely remove himself from such structural controls. The paramount factor in maintaining sobriety, then, is maintaining the necessary mental orientation--a matter of self-control.

Self-Controls

As I mentioned some time ago, self-controls in the latter phases of the alcoholic career are considerably more sophisticated than earlier self-controls. Drinkers become much more aware of the variables related to their drinking. They become aware that they are inclined to drink under certain kinds of circumstances, for particular reasons, and that they tend to remain sober under other conditions. These factors serve as a basis for controls. Such controls take a number of forms.

One mode of self-control is contrived to reduce the chances that fading will occur to a point where drinking may be resumed. A drinker

arranges periodic "reminders" of where he has been and what might occur if drinking is resumed. Ordinarily this is accomplished by a short trip through skid row, to a "dive" bar, or to some other alcoholic milieu, or through doing volunteer work in an alcoholic rehabilitation agency, where contact with other alcoholics can be maintained. One respondent, for instance, said he planned to come back a couple of times a week to do volunteer work at the institution he was currently in, after he was discharged. When asked why, he replied:

> Well, for any help that I can do anyone, or the hospital. And, in doing that it might help myself. It reminds me of my situation, which at this point I find very necessary, to remind myself of my position and situation....After awhile say I get out of here, lost all contact with everything to do with alcoholism, why I might become a little complacent. Chances are I would become complacent. Then I'd start conning myself, "What the hell, a couple of drinks isn't going to hurt." But, I've tried that too many times.

Another mode of self-control involves special strategies for riding out "weak" moments or crisis periods. One respondent, for example, arranged to participate in a religious retreat when he felt resumption of drinking might be forthcoming. By so doing, he was completely removed from the conditions which were likely to bring about resumption of drinking. At the same time, he was entering a situation in which alcohol was not available, even if he did decide to resume drinking.

Controlling triggers, such as anger, loneliness, or boredom, constitutes another form of self-control. This may be done either by attempting to avoid situations in which these mental states are likely to occur, or by attempting to gain control over the mental state themselves.

> I'm learning to control my temper. Because, the more I think of it, and I told you, when I'm mad is when I do this real heavy drinking.

Another form of self-control involves avoiding situations in which substantial temptations to drink are likely to occur. To do this, a drinker ordinarily needs to refrain from going into bars or other drinking locations (particularly those in which he previously drank), and to break off contact with persons with whom he formerly drank.

> I've done it for so long that I was aware of what, when I'd stop drinking I stay away from those social situations where I had drank before, well, to feel comfortable in them. So when I wasn't drinking, the way that I would handle that was I would just stay in areas where I was comfortable, in my work or something and stay away from social outlets.

A further form of self-control involves arranging the conditions of one's everyday life such that viable controls are ever present. For instance, one respondent, a woman, reported that she moved into close proximity to the church which she had attended as a child, and became actively involved in its affairs. She reasoned that this would provide her with strong controls over her drinking. Firstly, it provided her with time filling activities. When she was busy, she thought less about drinking. Secondly, it provided her with a "reason" not to drink. She had known many members of the church since childhood, and many of them were long time family friends. The thought of these persons becoming aware of her drinking problem distressed her considerably. She reasoned that as long as she remained in their general presence, she would avoid drinking to prevent them from discovering that she was "alcoholic."

The most commonly employed means of remaining under outside controls is entering a rehabilitation institution. Many drinkers find that this is the only way in which they can refrain from drinking.

> People come here in the house now, if they were a lot like me they would just stay in the house, they don't get out much. When they're in the house they're all right. But, when they're on their own they don't to -- they're going to start drinking, its almost a certainty.

The institutional setting provides many viable controls which aid drinkers in maintaining sobriety, so long as they remain in that setting. At the same time, it provides them with the basic resources for living. As one drinker put it, it provides a "haven."

Institutional Controls

The institutional setting posseses a number of properties which serve control functions. It, first of all, provides outside limits on behavior which control a drinker's behavior merely by virtue of his presence. In addition to these, other more direct controls are available which may contribute to a drinker remaining sober.

One set of outside limits found in the institutional setting is provided by rules designed to regulate residents' conduct. To maintain residency, a resident is expected not to drink, either on or off the premises, he is expected to remain in the institution except when given permission to leave, he is expected to attend therapy sessions, and so forth. If such rules are flagrantly violated he may risk being discharged from the institution.

Another set of outside limits provided by the institutional setting regards the time-filling activities and routines found therein. Referring back to Chapter III, as a drinker disengages from active participation in normal social networks, a void is created which is ordinarily filled with increased drinking-related activities. Likewise, when a drinker decides to attempt long-term rehabilitation and thus ceases to engage in drinking-related activities, a void is created. Previous to this, a drinker's life has centered to a great extent around drinking-related activities. When these activities are removed, a vacuum results. This generates two crucial problems for the drinker -- where to go and what to do.

Regarding where to go, most drinkers at this point in the supplanting process have burned their bridges behind them, so to speak, thus they cannot return to normal social networks. If they remain in the drinking milieu which they have recently resided in they run great risk of backsliding in their efforts to remain sober. The most likely solution to this problem, therefore, is to enter a rehabilitation institution, if an opening is available.[4]

If they gain entry into an institution, their problem of what to do is at least partially solved, for the duration of their residence in the institution. The institutional setting provides a drinker with activities and routines which fill the void created by the cessation of drinking. In addition to filling this void, these activities and routines constitute a set of outside limits on a drinker's behavior. If he desires to remain in the institutional setting, he must engage in the "therapies" offered. Although some therapies are voluntary, many are required. Thus, the drinker is expected to attend sessions in particular places at particular times. Many institutions also have general "business" meetings at which attendance is ordinarily mandatory. In addition to these, meals, recreational activities, medical services, and so on are ordinarily administered on a regular basis, in particular places at particular times. In short, outside limits on behavior are provided by the institutional setting, very much as they were previously provided by normal social networks.

In addition to the foregoing outside limits on behavior, the institutional setting provides controls which may more directly play a role

in reducing the opportunity to backslide. One such control is provided by comparing experiences, which as has been said previously, are difficult to avoid in the institutional setting. Comparing experiences may generate what could be referred to as "comparative hope."[5] The term "comparative hope" refers to optimism generated through comparisons with other drinkers. Comparative hope may be generated in several ways.

Firstly, comparing experiences may occasion perspective in regards to a drinker's problems. Through comparing experiences a drinker may see that his problems are very much like the problems of his peers, and maybe even less severe.

> I think I can learn something from being here.... That I am not the kingpin of the world, that I am not the only one with any kind of problems, and that other people have pretty much the same type of problems.

Secondly, comparing experiences may make a drinker feel fortunate in relation to what has occurred to others.

> I'm one of the fortunate alcoholics, I think. I've never gotten into any serious trouble as yet. I haven't lost my job. I haven't lost my family, which happens to quite a few of them here.

One respondent put it quite succinctly when he related his first experience at seeing drinkers well advanced in their careers:

> I felt like someone with no shoes meeting someone with no feet.

A third form of comparative hope occurs through comparisons with drinkers who have progressed farther along in their alcoholic careers, yet have managed to begin to "climb back out." This provides a drinker with the idea that if they can do it, so can he.

> One way it helped me to hear some of the stories these men tell of how far down they went before they started back up. Kind of frightens you, you know. Some of these men were well educated, had good jobs, and they practically ended up on skid row. This is one way it helps you. When they related their experiences, the problems they got into, to hear some of these men they've been in and out of state institutions -- it scares you, at least it did for me. In other words, I don't want to go that route. And, the men explain how they lost families, and also how they helped themselves come back up again. They have jobs again. They have self-respect again.

In general, comparative hope helps to keep a drinker sober because it generates optimism regarding his chances at successfully overcoming his problems and returning to a more normal life. It may facilitate a mental orientation which is conducive to sustained effort at long-term rehabilitation.

Another control which may prevent backsliding is antabuse. Kessel and Walton (1969: 130-131) provide a description of how antabuse functions:

> Antabuse is the well-known trade name for the chemical compound disulfiram. It comes in tablet form. By itself it produces no effects. However, it interferes with the way the body deals with alcohol. When alcohol is metabolized in the body it is oxidized to carbon dioxide and water. At an intermediate stage in this chemical process a toxic substance, acetaldehyde, is formed but it is so rapidly broken down that no ill effects are felt. When a person drinks on top of antabuse, this process is blocked, so that the acetaldehyde from alcohol is only slowly broken down and its level in the blood rises. Accumulating acetaldehyde brings about a sequence of physical sensations which each patient learns for himself....The first symptom to occur in the antabuse-alcohol reaction is flushing and warmth of the face. Then a pounding is felt at the temples as the heart beat accelerates. A headache commonly develops. Another common effect is a catch in the breath, as if there is some sort of obstruction in the windpipe; there may be coughing or a choking sensation. The patient

> becomes uncomfortably aware of his breathing because he has to work harder to take in the necessary air. There is generally an emotional accompaniment to the reaction; this is probably a direct effect of the acetaldehyde in the circulation, which may produce an anxious feeling.
>
> The effects of antabuse occur if alcohol is taken within about three days after a tablet is taken. Once this period has elapsed, and the drug has been totally excreted from the system, no further adverse reactions will occur with drinking. The treatment plan calls for one tablet to be taken every morning.

Antabuse is ordinarily given to those patients who want it, although some amount of pressure from both staff and peers is exerted on particular individuals to take it. If a drinker is reluctant or refuses to take it, he may risk being accused of being less than fully serious about wanting to remain abstinent. His accusers reason, "If you really want to quit drinking, why not take antabuse. If you don't drink it can't harm you."

Antabuse exerts its control by requiring that the taker refrain from alcohol consumption for several days after the last dose was taken. If this is not done, the symptoms described above by Kessel and Walton may ensue. Antabuse functions as a rather strong outside limit on drinking behavior, in that it forces a drinker to ride out weak moments or crisis periods. During the time it takes for him to rid his system of antabuse, the weak moment or crisis period may have passed.

For some drinkers, antabuse acts only as a partial control, and results in a change in drinking pattern from chronic to episodic. This occurs if a drinker periodically goes off antabuse. Antabuse will act as a control until the desire to drink is strong enough to carry past

the several days which are required to safely resume drinking. If this occurs frequently, a drinker may generate a pattern of episodic drinking.

Another control provided by the institutional setting comes about through the influence of peers. Peers are frequently more perceptive than staff at ascertaining when a particular individual is experiencing a weak moment or crisis which may lead to resumption of drinking. Staff persons have large numbers of activities which make attention to individual patients difficult on a close basis. Peers interact much more frequently, so they are generally more sensitized to one another's moods and experiences. I frequently observed drinkers expressing concern over particular peers. If they felt a particular person was having a "bad day," they would often attempt to keep him busy in conversation, playing cards, or whatever. Particular attention was paid to newcomers to the institution. Other residents ordinarily initiated interaction with them and ushered them around for several days to help them "settle in."

The staff in some institutions seem to be aware of the control functions which peers can serve. They organize their institutions in such a way as to maximize peer controls. This may be accomplished, for instance, by structuring the living quarters in such a way that interaction with peers is impossible to avoid. Newcomers may be required to live in group quarters, so that the chances of their finding themselves alone are minimal.

One closer form of peer control which I observed in several instances was what might be referred to as the "buddy system." This consists of two drinkers, usually at approximately the same stage in the rehabilitation

process, providing mutual support. If one starts to backslide, the other offers support and encouragement, if not a little castigation.

One further form of control provided by the institutional setting is what Strauss (1959: 109-118) refers to as a "coaching relationship." Strauss' definition of a "coaching relationship" is appropriate to this context.

> A coaching relationship exists if someone seeks to move someone else along a series of steps, when those steps are not entirely institutionalized and invariant, and when the learner is not entirely clear about their sequences (although the coach is).

In the context of alcoholic rehabilitation, coaches are most often therapists who have themselves experienced alcoholic careers, or drinkers who have experienced long-term success at abstinence. From the perspective of the drinker, a coach is someone who possesses knowledge and wisdom regarding "alcoholism" and "alcoholics." For this reason, he is someone within whom one may place faith. From the vantage point of the coach, a drinker with whom he develops a coaching relationship is someone who deserves special attention, for whatever reason (he is likeable, he is attempting rehabilitation with particular persistence, etc.). A coaching relationship in the context of alcoholic rehabilitation is informal. The parties in such a relationship come to have a general, usually unspoken, understanding that some sort of "special" bond exists between them.

Coaches function as rather strong controls because they command the respect of the drinker. The drinker refrains from drinking because he doesn't want to "disappoint" the coach, or look bad in his eyes. In

addition, a coach may be sensitive to weak moments and crisis periods experienced by those he coaches, so that he may attempt to head them off.

In the course of "working on it," in the manner outlined on the previous pages, drinkers come to gradually seat their lives within the rehabilitation milieu. Becoming seated in this fashion does not necessarily include full-time, extended residence in an institution. If given a choice, many drinkers would probably choose to reside in an institution for a long duration, because of the many controls which such residence offers. However, it is somewhat difficult to do so. Many institutions have an "up and out" philosophy which discourages or prohibits long-term residence.[6] Institutions which allow and encourage extended residence are ordinarily difficult to gain entry into because of stringent screening and lack of available space.

Some drinkers, however, go in and out of the institutional setting as their commitment to long-term rehabilitation fades and recurs periodically. They may have the option of unlimited residence in an institution, yet give it up to resume drinking for a period of time.

Most drinkers spend one or more stays of several weeks or months in institutional residence, followed by outpatient contact and periodic readmission. They frequently make the rounds from one institution to another, not in a quest for resources alone, but also in quest of structural controls over their behavior which help them maintain sobriety. Under such circumstances, their lives gradually come to be seated in the rehabilitation milieu.

CHAPTER VI NOTES

1. In the interviews which I conducted, I was continually struck with the similarity between experiences, characteristics and so forth which respondents asserted to be related to their subsequent alcoholism and those which I had. The phenomena which they mentioned were those experienced by most everyone, in the course of life. When I mentioned this to several respondents, they suggested I be careful because I "would make a good alcoholic." I mentioned that I didn't even drink and they asserted that there is such a thing as a "dry alcoholic," which they defined as persons who didn't drink, but who would come to drink uncontrollably if they did (a common rhetoric).

2. See Berger (1963: 54-65) for a general discussion of an everyday analogue -- i.e. reconstruction of biography.

3. For a discussion of the phenomenon of "faulting," see Yabroff (1973).

4. A problem frequently mentioned by respondents was the problem of "where to go." They claimed that when they decided to give permanent rehabilitation a good try, they experienced great difficulty in finding a place to go for long duration. Several half-way houses were available, except that they were difficult to gain entry into at exactly the moment that one needed, because they were short on space. Other institutions allowed stays of only several weeks, which they claimed was sufficient only to "dry out." They said they needed places to go for long duration -- as long as they needed to "get straightened out" sufficiently to attempt a return to normal social networks.

5. I borrow the term "comparative hope" from Barney Glaser.

6. In such cases, a fear that drinkers may become psychologically dependent upon the institutional setting is ordinarily expressed. Also, a suspicion may be present that long-term residents are using the institutional setting primarily for resources, rather than rehabilitation services.

CHAPTER VII

TRYING TO GET OUT

Once drinkers gain control over the immediate urge to drink, and satisfy their thirst for an "explanation" for their having become alcoholic, they ordinarily begin to think about returning to normal social networks. They therefore devise a recovery plan, which may range from very specific to rather vague in detail. Unfortunately, however, these plans, for a number of reasons, more often than not fail, whereupon drinkers get locked into their alcoholic careers, despite their best efforts to get out. In this chapter, I shall discuss recovery plans and the conditions which are responsible for drinkers getting locked into their alcoholic careers.

DEVISING A RECOVERY PLAN

Recovery plans ordinarily include priorities and procedures for the short and long range. Short-range plans ordinarily involve setting aside a period of time to, as one respondent put it, "lay fallow." During this period of time, drinkers are involved primarily with maintaining sobriety, as discussed in the previous chapter, and finding something "meaningful" to do to fill time (which, as we have seen, is related to maintaining sobriety).

Drinkers who reside in an institution find some time filling activities inherent in the ongoing activities of the institution. Even in an institution, though, drinkers are often faced with an abundance of time. Those who are residing in an institution frequently engage in voluntary tasks within the institution, such as running errands, assisting

staff, and the like. Some drinkers, particularly those residing in half-way houses which have fewer organized activities than most other institutions, sometimes volunteer for tasks outside the institutional setting, such as working with the blind or elderly. Such activities fill time, as well as providing the drinker with a sense of worth.

Other drinkers fill time with what they usually consider interim work, working at such jobs as janitoring, dishwashing, or general laboring. The importance of work at this time is not so much in making money as it is in filling time and providing structure to everyday life. As one respondent put it when asked if he thought he might resume drinking if he were not employed:

> Well, we'd have an awful lot of time, but let's see, uh, you'd have to do something with the time. Fortunately I got a job about a month I'd say, or two months after I quit drinking. There's several people in here who've been unemployed for quite a while and haven't gone back to it. It's not a matter of being unemployed. I think its a matter of having something to do with your time, even if its not earning money. Something to do with your time and with your mind. And even looking for work could be something to do with your time.

Eventually, drinkers begin to make long-range plans for returning to normal social networks. They may begin to become aware that they might become too accustomed to living in the institutional setting, and that if they don't make long-range plans they may never get out.

> These are things, though, at this particular setting, if this stays I'll be perfectly satisfied. The only thing is we have to watch is we don't get into permanent satisfactions. Then I'm defeating what I'm trying to do now.

Long-range plans are important, both psychologically, and practically. They give the drinker a goal towards which to strive -- something to make

continued abstinence worthwhile -- as well as providing long-range organization to his life.

> My biggest problem is, here I could stay sober probably the rest of my life. But, when I leave here if I don't have something to -- some type of goal or some type of a program that I'm comfortable in, why I might stay sober for six months, or I might stay sober for a year, or I might stay sober for another month. But, if I don't have something that I am definitely sure is going to take the place of where I am, then it's just going to be a matter of time before I fall. Now it's no difference whether that I've blacked out because I will go right back to where I am, or was six months ago, see. So this is what most of the talk that is around here are about, is what the hell do you do while you're here is to use everything that the facilities that they possibly have to try to get your thinking, by reading, by talking, by counseling, or by any other way you can possibly get it, to be able to set up a definite program so when you leave here you know what the hell you're going to do.

Long-range recovery plans ordinarily include at least two priorities -- accumulating resources and relearning the social skills necessary to make it in normal social networks. Most drinkers feel it is important for them to find residence outside of an alcoholic milieu once they begin to ease themselves out of the rehabilitation milieu. This will require money for a rental deposit. Furthermore, they will have need for transportation and the expenses of daily living for a month or more, until they receive an income from employment. It will thus be necessary for them to save at least several hundred dollars to "make a go at it."[1]

Money is saved either by judiciously budgeting one's welfare money, or by getting a job. Those who become employed at this time usually seek low skill (and therefore low pay) jobs, which they consider temporary.

Low skill jobs are sought for several reasons. Firstly, drinkers ordinarily do not yet feel "ready" for a "responsible" job. The pressures of such a job, it is feared, may trigger resumption of drinking. A low skill interim job may function as a "test" of one's readiness.

Secondly, some drinkers fear that if they find a "good" job and fail to perform properly, their chances for another good job may be foreclosed. It may become merely one more failure in a poor job history, rather than a step in the other direction.

Thirdly, drinkers may refrain from searching for a permanent job until they have a private address and telephone, fearing that if they give an alcoholic rehabilitation institution as an address (or an address in a skid row area), they will not be seriously considered for employemnt (a very realistic fear). Furthermore, job hunting requires transportation and a "respectable" wardrobe, both of which require money, which a drinker is unlikely to have much of at the moment.

A fourth, and very compelling,reason for not searching for a permanent job at this time is quite simply that such jobs are very hard to come by under the circumstances. Drinkers are aware that employers are extremely reluctant to hire persons with a drinking history. If they remain employed at an interim job for a period of time, they may have more success in convincing an employer that they do not constitute a risk.

The second priority of most recovery plans involves learning once again to interact and function in non-alcoholic settings. Many drinkers at this stage have interacted only within alcoholic milieus for so long that they have lost the social skills and confidence for getting along

in non-alcoholic settings. They generally make plans to polish up these skills by gradually reentering non-alcoholic settings. One way in which this is done is through volunteering for "charity" type work, such as working with the blind or elderly, as discussed previously. Another way in which skills can be polished is by finding employment in a temporary low skill job. In addition to money, such jobs may offer a drinker the opportunity to interact with non-alcoholics. Some drinkers who lack immediate confidence that they can function in a non-alcoholic setting compromise by attending Alcoholics Anonymous meetings outside of the institutional setting. Regular members of such meetings are usually those sort of half way between normal social networks and the rehabilitation milieu. Such persons may "understand" the problems of interaction which a drinker might have. In this sense, they do not constitute as much of a "threat" as others might.

Rhetorics ordinarily play an important role in both short-and long-range recovery plans. Some drinkers follow a particular rhetoric set (such as Alcoholics Anonymous' "twelve steps") very closely, while others use rhetorics more generally, adhering to those which "make sense" within the framework of their particular circumstances.

In addition to providing an "explanation" for one's alcoholism, rhetorics may serve as a foundation for one's recovery plan. The primary way in which rhetorics perform this function is by providing prescriptions and proscriptions for behavior. Rhetorics suggest types of behavior which are assertedly therapeutically rewarding, and types of behaviors which are assertedly anti-therapeutic. In short, rhetorics act as guides for behavior. They "tell" a drinker what to do and not to do, and how to solve problems in his recovery trajectory.

> They go on this idea that what happened yesterday is past, and you don't know what's going to happen tomorrow, so don't worry about tomorrow. You live one day at a time. So you handle this problem one day at a time. Don't worry about what you did in the past.... So with this in mind I know exactly how I'm going to handle it when that situation comes up again.

Rhetorics, furthermore, provide organization and pacing for recovery plans. They suggest that one do certain things and refrain from doing other things in a particular temporal order and at a particular pacing. For example, it is ordinarily considered ill-advised to enter drinking settings early in one's recovery trajectory, as one may easily succumb to temptations to drink. However, later in one's recovery trajectory, a rhetoric may urge, one should "test" one's ability to function in drinking situations without drinking. After all, it is reasoned, we live in a drinking society, so one has to learn to get along in this society, even if one cannot drink.[2]

Unfortunately, despite planning and great effort, recovery plans are ordinarily doomed to failure, and drinkers get locked into their alcoholic careers. I shall now turn my attention to the conditions which bring this about.

GETTING LOCKED IN

The goal of a recovery plan is the eventual disengagement from life in the rehabilitation milieu and reentry into normal social networks -- esentially a reversal of the supplanting process. Several crucial problems need to be overcome in order to accomplish this. First of all, one must find a permanent job outside an alcoholic milieu. Secondly, one must build up a cache of money to get a foothold in a non-alcoholic setting. Thirdly, one must build up the social skills and confidence which are prerequisites for interaction and life in non-alcoholic settings.

Finding a permanent job outside of an alcoholic milieu is a very difficult thing to do, for several reasons. First of all, the stigma of alcoholism is virtually insurmountable when it comes to employment. Alcoholics have the reputation of being unreliable, irresponsible, and untrustworthy. One would think that alcoholic rehabilitation institutions would be places in which one could "launder" one's reputation. However, they do the opposite. The longer one remains in the rehabilitation milieu, the more concrete, undeniable, and traceable the stigmatizing alcoholic label becomes.

Permanent employment is made more difficult by the fact that as a drinker progresses through his alcoholic career he ordinarily burns his bridges behind him, so to speak. Thus, when he attempts to find a job in normal society, he has no "clean" contacts with normal social networks, which may produce good job leads or references.[3] Whatever references he may have acquired in the rehabilitation milieu may only infect him with stigma.

Furthermore, the longer a drinker has been living an alcoholic life, the longer it has been since he has been employed in his ordinary occupation. Over this period of time, his occupational skills, and his confidence in these skills, have surely degenerated substantially. He may find it extremely difficult to convince a potential employer that he is qualified for a job.

Additionally, drinkers are usually deluged with an "honesty" rhetoric which asserts that they should stop "conning" and be completely honest and open in their relations with others. This ordinarily neutralizes the skills which they may have previously used to cover up their biographies in order to find employment.

A second problem with which a drinker attempting to return to normal society is confronted with is that of building up a cache of money to pay for such things as rental deposits, transportation, and a "respectable" wardrobe. This may be attempted by either finding an interim low skill, low pay job, or by carefully saving part of one's welfare money (usually disability payments). However, welfare payments or low skill jobs, alone, usually barely pay for the expenses of everyday living, so that saving is either impossible or so slow that a drinker may become discouraged and give up on his recovery plan.

Many drinkers attempt to combine welfare payments with a job. This path, however, is replete with pitfalls.

If a drinker takes a low skill, low pay job, he may find it boring, unchallenging, or distasteful to the extent that he cannot endure it, particularly if his previous normal occupation had been one which involved skill and responsibility. Additionally, because of the extremely low pay usually given for low skill jobs of the type which he finds

available, he may feel exploited. In any event, his original enthusiasm for working at such a job may begin to fade when he is faced with the daily realities of the job.

Furthermore, if a drinker receiving welfare assistance begins to save money, he runs the risk of having his welfare payment reduced or cut off, because of rules which forbid assets over a certain amount. This puts him back where he started, having to spend his available money on the expenses of daily living. One alternative would be simply to hide one's money from welfare agents. However, the "honesty" rhetoric mentioned previously reduces the chances that this alternative will be chosen.

In short, even if he finds interim employment, a drinker will find it extremely difficult to save sufficient resources to attempt a return to normal society. No matter what he does, he finds he remains dependent upon the resources of the rehabilitation milieu.

Those who do reach the point of seriously attempting a return to normal society frequently find the experience to be more than they can manage. They find that their skills at normal social interaction in non-alcoholic settings have become so rusty that they are unable to muster the confidence to try them out. If they do manage to find a setting in which to test and polish them (an accomplishment in itself), they may find the experience to be so traumatic that they become afraid to try it again. They find that their social skills are those which they have developed over the years for living in alcoholic milieus. They have come to speak and understand "a different language."

Furthermore, many drinkers had problems getting along in normal society before they entered alcoholic life (a fact which may have contributed to their having been eased out of normal life). Now they are trying to return to normal society with fewer skills for getting along than previously, with a long history of problems, and with shaky confidence in their abilities. Furthermore, their reception will likely be unenthusiastic. They quickly discover that society is not awaiting them with open arms, ready to forgive their transgressions and reward their efforts at rehabilitation. Instead, society is suspicious or indifferent.

Under such conditions it is not surprising that many drinkers fall back into an alcoholic milieu, which they find much more comfortable and understandable, and for which they are equipped in terms of skills, knowledge, familiarity and confidence. Their attempt to return to normal society will, on the other hand, likely have been frustrating, unrewarding, uncomfortable, and possibly even terrifying.

For those drinkers who find themselves in the predicament of wanting to remain abstinent, but being unable to return to normal society, there are several alternatives. First of all, if they have the requisite skills, they may become what Wiseman (1970: 237) refers to as "live-in servants" for rehabilitation institutions. Institutions frequently have need for "reliable" help for general tasks, such as dishwashing, cooking, janitorial work, and the like, for which there are low or no budgetary allowances. A drinker may be able to work himself into such a position and remain in the rehabilitation setting indefinitely. One respondent reported having lived this way for years, while remaining abstinent.

A drinker may also con his way from institution to institution, staying in each one as long as he can manage. One respondent reported

having conned his way into institutions for a long period of time by faking a drunk each time he needed a place to go, although he had been abstinent for a number of years.

A few drinkers who have the requisite skills, motivation and opportunity become professional rehabilitators. The skills and experiences which they have gained in their own alcoholic careers become valuable within, and only within, the rehabilitation milieu. Their drinking history does not stigmatize them in this setting, but instead gives them, in some ways, an edge over rehabilitators who have not experienced an alcoholic career. Their first-hand experience is a valuable tool.[4]

Those careerists who are unable or unwilling to do any of the foregoing, resume their drinking careers either to eventually return once again to the rehabilitation milieu, to try to climb back out into normal society again, or to die.

CHAPTER VII NOTES

1. This, in itself, may present a threat to one's recovery plans. Having such a large amount of money at one's disposal may tempt one to use it to finance a long drinking binge. Several respondents reported having done this with money which they had saved as part of a recovery plan.

2. A number of respondents reported having developed strategies for handling drinking situations. One respondent, for instance, said he merely ordered a ginger-ale or Seven-up with a cherry in it and declined to announce that it did not contain alcohol. Another respondent said he merely kept a drink in his presence, but never drank it. This gave other persons the impression that he was drinking. Such strategies protected careerists from pressures exerted by others to get them to have a drink, without straining interaction by disclosing one's problem with drinking.

3. As Wiseman (1970: 223-226) puts it, he has used up his "social margin."

4. Many respondents reported having more confidence and trust in rehabilitators who had experienced the same things they were experiencing. They reported, also, that they had much better rapport with such rehabilitators. They claimed that only other alcoholics or ex-alcoholics could "really" understand their plight.

SUMMARY AND IMPLICATIONS

CHAPTER VIII

SUMMARY

The foregoing pages have consisted of an analysis of the process by which persons who come to be labeled "alcoholic" have the conditions of normal life supplanted by the conditions of life within the alcoholic rehabilitation milieu. I have referred to this phenomenon as the "supplanting process."

The analysis has included discussion and integration of the many variables and phenomena which comprise the supplanting process. To summarize the major properties of the processes: Drinkers are eased out of their normal social networks, usually, but not always, as a consequence of drinking behavior which others define as in excess of ordinary. As they are being eased out, the limits on behavior which participation in normal social networks provides begin to erode, which further facilitates the process of being eased out. These two phenomena begin to interact in an accelerating process, one feeding the other, which ordinarily results in complete disengagement from normal social networks. A usual consequence for the drinker is downward mobility, socially, occupationally, and residentially.

Eventually, drinkers may come to enter the rehabilitation milieu and become receptive to its services. Entry may occur either as a result of drinkers becoming receptive to rehabilitation services, or for pragmatic reasons. Receptivity to rehabilitation services is generated by what I have referred to as "realizing experiences," during which drinkers come to have major revelations and changes in outlook regarding their

drinking and its consequences. Realizing experiences are brought about in at least four ways. Firstly, they are brought about through the development of a history of self-control failure. Secondly, they are brought about through the experience of a severe drinking-related crisis or a buildup of such crises. Thirdly, they are brought about through what I have referred to as "comparing experiences." Comparing experiences are experiences in which drinkers compare themselves and their circumstances with those of other drinkers. Lastly, realizing experiences are brought about through the influence of the many rhetorics which are espoused in the rehabilitation milieu. These phenomena may occasion realizing experiences either singly, or in interaction with one another.

Once drinkers become receptive to rehabilitation services they ordinarily come to accept the alcoholic label, or one of its variations (such as "problem drinker"). The alcoholic label is usually viewed as a range, from "heavy drinker" to "severe alcoholic" (or "real" alcoholic), rather than just as a single phenomenon. Acceptance of the label may come at just about any point in the alcoholic career, although it occurs most frequently at about the time of receptivity to rehabilitation services.

As drinkers come to take the notion of long-term rehabilitation seriously, they begin to gradually seat their lives within the rehabilitation milieu.

Once drinkers become receptive to rehabilitation services, the priorities of their lives shift from those of maintaining a drinking career to those of accomplishing long-term rehabilitation. Many at this point possess a strong urge to find an "explanation" for their having

become alcoholic, which they ordinarily find in one or more of the explanatory rhetorics available in the rehabilitation milieu. The most paramount problem at this point, however, is that of maintaining sobriety. This is accomplished (or at least attempted) through a number of self-controls and through the external controls available in the rehabilitation milieu. Drinkers ordinarily find that self-controls alone are not sufficient to maintain sobriety. Thus, they begin to spend more and more time within the rehabilitation milieu, eventually coming to center their lives within the setting.

Eventually drinkers come to think about returning to life in normal society. They ordinarily formulate plans of varying degrees of specificity to facilitate such a return. Short-range plans ordinarily include means of remaining sober and ways to fill time with "meaningful"activities. Long-range plans ordinarily involve accumulating resources for an eventual attempt to return to normal society, and attempting to polish up one's rusty social skills. Unfortunately, however, recovery plans are usually doomed to failure, for a number of reasons. Among them are the inability to save enough money to make a return attempt, the inability to find permanent employment because of the stigma of alcoholism and loss of previous occupational skills (among other reasons), and the lack of confidence or inability to function in non-alcoholic settings. Drinkers attempting a return to normal society usually undergo experiences which are frustrating, unrewarding, uncomfortable, and even terrifying. Thus, they return to an alcoholic milieu where they possess the necessary skills, knowledge and confidence to get along.

Under such circumstances, drinkers become locked into the alcoholic career, to become "live-in servants" (Wiseman, 1970: 237), to con their way from institution to institution, to, in rare cases, become alcoholic rehabilitators themselves, to return to their drinking careers, and possibly even to die.

The analysis contained in this monograph was accomplished using "grounded theory" techniques (Glaser and Strauss, 1967), in which concepts and variables are "discovered" through inductive analysis of raw data. The data for this analysis was drawn from intensive interviews and participant observation.

IMPLICATIONS

This study has implications for sociological theory, for research in the area of alcoholism, and for practical application in alcoholic rehabilitation.

Theoretical Implications

The theoretical implications of this study concern the conceptual development of the supplanting process in other substantive areas, and the development of the process on the formal theory level. It has implications in both these regards because of its generic nature.

Early in this monograph I referred to the supplanting process as a "basic social process," which may occur in various contexts and substantive areas. In the foregoing pages I have analyzed this process as it occurs, substantively, in the alcoholic career. To illustrate the generic qualities of the process, it is appropriate to discuss it in more general and formal terms. As my discussion is for illustrative purposes only, it shall be brief and somewhat conjectural.

The supplanting process is a major component of what Glaser and Strauss (1971) refer to as "status passage" (a phenomenon by which persons traverse from one social status to another, such as from healthy person to invalid or from non-deviant to deviant). The process occurs always as a consequence of a status passage, although not all status passages engender major supplanting. The supplanting process occurs within the time frame of a status passage. That is, the conditions of one's life begin to substantially change at approximately the time at which one begins to leave one's old status and stabilize at approximately the time at which one comes to firmly possess one's new status.

The supplanting process includes, to a great extent, the most salient experiential components of a status passage. This is due to the substantial life altering import of the process. As one undergoes the supplanting of one set of major conditions for another, one experiences changes in several fundamental aspects of one's life, such that one begins to experience life much differently than before.

Thirdly, one's relationships with others may be greatly altered. For example, a middle-aged man who, through an accident, becomes physically handicapped and confined to a wheelchair may become dependent upon his wife in ways in which she was previously dependent upon him.[1] She may, for instance, assume a dominant role in providing family income. Instead of playing the role of provider, he comes to assume the role of one who needs to be provided for. This may significantly alter power symmetry in the relationship, to the extent that the wife assumes the major decision-making role, which the husband may have previously held.

Fourthly, as one experiences the supplanting of one way of life for another, one's beliefs and ways of viewing and defining the world may change. Switching from one occupation to another, for instance, may bring about such changes. If a truck driver changes his occupation to that of policeman, he may begin to view what he once considered a "pretty good" world as a world full of evil, distrust, and disrespect. Similarly, as a college student becomes a businessman, his political inclinations may begin to shift from the left to the right.

One last and very important experiential property of the supplanting process is identity transformation. As one undergoes a change of status, one comes to view oneself differently, and to project oneself to others differently. For example, as a graduate student becomes a professor, he may begin to think of himself as being superior to his students (who were once his peers). He may begin to have more confidence that his beliefs and knowledge are superior to others. He may mentally "thrust out his chest" for his own self-approval. At the same time, he may begin to wear more formal clothing and conduct himself in a more "mature" manner, for the benefit of others (or in the service of their images of him). His identity in the eyes of others will also undergo change. Others may now see him as an "authority." They may begin to act towards him with special deferences (such as referring to him as "doctor" or "sir"). In general, when one comes to possess a new identity, one's relationships to others are altered, as discussed above.

It is evident that the above discussed properties of the supplanting process may be found in a wide variety of contexts and substantive areas

(I used several different substantive areas in my examples, to illustrate this). The implications for conceptual development of this process in substantive areas other than the one analyzed in this monograph are obvious. It would be valuable to study the supplanting process as it occurs in regards to retirement, chronic illness, deviant careers, occupational careers, marriage, divorce, or drug use (particularly given modern conditions in which drug subcultures have developed), just to name a few areas. Its implications for the development of a formal theory are also evident. Through further research or study of literature in relevant areas, one could discover properties of the supplanting process which are cross contextual (such as those discussed above), and integrate these properties into a formal theory (which might then be integrated into Glaser and Strauss' formal theory of status passage).

Research Implications

In regards to the implications which this study holds for research in the area of alcoholism, several things are apparent. First of all, this analysis illustrates the value of conducting inductive research to discover "grounded" variables. Such variables may become very useful in the long time quest to understand that phenomenon which is commonly referred to as "alcoholism." They can supplement, and in many instances, replace more conventional epidemiological, sociological, and psychological variables and concepts employed in alcoholism related research. Many avenues of alcoholism research have been attempted with, unfortunately, too little success. The type of research represented herein will, I believe, prove to be another fruitful avenue in this area.

The present research also has implications regarding the ways in which "alcoholism" may be viewed. It has commonly come to be viewed as a "disease," or as a pathology of mainly psychological properties. This analysis illustrates quite clearly that alcoholism is a social and social psychological phenomenon, which involves interaction between individual psychologies and the social contexts within which they operate. More studies of alcoholism in this light would prove to be fruitful.

Some more specific implications are also inherent in this research. My analysis has been aimed primarily at outlining a very complex process. Many of the variables discussed within could be researched and analyzed in closer detail, if further data were collected. Just about any of the major variables discussed in this analysis could serve as a basis for more detailed research.

Furthermore, the content of the analysis itself suggests at least one possibly fruitful direction for further research. This analysis has focused on the variables which result in drinkers' normal lives becoming supplanted by alcoholic lives. This process may occur, to a great extent, independent of amount and frequency of alcohol consumption. That is, one may find heavy drinkers whose normal lives are not supplanted by alcoholic lives, although they may consume more alcohol and/or drink more frequently than other drinkers who suffer an opposite fate. This analysis has uncovered some of the variables which account for this, such as the extent to which a particular drinker's normal social networks tolerate drinking behavior. Other variables could be discovered using similar methods, which might cast more light on this rather curious phenomenon. In short, "What variables operate to keep a heavy drinker from becoming labeled and treated as an alcoholic?"

Practical Implications

This analysis also has practical implications for alcoholic rehabilitation. First of all, it appears that some sort of effort at heading off being eased out and the erosion of limits on behavior would be valuable. In other words, it appears that there might be ways of inhibiting the supplanting process before it becomes irreversible, which seems to occur once a drinker has disengaged from participation in normal social networks. Such efforts would necessarily have to involve establishing rehabilitation efforts within normal social networks, such as in occupational settings. At present most rehabilitation services are offered out of the contexts in which drinking problems evolve. If drinking problems are in fact, as has been suggested by this research, generated through interaction between individual psychologies and the contexts within which they operate, it stands to reason that rehabilitation must be aimed at remedying the interactional patterns which occasion the problems. This may reduce the number of persons who eventually reach the rehabilitation milieu.

Implications are also inherent in this research regarding rehabilitation as it takes place within the rehabilitation milieu. One thing which could be attempted, for instance, is to develop ways of increasing the chances that a drinker will undergo a realizing experience of sufficient cogency to prompt receptivity to rehabilitation services. This might be accomplished by more calculated use of rhetorics, or by structuring comparing experiences with drinkers at various stages in their careers.

Some use may be made of the distinction between drinkers who enter for pragmatic reasons and those who enter to receive rehabilitation services. If more attention were paid to distinguishing these two categories of drinkers, each could receive the "treatment" which would be more helpful towards rehabilitation. Drinkers who enter for pragmatic reasons could be exposed to treatments which might facilitate realizing experiences. Drinkers who enter for rehabilitation services might be exposed to treatments aimed more at helping them maintain sobriety, so rehabilitation may continue.

A further suggestion regarding recovery plans can be made. Given that most drinkers devise at least vague recovery plans, it might be therapeutically useful to assist them in designing, organizing and pacing them. Recovery plans could be formalized, for instance. Pledges to remain abstinent are frequently successful, at least for their duration. Thus, "pledges" to adhere to a formalized recovery plan may be useful for some drinkers. It may give them concrete measures of success towards which to continuously strive.

One last implication inherent in this research concerns which variables rehabilitation should be aimed at. As it currently is practiced, alcoholic rehabilitation, probably because of the "disease" concept of alcoholism, is focused primarily on the psychology of individuals. This analysis clearly demonstrates that the most crucial problems once a drinker has become receptive to rehabilitation services are not those of a psychological nature, but those of a very practical nature. Drinkers are badly in need of assistance in relearning social and occupational (those needed for good, permanent jobs) skills. They are also in need

of the resources necessary to establish life in normal society, such as "respectable" clothing, and transportation and rent money to serve them until they get established. Such resources might be made available to drinkers who have successfully adhered to a formal recovery plan.

Drinkers are also in need, quite simply, of places to reside outside of a drinking milieu, until they get sufficiently "straightened out" to attempt a return to normal society. It is quite clear that maintaining sobriety and adhering to a recovery plan is all but impossible to accomplish outside the rehabilitation milieu. Drinkers appear to need rather long stays in a "sheltered" sort of setting in order to begin to develop the skills and confidence necessary to make reentry attempts.

Another type of assistance which returning drinkers would find very useful concerns their lack of social contacts with normal society. Employment services for alcoholics might be given more attention, for instance. The possibility of offering incentives to employers for hiring alcoholics long on their way to "recovery" might be considered. It would additionally be valuable to structure contexts and situations in which drinkers could polish their social skills and gain confidence at interaction with non-alcoholics. To be rather light about it, a sort of "take an alcoholic to lunch" program might be developed, in which non-alcoholics might volunteer to interact with returning alcoholics to enable them to gain social skills and confidence.[2]

One final, and important suggestion which may be offered on the basis of this analysis is that returning drinkers need to be prepared for the cold reception they will more than likely receive from normal society. The burden of blame for this eventuality need be shifted off their shoulders back onto society, where it belongs.

CHAPTER VIII NOTES

1. For a discussion of the ways in which relationships are altered when children are crippled from polio, see Davis (1963: Chapter 6).

2. One general implication of the foregoing discussion, suggested to me by Don Cahalan, is that when rehabilitators enter into a person's life to institute change, they should be alert to unintended consequences. As is suggested by this analysis, unintended consequences may be as difficult to deal with as the original problem -- hence, in the case of the alcoholic, the need for after-care to reinstate them in a working, non-alcoholic social milieu.

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