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Communication Patterns in an Alcoholic
Rehabilitation Program

COMMUNICATION PATTERNS
IN AN
ALCOHOLIC REHABILITATION PROGRAMME

By

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Abstract

Changes in communication patterns were observed between the staff group and a changing patient group over the course of one year, 1976-1977, and analyzed for this study of the Alcoholic Rehabilitation Programme, Chedoke Hospitals, Hamilton, Ontario.

The original communication patterns promoted open, direct communication between staff and patients as well as a sense of community and purpose. The purpose around which the two groups joined was to help the patients to overcome their alcoholism through therapy. While there was always a basic distinction between the two groups in their perceptions of their roles and functions, there was convergence in understanding of their unified purpose. A gradual movement took place over the course of the year toward greater formalization in the communication outside of direct therapy. This increased formalization of communication led to and was augmented by rigidity in role and functioning expectations of staff held by patients. Several factors seemed to have played a part in this process: The nature of the therapeutic relationship increased

responsibilities outside of direct therapy which made staff less visible; pressure by patients for staff to exemplify the ideal life style (which was taught as an ideal), and gradual movement over the year by staff to adhere to such a lifestyle; greater patient group solidarity, and increased formalization in contact with staff outside of direct therapy.

These changes are analyzed in this study in light of both anthropological and psychological theories of communication in the hope of suggesting not only the process of the changes but also their ramifications for therapy.

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I. Introduction

During the period from December 1976 to December 1977, the author was privileged to be a participant/observer in the Alcoholic Rehabilitation Programme at Chedoke Hospitals, Hamilton, Ontario. Through this time, observations of the inner workings of this unit including the administration, staff, patients and physical setting were made. The interactions of these elements around a common problem and presumably common goal were observed and documented for this study. This study began as a collection of material for an ethnography of the unit, however, during the initial period of collection a compelling pattern was observed in the relationships between staff and patients. Patterns of communication between the two groups appeared to be undergoing change, and since communication is a sine qua non of therapy, the focus of this study became the elucidation of both the patterns and the nature of the change.

In any social system there are relationships between or among groups which are prescribed by the groups' definitions of themselves and the other group(s). The perception of the situation in which such relation-

ships occur will also serve to define the nature of the interaction among the groups. In the case of the groups under study, the situation was a health care setting in which the purpose of the programme was to provide a setting in which relationships between willing patients and therapists could occur for the benefit of the patient. The purpose thus seemed fairly clear and simple, and the expected relationship, amicable; a situation and purpose which should have fostered open, direct communication between staff and patients. However, the process which was seen to be taking place at the inception of this study suggested rather a movement away from the expected clear, direct communication. Casual communication between therapists/staff and patients in addition to therapeutic intervention, was the rule at the beginning of the year under study. During the year, for reasons which will be explored at length, this communication became circumscribed. Concomitantly, expectations of role and functions between and within the two groups changed, assuming far more formal characteristics and subsequently reinforcing distance.

Over the course of the year, changes were seen to occur in patient relationships. A sense of community and purpose among the patients was observed from the

inception of this study. However, as the relationship of patients to staff changed, so did the relationships among patients. Where there had been casual communication with staff around problems in the patient group, secrecy became the norm. Where staff help in solving community problems had sometimes been sought, there was increased pressure to solve the problems internally. In addition, a formal structure was finally created which tried to take upon itself the task of mediating among patients and between staff and patients, real or perceived problems. This structure too, as will be demonstrated, helped to reify the division between staff and patients, and reinforce expectations of roles and functioning both between and within the two groups.

The purpose of this study is to elucidate the nature of the original relationships between staff and patients, the nature and process of the changes, factors in perception of roles and the situation which may have effected or affected the changes, and finally to try to discern the direction and potential impact of such changes. In the attempt to do all of the above, both Anthropological and Psychological theory will be incorporated in seeking an understanding of the changes which took place, their movement and potential future.

The value of such a study is twofold. First, its academic usefulness lies in the revalidation of the Anthropological perspective in a health care setting. Secondly, the examination of these phenomena may be useful for others involved in health care programmes where similar communication issues may arise and have ramifications for the functioning of such a programme. In addition, hopefully this study may provide a useful mirror for the programme which was studied and offer insight into the nature of unplanned change.

To fully appreciate the descriptive material, a review of the relevant literature will be presented, as well as the literature upon which the analysis will be based. In addition, a description of the programme as well as problems which were regularly seen as adjuncts to alcoholism at the unit will be presented to aid in understanding basic communication issues in this situation.

Introduction to the Literature

The choice of an analytical framework was dictated by the focus of the material under study. In dealing with what were seen as two separate systems in contact and their interaction and communication patterns,

the combination of anthropology and psychology appeared to be essential. In addition, since this study dealt with a therapy situation in which clear communication was essential, and the trends suggested changes in communication patterns, a theory which dealt with communication and roles seemed appropriate. The choice of a theory which could also deal with and explain in terms of communication, the process of progressive change, seemed, in light of the descriptive material, ideal.

The theoretical framework which was chosen to be used in the analysis of the data presented here was developed by a number of individuals over the course of some forty years. The original observations which led finally to therapeutic uses of Communication Theory, were made by Gregory Bateson while doing fieldwork among the Iatmul of New Guinea for his book, Naven (1936). While observing various initiation rites, the relationships between the initiates and the initiators struck Bateson as defying "normal" behavior. Bateson found elements of these same relationships in the behavior between men and women among the Iatmul. Bateson observed that these behaviors could only be understood in terms of the relationship of one individual or group to another.

As a much later contributor to this theory wrote:

If a person (group) exhibiting disturbed behavior is studied in isolation, then the inquiry must be concerned with the nature of the condition and, in a wider sense, with the nature of the human mind. If the limits of the inquiry are extended to include the effects of this behavior on others, their reactions to it, and the context in which all of this takes place, the focus shifts from the artificially isolated monad to the relationship between the parts of a wider system. The obvious human behavior then turns from an inferential study of the mind to the study of the observable manifestations of relationship.

Watzlawick, et al. 1967:2

These relationships between both individuals and groups seemed to fall into two categories; symmetrical and complementary relationships as Bateson called them.

Complementary relationships were characterized by Bateson as relationships either between individuals or groups, in which the behavior of one partner demanded a complementary behavior by the other partner (1958:308). Examples of complementary relationships include, mother/child, teacher/student, doctor/patient, etc.

Symmetrical relationships were characterized by Bateson as relationships either between individuals or groups in which the behavior of one partner demanded the same or equivalent behavior by the other partner (1958:311). Examples of symmetrical behavior are strength met

with strength, weakness with weakness, etc.

Bateson went on to identify the potential for change in such relationships. Bateson observed that in both complementary and symmetrical forms, change had a tendency to be progressive. That is, if submission was met with assertion, that assertion in a complementary relationship demanded further submission. This process, according to Bateson, contained the seeds of what he called complementary schismogenesis. In the same way, he suggested, in a symmetrical relationship, boasting met with greater boasting had the potential for escalation to become a process of symmetrical schismogenesis (1958:182-83). Bateson defined schismogenesis as "...a process of differentiation in the norms of individual behavior resulting from cumulative interaction between individuals." (1958:175). In both relationship types, as escalation occurs, and both groups struggle to maintain control of the relationship by their exchange of behavior.

Bateson suggested that while both patterns of relationship were normal, once escalation had begun, if there were not cultural or group norms which limited its potential, the outcome might be dire (1958:194ff.). Possible outcomes of such divisions were the distortion

of the personalities, hostility, increased inability to understand one another's emotional reactions and mutual jealousy (1958:187-88). Further, Bateson suggested that as the process escalated, a point could be reached when each became

...mutually contra-suggestible. In place of patterns of behavior which were perhaps originally adopted in an attempt to fit in with the other party, we now have patterns of behavior which are definitely a reaction against the other party. Thus the schismogenesis takes a new form, and the relationship becomes less and less stable."

(1958:189)

Bateson also noted in his studies that as individuals form groups, the ethos (the emotional tone of culture) which was passed on to the individual helped to formulate his understanding of relationships and of his position, thus speeding enculturation and reifying the group's norms. Bateson also recognized the import of these progresses both on an individual level, i.e. within the personality of an individual, and also in dyadic relationships (1958:178-82). However, his major emphasis was on inter-and intra-group relationships.

With the advent of cybernetic theory and with the application of Russell's theory of logical types (Whitehead and Russell:1910), Bateson's formulation of the movement of schismogenesis and of the inexorable

breakdown of a system, were reformulated. Corrective feedback, meta-learning and meta-communication explained how a system which had become schismogenic could remain stable or even return to its original state. These developments also helped to explain why patterns could be broken, since they were only a set of perceptions about the parameters of and options for behavior within a relationship. If that set of expectations or perceptions could be transcended then the pattern could be broken.

Later work by Ruesch and Bateson (1951), Communication: The Social Matrix of Psychology, and Bateson's Steps to An Ecology of Mind, (1972) removed the use of these theories from an esoteric cultural context and focused on the individual. The use of this model in a psychiatric context, especially dealing with schizophrenics, produced a further refinement, the theory of double binds; very simply, the double-bind is basically a "damned if you do, damned if you don't" situation.

The Communication Theory in Psychiatry was further developed in work done by Watzlawick, Weakland, Fisch, Beavin, Jackson and others in the area of marital and family intervention. Their work focused almost exclusively on dyadic relationships. (See for example: Watzlawick, 1964; Jackson, 1965; Watzlawick, Beavin and

Jackson, 1967, and Watzlawick, Weakland and Fisch, 1974.)

Thus, Communications Theory has been used over the years to elucidate group to group interaction and the contribution of the individual to that process. It has been applied to the action of schismogenic process on individuals and finally, in the process of communication between two individuals.

In the discussion of this study, the focus will once more be on group to group interaction and communication, and the individual's contribution to the process. The analysis will also have the advantage of the forty years of development of Communication Theory, with which to focus on therapist-patient relationships.

The problems and attitudes associated with alcoholism have been well documented in the literature. This part of the review will focus specifically on common attitudinal and emotional features of alcoholics seen for treatment in various facilities in both Canada and the United States. The common features will help to lay the groundwork for looking at communication problems.

Two types of alcoholics have commonly been identified as cited in the literature. The first type are classified as hypomanic or "interest" alcoholics, and the second type as "stress-type" alcoholics.

The hypomanic, or "interest-type" alcoholic was characterized by both Rosen (1966:1286) and Jones (1968:10). Common features suggested included: direct hostility, rebelliousness, self indulgent, socially at ease and "...perhaps even indifferent to conventional morality and/or social controls." (Rosen; 1966:1286).

The "stress-type" alcoholic was characterized by Rosen (1966), Sands, et al., (1967), Solari (1970), Reading (1972) and Barry (1976). Common features suggested included; low frustration tolerance, high anxiety levels, poor self image, over sensitivity, feelings of inadequacy, social rejection, and depression.

The literature is rife with descriptions which suggest two common types of alcoholics with different presenting characteristics. The situation is that of a complex group of characteristics in people already labelled with the stigma of alcoholism as well as the other problems. Perry suggested that a potential barrier to rehabilitation of the alcoholic included the alcoholic's "...fear of the punitive and moralistic attitudes of the community which he has, over time, incorporated into his own self image..." (1970:7). Barry suggested that another barrier to rehabilitation is that, "Alcoholics are notoriously resistant to therapy. This is partly because they have acquired a strong habit of

alleviating tension and distress by the drinking. A further obstacle to successful treatment is their fundamental ambivalence." (1976:455).

Aside from the typologies presented, a potential barrier to rehabilitation as suggested by Perry, et al., are the attitudes of the community. Problems which emanate from being an alcoholic in this society, quite aside from any direct effects, seem to stem from an understanding of what being an alcoholic means in North American culture. The alcoholic is seen as stereotypically weak, lacking in self respect, irresponsible, untrustworthy, and above all, driven by his or her compulsion to drink. This stereotype, even where it contains elements which might partially reflect the situation of certain people in some stages of alcoholism, does not, in fact reflect the form or functioning of alcoholism for the majority of alcoholics. In that the stereotype does not reflect the reality for many, it creates a picture which obviates, for most people, early recognition of the problem. Whether or not the pejorative picture is reality becomes irrelevant in that it defines criteria for recognition of the problem. The stereotype similarly creates a bind for persons who may feel that alcohol is having a negative effect on his/her life functioning, but by seeking help or even recognizing the gravity of their

problem must classify themselves within the stereotype, both for themselves and others.

To be an innovator, to break through and challenge what is held by a society to be truth is, at the best of times, a task for those who are willing to endure censure. This is in effect what is asked of people who have a problem with alcohol abuse. People whose lives may be still intact, and who may be functioning effectively in most situations are not, for the most part, willing to hold themselves up for the potential disdain, contempt and pity which may follow an admission of alcoholism. In view also of those characteristics which were described in the literature, it becomes even more difficult for the alcoholic to take such a stand. Further, to challenge a person whose life may be basically intact by suggesting that they are abusing alcohol, is virtually certain to be greeted with denial, fear and hostility in the face of this stereotype, thus preventing for many the early resolution of their problem.

Finally, Reading sounded a note of caution saying,

Individual alcoholics differ widely in their manner and degree of manifesting these 'typical' features. Furthermore, it is important to remember that even when they are all present, they do not represent the entirety of a given individual's personality.

Despite the similarities, each alcoholic has a unique personality that must be reckoned with, especially if one is to treat him.

(1972:68)

Beyond the consistency of many of the emotional features cited in the literature, there were problems which were common to many of the people seen at the unit during the year under study, which merit mentioning.

Many of the patients seen at the unit had problems which were secondary to their alcoholism, but which may have been precipitating factors in accepting treatment. For some, participation in treatment was a response to growing pressure in several areas of their lives. The pressure, in some cases having precipitated an acknowledgement, whether sincere or not, that things could not go on as before. These problem areas included problems related to health, vocation, social relationships, and marital and family relationships.

(1) Health

Some of the major health problems which were seen at the unit or which had been commonly experienced included: Liver damage, gastritis, ulcers and malnutrition. Other problems seen included lung problems probably secondary to smoking and poor nutrition, since a majority of the patients were cigarette smokers. There

were obviously a variety of other health problems related by three hundred people, but these constitute typical health concerns. Liver damage was the health problem most often cited as having precipitated a decision for entering treatment.

(2) Vocational

Common problems seen included: Absenteeism falling production rates and lowered quality of work produced. Also, in some cases, behavior changes which may have been disruptive to life at work had been noticed by employers. Many patients who came for treatment had problems in this area, and a fairly high proportion felt that even if their jobs were not currently threatened, that they would be if they persisted in their drinking. In many cases, the threat of job loss, whether immediate or in the near future, was a major motivating factor in entering treatment. In some cases, constructive coercion employed in the job situation was the person's sole motivating force in seeking treatment.

An interesting aspect of this discussion of employment is that, a large proportion of the employed group, when referred from industry were considered to be excellent, conscientious workers when they were not drinking.

(3) Social Factors

Some common problems experienced by the patients in the area of social functioning included: the loss or withdrawal of friends as the drinking problem became more severe and obvious, a gradual withdrawal by the person from clubs and organizations and withdrawal from his/her circle of moderately drinking friends commonly occurred. A gradual loss of leisure activities such as hobbies or crafts as the problems became more severe was also noted. With all patients, there seemed to be a gradual shutting down of social contacts to accomodate the time spent drinking, this left the person with a relatively restricted social life.

(4) Marital and Other Familial Relationships

Most of the people seen at the programme were married (52%). (See Table 1). If the other categories, separated, widowed, divorced and commonlaw were to be included, fully 82% of people seen either were or had been involved in a close, marriage-type relationship. The toll which alcohol takes on such intimate relationships may be only partially suggested by the 25% who were separated or divorced. In a goodly percentage of these latter cases alcoholism was a contributing factor

Table 1: Patients, General Statistics, October 1976
to October 1977.

79% of 279 Treated Patients were Employed

Referral Sources

50% from Industry

20% from Family Physicians

30% from Other Agencies and Self-Referred.

<u>Age</u>	<u>% of Treated Population</u>
18 - 29	21%
30 - 39	29%
40 - 49	30%
50 - 59	17%
60* and over	3%

Marital Status of Treated Population

Married:	52%
Single:	20%
Separated:	17%
Divorced:	8%
Commonlaw:	2%
Widowed:	3%

*Normally, admission was limited to people between
ages 18 and 65, however, exceptions were made.

to the failures of the marriages. Other problems not reflected by the statistics which were fairly common included a loss of trust within the family system; loss of respect; guilt over past events, anger towards the drinking partner, a loss of responsibility in the family system, and sometimes financial problems either due to or exacerbated by the drinking behavior. Other problems included a loss of satisfactory sexual relationship, a generalized feeling of distance from those in the family system, and a vague or distinct feeling that the family was slipping away.

The problems which have been chronicled have been virtually ignored in the body of material and the analysis in this thesis, since these outside problems were not always directly observable in the patient's life at the unit. While these problems may have had impact on treatment, they appear here only to try to illustrate potentially covert forces which may have affected attitudes.

The Unit

To understand the context from which the material to be presented was drawn, it will be useful to present an overview of the programme, its history and purpose.

The Alcoholic Rehabilitation Centre was located on the Chedoke Hospital's grounds in the Moreland Residence. The programme in its current form, and under the auspices of Chedoke Hospitals, began operation in October, 1976. The programme occupied two buildings on the hospital grounds and had facilities for the treatment of approximately twenty patients at any time.

The programme served a coeducational population drawn from the following areas: Hamilton, the counties of Brant, Dufferin, Haldimand, Norfolk, Wellington, Wentworth and the Regional Municipalities of Waterloo and Niagara.

Men and women with a predominate alcoholic problem were referred to the treatment centre from a number of sources. Referrals were accepted from social service agencies, industry, medical facilities and from the individual with the problem.

The admission criteria included that the individual had to be sober or detoxified before admission to the programme and free of serious medical complications. The person had to have court charges finalized prior to admission and had to agree to take protective medication as prescribed such as Antabuse (disulfiram) or Temposil. The person had to agree to be involved in all phases of

the treatment programme which included an assessment interview, two days of orientation, four weeks of residential treatment as in-patients and fourteen months of follow-up as outpatients in the community. The involvement of the person's family in various activities was also strongly encouraged.

The therapies offered spoke to the whole life system and included: Assertiveness training, individual counselling, Antabuse/Temposil lecture and therapy, transactional analysis, recreation therapy, vocational assessment and counselling, educational lectures, sexual assessment and counselling, educational lectures, sexual counselling and education, Alcoholics Anonymous, reality therapy, group therapies, relaxation therapy, psychodrama, family therapy, psychological testing, life skills groups, leisure counselling and a lecture series for the patient and his or her family.

The philosophy which underlay the programme was that each person was capable of change. The emphasis was on personal responsibility and the development of the individual's potential to its fullest, towards individual goals at their own rate. There was direct and ongoing consultation with the patient and facilitation of such growth which allowed the individual to take credit and

responsibility to a large degree for success. This in turn, was designed to help the individual to begin to take full control of his or her life in a structured environment and under professional direction. This environment also allowed the patient to begin again to encounter the risks and benefits associated with change and responsibility in expanding their worlds.

Further, the programme philosophy suggested that to facilitate the reorganization of a system disorganized by alcoholism required the cooperation of both the affected individual and his or her support system for the greatest potential for success. A multifaceted approach to the problem of alcoholism was taken to promote the greatest possibility of life change for the individual.

II. Methodology

Bias and Problems

Being a therapist as well as an Anthropologist presented problems in the collection of data in a health care programme for this thesis, similar to those met regularly by applied anthropologists. The role of the therapist dictated that observation and interpretation of patient behavior and subsequent intervention to try to affect positive change were priorities. As an Anthropologist, as an observer of behavior, it was preferable to allow the interplay of behaviors to proceed uninterrupted and take its natural course. Allowing the behavior to proceed without intervention permitted the study of the full range of behaviors, whether destructive or beneficial. However, as a therapist/anthropologist, the clinical side of the role had to be dominant even while the Anthropologist observed the behavior. The therapist interceded and helped the patient to try to understand and change his or her behavior. If in this process the Anthropologist's perspective was useful, then it was brought into play. The Anthropologist as strict observer did not play a part in this situation

except as an observer. This must raise some question as to the objectivity of observations presented in this thesis. The only answer to this question is that the therapist's role had to be dominant and the only interest had to be the ultimate welfare of the patient. Any analysis beyond that immediate goal was carried out after the fact, and was therefore, to some degree free of therapeutic intent. This telescoping of observations allowed the author to observe herself as well as the patients and other staff. This allowed the author to further separate the role of anthropologist to allow analysis and interpretation on a very different level from that on which the therapist worked. In this analysis there was little or no interest in clinical intent or intervention; the material gathered was for long range analysis of patterns and, until those patterns became clear, could not interfere with events as they occurred. This facet was a function of academic interest and as such was critical of premature analysis or interference in events.

As a functioning member of the society, the advantages of this position were that there was access not only to the events, but to the impact of those events. As strictly an observer, there could not have been the experience of the force of those events on the goals and intervention, nor an understanding of the stresses and

frustrations involved.

As a therapist, observations of patient-patient interactions were sometimes limited by being in the position of therapist. On occasion, when a therapist entered a room, conversations were halted and resumed only when that person left. On such occasions, the scope of the observations was obviously limited; however this degree of curtailment only happened occasionally. Another limiting factor in making observations was that on entering a situation in which patients were socializing, the therapist tended to become the focus of the conversation. The therapist seemed to be seen as an authority on a broad range of subjects, and unless the focus was turned away, the conversation continued to revolve around that presence. The author handled such situations on many occasions by denying knowledge or opinion on subjects. This denial seemed to allow the focus of the conversation to shift away and follow normal patterns. Once this shift was accomplished, there seemed to be acceptance of the author as observer in many casual exchanges and this pattern was repeated with many groups who went through the unit in the course of the year. The fact that at times therapists were seen as interlopers and their presence rejected will be dealt with in some detail in Chapter vii. This complete rejection was a rare

phenomenon at the beginning of the year under study,
but one which was seen more frequently as the year went
on; this too will be dealt with in some detail.

III. Physical Setting

The physical setting in which the patients found themselves seemed to be perceived and interpreted to reinforce a particular set of assumptions. These assumptions included that there were areas of the unit which "belonged" to therapists and where patients could not or should not go. These assumptions contradicted assumptions by therapists of patient movement at the unit at the beginning of the study. However, these expectations were reinforced over the period, and validation was eventually gained by changes in therapists' behavior.

The patient expectations seemed to dictate a facet of the power positions of both groups. In describing the setting in some detail the assumptions, expectations and the outcome of their enforcement will be illuminated.

The unit was housed in an old brick building which had been a nurse's residence. The patients lived in this building during their four week stay. In addition, there were offices and meeting rooms contained within the building. For the first part of the study, all therapy took place in this building. For the

re-opening of the programme under the auspices of Chedoke Hospitals, the building was refurbished in the summer of 1976. The only structural change which took place was the creation of Conference Room Two. This building was known as The Moreland Residence (Diagram 1).

A second building, which was adjacent to the Moreland Residence, was the East Pavilion. This building was given over to the Programme, and refurbishing begun in the Spring of 1977. Its gradual use as a recreation area began in the Summer of 1977 but it was not used regularly until nearly the end of the year under study. Therefore, only tentative analysis of its impact will be offered in this thesis.

The Moreland Residence was three stories high. The top floor was employed exclusively as male bedroom area. There was also a small commonroom on the third floor. The second floor was known as the "women's floor". However, due to a paucity of female patients, the bedrooms were often used for male patients. Half of the second floor was given over to staff offices. About three-fourths of the main floor was used for offices, the remaining third or better was used directly for therapy.

The second and third floors were identical

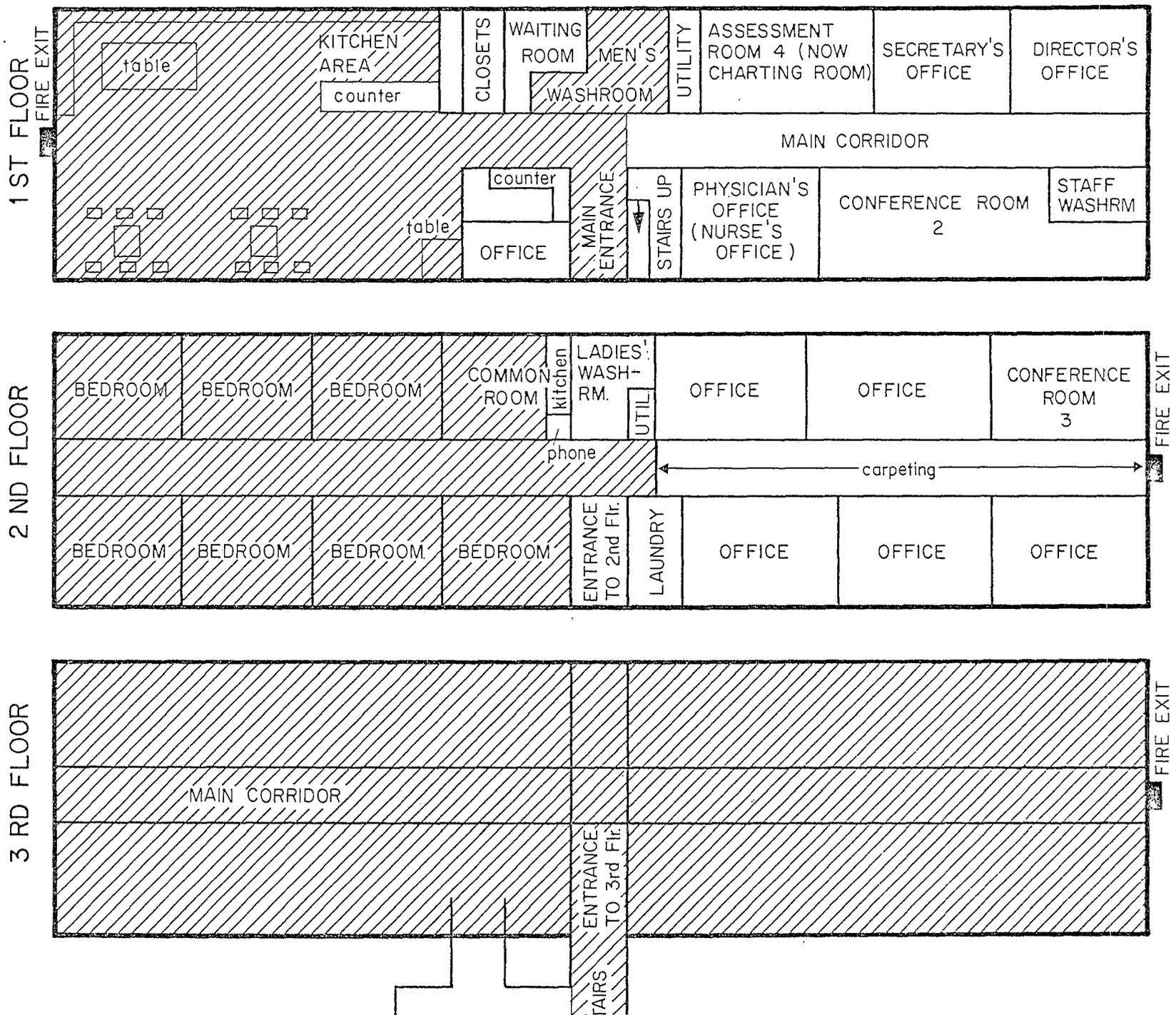
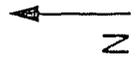


Diagram 1: General Floor-plan of Moreland Residence

in structure. Offices on the second floor were distinguished from bedrooms only by their furnishings. On both floors there were commonrooms. However, only the commonroom on the third floor was actively used by patients. The commonroom on the second floor was virtually never used by patients or staff. The only differences between the two rooms were their respective floors and a television set in the third floor commonroom.

The bedroom areas were virtually deserted during the day, since all patients were involved in groups. However when occupied, the third floor, according to reports and observations, had a dormitory atmosphere. The patients joked and talked in the hall and the washroom and general horseplay often took place at these times. Because it was a bedroom area and unused during the day, the third floor was rarely visited by staff other than the housekeeper and the night staff. Because of this relative isolation, the presence of therapists was cause for some excitement and surprise. The attitude of patients seemed to be that there was something wrong if a therapist went to the third floor. Because therapists understood that this reaction took place, they became more reticent about going to the third floor over the course of the year, thus reinforcing the

isolation of this area. The patients seemed to perceive that the third floor was a patient area and gradually, that attitude had an effect on therapists' perception of that area.

The second floor was a dual purpose area as mentioned, housing both bedroom area and therapists' offices. It also contained the laundry room and the pay telephone, both of which were important areas for patients. The floor was almost evenly divided between the cluster of staff offices in the south end of the hall, and bedrooms at the north end of the hall. The commonroom, telephone and laundry room were approximately in the middle. The commonroom, as mentioned, was virtually never used. However, the telephone was an important feature as it was the only patient accessible phone in the building. A small phone booth without a door had been cut out of the wall. The phone was important in several ways. First, it was the patient's only access to family and friends other than visits. There was also only one phone and so, on many occasions, jockeying for time on the phone became a matter of major importance to the patient group. Secondly, the phone was in full view of both the stairs and the hall so that the person using the phone could be seen by, as well as see, other people in the area. Due to this visibility, both thera-

pists and patients became aware of anyone who used the phone excessively or during groups. The use and abuse of the phone was a subject which often came up in community meetings, and became a vehicle for the discussion of individual and group response and responsibility in a community.

The beginning of the south end of the second floor was marked by a carpet which ran the length of the office area. There were eight therapists who had offices on the second floor, a large number compared to the number of patients who normally occupied the second floor beds. The beginning of the carpeted area marked the end of the area of the second floor which patients perceived as free access area. It was extremely rare for a patient to move past this point except on specific business with a therapist. An inquiry by a staff member as to whether a patient needed help in finding a particular staff member when someone did venture into that area, generally elicited one of two responses. The first response was a subdued and nervous answer, which suggested that the patient was uncomfortable. The second response was seemingly of relief at the offer of help. Both responses were out of the ordinary for most patients, but so was the question which suggested that there was

general recognition that that area was foreign territory for patients. The exceptions to these responses came from fourth week patients and outpatients who seemed to feel more comfortable moving in this area. The conference room on the second floor was open most of the time, however, it was virtually never used by patients.

Structurally, there were no differences between the two ends of the hall, however the perceived differences were obviously great.

The second floor, like the third, was rarely occupied by patients during the day other than for use of the phone. Staff on the other hand, spent much time on the second floor when not occupied with the large patient group. While it was rare that a therapist would have approached a patient in his or her bedroom, it was far more likely to happen on the second floor, again, indicative of the fact that there was generalized recognition of the qualitative difference between the two floors, and perhaps reinforcing this difference.

The first floor was roughly divided into offices and conference rooms. Much of any patient's time on the unit was spent on the first floor. The south end of the first floor contained the programme director's office, conference room two, the physician's office, the unit secretary's office, the charting room

and the men's washroom. Except for the charting room which was formerly an assessment room, none of these areas changed function in the year under study. The only demarcation of this area from the north end of the hall was an archway approximately equidistant from each end of the building. However, once again, areas in the south end of the hall were rarely approached casually by the bulk of patients who went through the unit. Again, the exceptions were patients in the latter part of the four weeks as inpatients and those in the outpatient sequence. This area of the first floor was heavily frequented by staff. Not only were those with offices there, but those using the charts, talking to other therapists, etc. In addition, approximately three months before the end of the year under study, the assessment room on the first floor was converted to a charting room, which ensured a larger concentration of staff in this area.

While most areas in the south end of the hall had specific staff functions, conference room two was the exception. This room was used largely for groups and so all patients spent time there during most days. However, this room again, was virtually never used by patients outside therapy groups despite being open and

comfortable. Two factors may have played into the lack of patient use of this room. The first factor may have been the room's proximity to largely staff areas. The second factor was that this room was used at lunch and in the afternoons for staff meetings, and consequently may have been designated as a staff room.

One area which patients did approach relatively freely in the south hall, was the physician's office. This office was almost immediately beside the arch, and patients who needed papers signed by the physician or who wanted attention for a physical ailment went there freely. During virtually the entire year under study, medications were given out from this office, and so, most patients visited this area daily. This pattern however changed toward the end of the study and the impact on free access, if any, cannot yet be assessed.

The front hall was divided by a doorway through which there was free access to the south end of the hall, conference room one, the front door and the stairs to the upper floors. The hall was used basically as a passage way despite the presence of a couch. Occasionally a patient and his or her spouse or friend used this area, however it afforded little privacy due to the multiple accesses.

In the main part of the hall there was a reception desk, behind which was a therapist's office. Despite this office, this main part of the hall was travelled freely by patients. The only area not used regularly was behind the desk.

The waiting room which was adjacent to the main hall was occasionally used by patients to visit with their families or friends. The waiting room seemed otherwise to be infrequently entered. Several factors may have played a role in this, including the fact that it was used for the above purpose and was seen as a rather private area. Another factor may have been that people waiting for assessment used that room and patients seemed to be acutely aware of the need for privacy in that situation.

Conference room one was, for this analysis, a very important room, as most patient activities were carried out there. Conference room one was a large square room which housed an area in which most lectures were given as well as kitchen and socializing areas. The entire room was used freely by the patients, and on occasion, subdivided by the patients to house subgroups which occasionally formed. If a particular patient was ostracized by the main patient group, this room was the

area which was seen as being off limits during socializing time and which was avoided by that patient.

The East Pavilion as an area for patients became accessible late in this study and so its impact on patient movement was difficult to assess without more time for observation. Despite limited observations, there seemed to be some patterns which had begun to form. The patient's use of that building was limited by two factors. The first limiting factor was that to gain entrance to the building a key had to be obtained from a staff member. Secondly, the times when patients were allowed in that building were limited. In addition, the facilities offered by that building at the end of the period of observation were quite limited; future renovations however promised to change that situation. During the time it was available in this study, few patients made extensive use of the East Pavilion. This was despite the fact that it was physically separate from the main building and afforded privacy from the main group of patients and staff. While these observations were at best preliminary, there seemed to be a trend towards the use of this area by those who were least involved with the main patient group, i.e., those who had been ostracized, those who had refused to participate

with the group, or those who had formed small, resistive groups which did not interact with the larger group socially.

Conclusions

It is clear from this section, that there were areas which the patients perceived to be free access areas for them, and areas which they considered to be off limits. It would be logical to suggest that those areas which the patients saw as being off limits were areas in which they would not normally have business, however, that was true in only a limited sense. There were areas on both the first and second floor which were both open and comfortable which had few if any other purposes during free patient time, and which were ignored by the patients for socializing. It is also clear that the areas seen by patients as being free access areas were physically quite restricted. The obvious common factor among those areas perceived as non-patient areas was that they were areas deemed by the patients as staff areas. Patients designated several of these areas and showed deference and anxiety on entrance. This behavior in turn, demanded a complementary response by therapists, thus validating patients' expectations of a power rela-

tionship. These expectations and responses eventually led to changes in therapists' assumptions about "free" areas, which helped to reinforce the original patient assumptions.

IV. Hospital Administration and Other Influences

While life at the unit is being treated in a partial vacuum in this study, there were factors extraneous to direct treatment which clearly coloured patients' initial perceptions of treatment. The position of the unit vis a vis both the hospital and the larger community and the unit's internal power structure are factors which will be shown to have played such roles. These relationships will be seen to have defied patient expectations of normalcy. Patients often tried to force power relationships on structures where none existed to be able to structure their environment. These relationships if found would have served to validate the patients' position in both the unit and the larger system, as largely powerless.

The unit was under the auspices of the Continuing Care/Rehabilitation portion of the hospital, which oversaw the administration of the unit and in turn was answerable to the larger hospital administration. Some members of the unit's staff were related to departments within the hospital by professional affiliation, however the staff related basically to the unit's administration with regard to treatment and only secondarily to their

departments.

The unit had extensive liaison with the outside community in terms of industry, social services, other health facilities and personnel and community organizations. While this liaison was basically to make the community more aware of the problems around alcoholism and the service available, it also allowed the community to respond to the service as they perceived it. While this allowed for free communication, there was no direct involvement in nor control of the unit by any outside agency.

The unit was administered by a programme director, experienced both in administration and treatment, thus he related to staff both for treatment and general administration. During the year under study, the programme director related to the therapists on a one to one basis, that is, a simplex basis. (Diagram 2) Each therapist was responsible to him for all facets of his or her work. Those therapists who had professional affiliations with outside departments related to those departments, but were directly responsible to the unit's programme director.

During the final period of this study, changes in the simplex nature of those relationships took place.

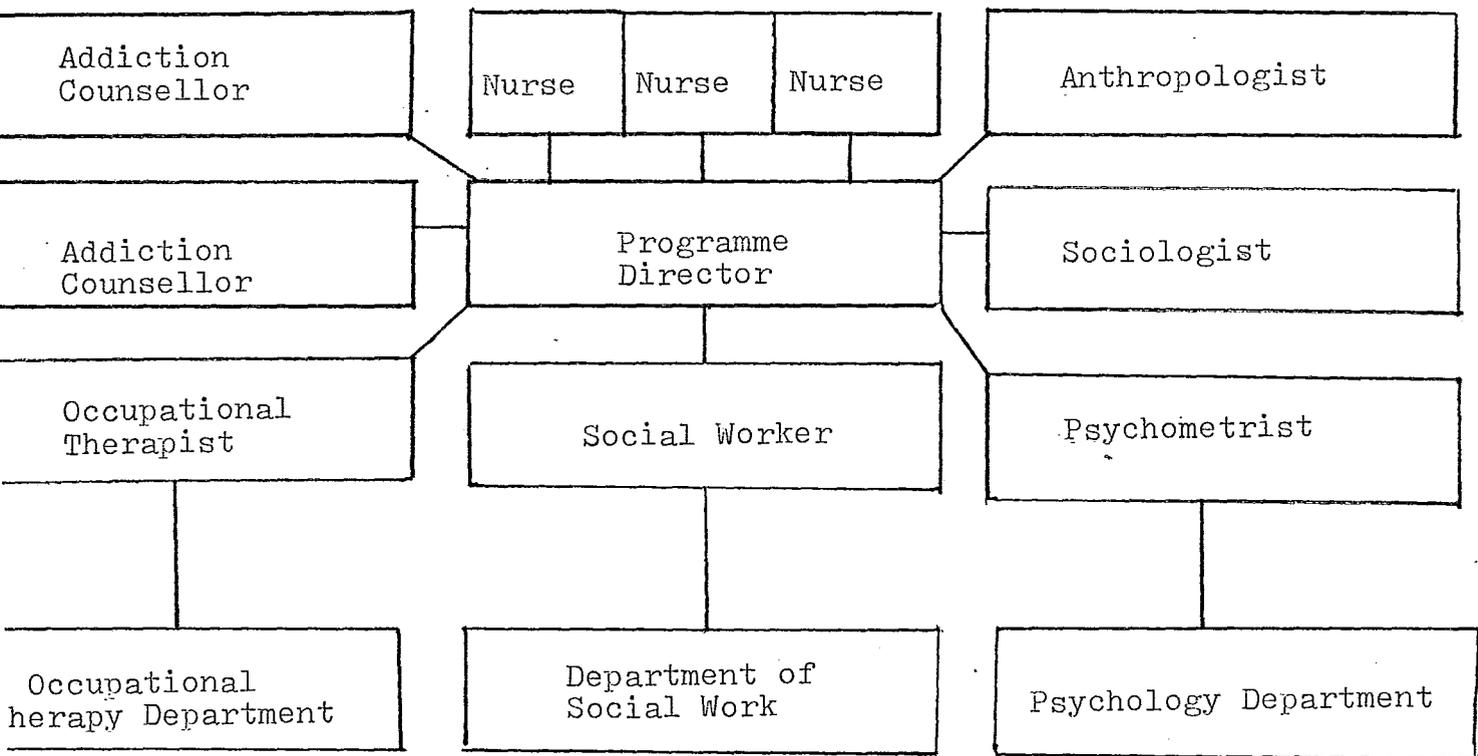


Diagram 2: Staff Structure: Original Simplex Model

To streamline the system, where there were several people representing one profession on the staff, one person was designated to relate directly to the programme director on matters concerning functioning of that group on the unit. That change had occurred in only one professional group at the unit at the end of the period under study. (Diagram 3). That change occurred so close to the end of this study, that its ramifications are difficult to suggest and none were observed. However, the area in which future observations will be of interest will be in patient's perceptions of responsibility and authority at the unit.

There seemed to be an expectation which grew among the patients over the year that there was a multiplex structure within the therapeutic staff, long before any such changes took place. They seemed to expect that there was a line of distinct authority within a hierarchy if only that line could be discerned. Examples of this belief were numerous in the year under study. One patient in a group attended by two therapists, asked which one was in charge. When the patient was told that they were co-therapists and neither was in charge, expressed his disbelief and demanded to know who was higher. Despite explanations, the patient continued to return to the subject throughout the session and into a subsequent

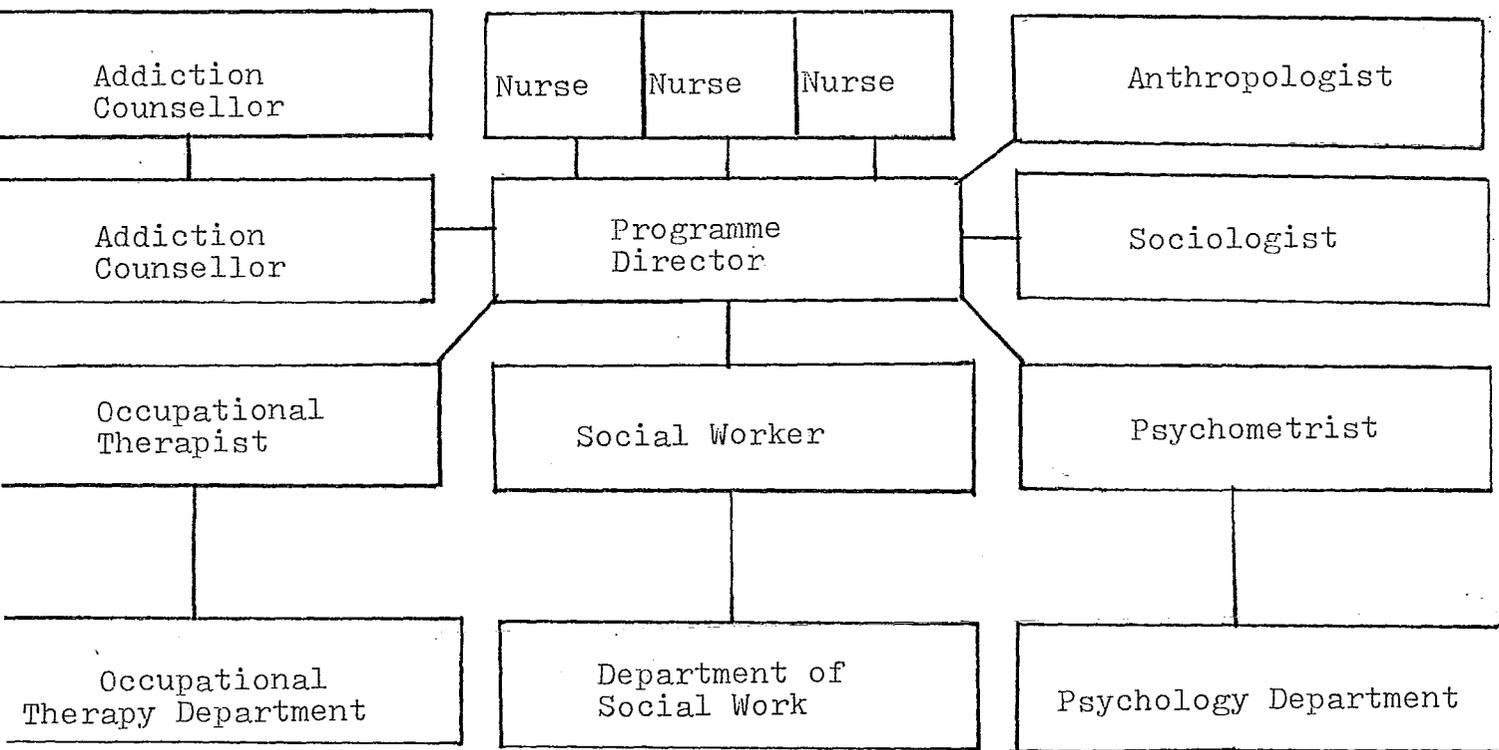


Diagram 3: Staff Structure: Change to Partial Multiplex Model; note relationship of Addiction Counsellors.

group, and never seemed to be satisfied that he had been told the truth. On one occasion, when one member of a therapy team was seen more often by the patients, the group decided that the one visible therapist was in charge of the group. For a time, if they disagreed with one of the other two therapists, they turned to the one and demanded verification. On another occasion when a patient wanted permission to leave the unit early to go home, he first went to one of his co-therapists to ask permission. When it was suggested that he speak to his prime therapist, he said that he would go there next, but that he did not want to go over the head of the co-therapist and he felt he should go through the proper lines of authority. These are just three brief examples of the types of transactions which have occurred in the past. The examples used actually happened, but are used only to indicate the various situations in which questions of authority and responsibility came up. There was a persistent feeling to those transactions that even after the patients were assured that there was no hierarchy, that those who were searching for one simply left the conversation convinced that the lines were there but secret.

Another area in which patients tried to discern

power or influence relationships was in the relationship of the unit to outside agencies. Because referrals were made from outside agencies, even though admission was voluntary, patients seemed to see a close relationship between those agencies and the unit. Despite assurances of hospital ethical and legal boundaries of confidentiality, there were often questions about how much information would be shared with outside agencies. One example of this occurred during an interview when a patient was giving little information. On being asked why he was reticent to give information, he said that he didn't want his situation known to his company, and since they had referred him, obviously the therapists were going to tell them all that was learned. On another occasion when a patient appeared to be simply mimicking what had been said and this was discussed with him, he said he wanted the company to know that he was doing well in the programme. One patient was startled when his therapist asked his permission to call the medical department of his company to get results of hearing tests. He said he had assumed that the therapists were always in contact with the company. These again are only a few examples, but illustrate the patient's perceptions during their initial time at the unit as to the relationship of the unit to

outside agencies.

The question of direct influence by other agencies was often asked and many patients came into the programme believing that the unit was financed and secretly run by industry. Those questions often faded when answered directly and once the patient had gained confidence in the therapists and the programme. However, there often remained questions as to who did have influence and power in the unit, as patients could not see clear lines of authority except for the simplex relationships of therapists to each other and the programme director. These questions often came out as flat assertions, viz., "the unit is financed by industry and that is why there are so many people from industry here", or "obviously industry people must get priority since industry finances this place".

Conclusions

The seeming need to understand lines of power as shown in this chapter may be viewed in several ways. First, the patient entered a place where relationships, customs and even language were to some degree foreign. To have been able to acclimate themselves quickly meant patients had to be able to discern the patterns which

would allow them to understand the system. In the community, most systems have power relationships, and these are often discernable through overt power or title or in deference given by others. This discerning of power relationships also allows the person to decide who are "safe" people to approach, and who are too powerful to approach safely. This understanding further allows the person to have a higher authority to approach if there is a disagreement with the person with whom he or she is in direct contact. Finally, understanding power relationships allows the person to understand at what level he or she may potentially fit in the hierarchy, and thus to gauge his/her potential power in the situation. Without an obvious hierarchy, this process is thwarted to some degree, as familiar patterns will not fit in this new situation. The referral then to outside agencies and covert relationships was not then so difficult to understand in view of a patient's attempt to incorporate patterns of expectations. If therapist's relationships change in the future due to the move from simplex to multiplex relationships, however slight the shift in fact may be, the patients may realize the multiplex form for which they seemed to search. Whether or not this will have any detrimental effect in terms of therapeutic

authority of those seen to be at the bottom of this hierarchy is yet to be seen, but will merit close observation. In addition, power relationships among therapists may allow patients to cement their perceptions of their position, power, and responsibility in this setting.

V. Therapists

The following description of the relationships of therapists to one another and the perception and reactions of patients to the team as a whole, helps to provide background for later discussion of the changes which occurred over the course of the year. It is essential to understand the perceptions and reactions in terms of the life position and problems of the patients who came to the unit, as already discussed.

The people who comprised the multidisciplinary therapy team which staffed the programme came from a variety of academic and therapeutic backgrounds. Those backgrounds included addiction counselling, occupational therapy, nursing, sociology, psychometry, social work and anthropology, as full time therapists, as well as a variety of other professions represented on a part time basis. When speaking about therapists and their relationships, the reference will be only to full time therapy staff as they related to each other and the patients on a continuing and encompassing basis. The part time therapists, on the whole, came to the unit for specific periods of time to fulfill specific respon-

sibilities and were rarely involved in the day to day functioning of the patients or the unit.

Each therapist was qualified in their field, and if from an academic background unrelated to therapy, had training and experience in therapy. Each therapist carried a patient caseload, meaning that they were responsible for those patients and their individual needs while at the unit. Each therapist also followed his/her own patients through the fourteen month out-patient sequence of the programme. In addition, each was responsible for a series of lectures or groups which reflected his/her academic and therapeutic specialities. The development of such material or approaches was also shared by therapists, as reflected by the examples given in Diagram 4. All of these responsibilities were shared by all therapists and provided for a unified set of concerns and problems. In addition, each was involved in a smaller grouping of therapists who worked together in intensive small group therapy. (See diagram 5.) The therapists involved in those teams acted as co-therapists to each other and each other's patients. As well as being involved on this smaller scale, all therapists were responsive to the larger team which met daily and discussed concerns, approaches and problems.

The therapists were multiethnic in origin, basically middle class socioeconomically, and had an average of approximately five years post secondary education among the ten full time therapists. The average number of years of experience in therapy was approximately eight years. The average age of the therapists was thirty five years; the range, twenty-five to fifty.

Due to the smallness of the team and the interlocking nature of the responsibilities and relationships, the relationships developed among the team's members became crucial to the quality of the total team functioning (see diagram 4 and 5). Therefore, interpersonal problems which might, in another setting, have gone unresolved and tolerated, were quickly and amicably worked out. In addition, because of the nature of the work and its concomitant strains, the smallness and closeness of the team provided a forum for the healthy release of tensions. Finally, and perhaps most importantly, there was continual feedback from and to all members with regard to their performance as therapists and team members. This sort of critical feedback could only have been tolerated in a situation in which the members were basically comfortable with themselves and each other.

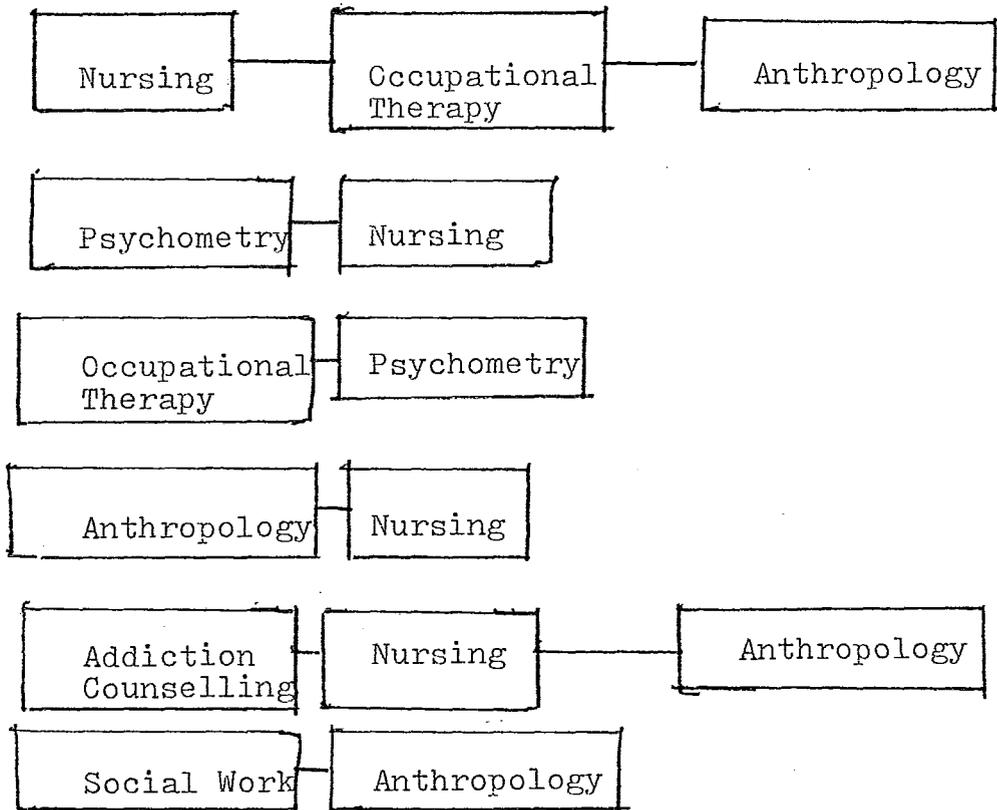


Diagram 4: Staff Structure: Shared Lectures or Groups, including development of material or approaches, to illustrate interlocking nature of responsibilities. Combinations of disciplines occurred spontaneously.

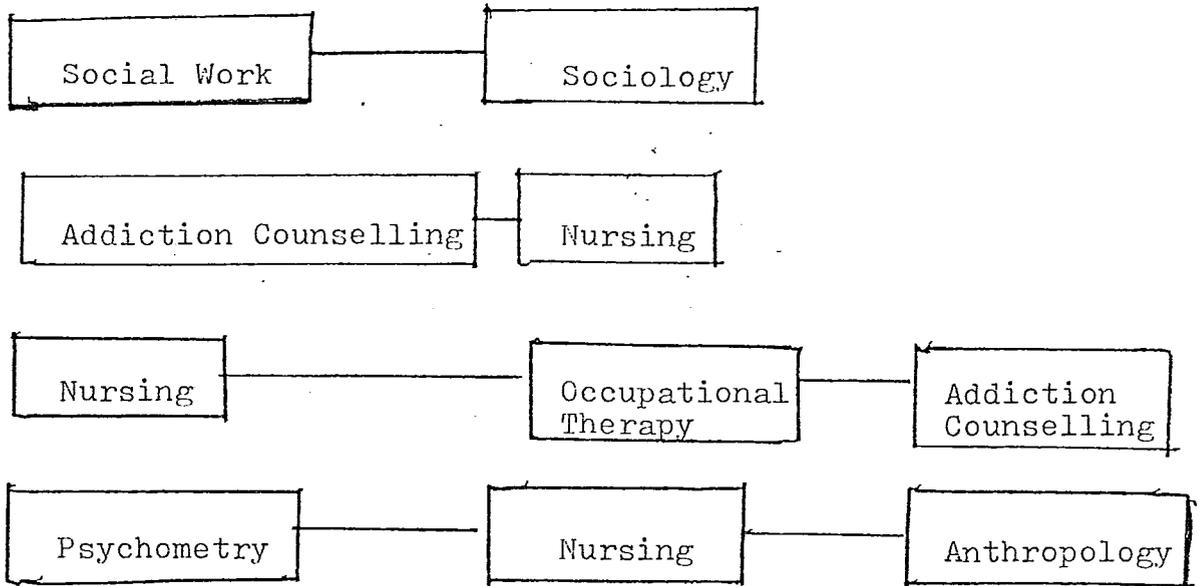


Diagram 5: Staff Interrelationships: Therapy Teams. Example of interconnection among team members. These combinations of disciplines occurred during the year under study; the composition was unrelated to discipline.

The closeness of the team aside from having been demonstrated on a daily basis, was also demonstrated in extraordinary circumstances. During the time a therapist was ill or otherwise absent, the team members met his/her commitments as well as their own usual work. Each member took on whatever responsibilities he/she could during that time. That was not only so that the continuity of treatment could be maintained which was most important, but also so that he/she could feel comfortable recuperating fully before returning to work, knowing that the needs of his/her patients were being met.

If a team member had been unwilling to be involved at the level described, it would quickly have become difficult to work in this setting. All of these factors provided for an impression of a purposeful and comfortable group of people, who were in a group with which they were basically happy and professions in which they were competent and comfortable. This relationship provided for an atmosphere which suggested a far stronger commitment than a group of people simply working together and, this atmosphere pervaded much of the therapists' functioning at the unit. As several patients commented, each therapist carried him or herself with confidence and looked happy and comfortable.

While this team functioning made for a more cohesive and comfortable group, and obviated many long term problems, it presented the patients with a formidable front. Because discussion of approaches was encouraged, a patient who went to several different therapists received essentially the same information, differences occurring when specific expertise was involved. This closeness also meant that the basic intent of the philosophy of treatment was consistently relayed to patients by all members of the therapy team, whatever their background.

Conclusions

Therapists at the unit were a highly cohesive group and presented a unified approach to the patients. The comfort of the group was obvious to patients, and while seen as reassuring in some ways, this group relationship was challenging in other ways.

VI. The Patients

The purpose of presenting the descriptive material in this chapter describing patients' relationships at the unit is to illustrate patient's expectations of behavior and functioning both within the patient group and towards therapy and therapists. Individual cases were chosen to illustrate trends in behavior and expected responses to that behavior. This material is also intended to illuminate the kinds of responses patients had to entering therapy; these responses will become important in the discussion of time/change limited attitudes. The development of the patient council and its perceived functions will give further evidence as to patient expectations of roles vis a vis therapists. In addition, the expectation of not giving therapists information about other patients which developed among patients, will further point to the type of power relationship which developed.

During the year in which this study was conducted, there were approximately three hundred patients treated at the unit, with an average patient population of twenty at any given time. The unit worked on an open

group concept, that was, patients were admitted in a staggered fashion and discharged normally, four weeks later. Therefore, the composition of the patient group changed from week to week with groups of patients being admitted or discharged. Each patient was normally at the programme for four weeks, and so the potential for observation fairly lengthy.

The normal composition of a patient group was largely male with the majority being between thirty and forty-nine years of age. Many of the patients were referred from local industry, representing largely blue collar professions. Better than half were involved in an intact marital situation while at the unit. All patients, aside from other differences, had a problem with the excessive consumption of alcohol which had in most cases, affected one or more major life areas; health, family, social or employment. In addition, all had been assessed, accepted for admission, and had agreed to remain free of alcohol for the duration of their stay at the programme, and to take "protective" medication to ensure this sobriety, such as disulfuram or "Antabuse". All patients entering the programme understood that they would be required to take such medication, which, while normally undetectable in the

system, became active only with the consumption of alcohol, whereupon, the person had varied reactions in relation to the amount consumed and the blood level of the medication. Such reactions ranged from very mild to severe. All patients were appraised of the consequences of drinking on these medications. All patients also agreed to become fully involved in the programme for the four weeks and the fourteen month follow-up programme.

Patients who entered the unit seemed to fall into four rather distinct categories in terms of their behavior and demeanor. The first group was distinguished by its bravado. Under conditions of insecurity, they displayed marked disregard for their position and the challenge offered by entering the unit. A patient who was typical of this first category was Mark (Case #1) (not his real name), during his first week at the unit, he appeared ingratiating and carefree. He was friendly to everyone, related no problems to anyone, said that he had none, but was having a good time and was delighted to be at the Unit. That attitude persisted for approximately one week, at which time he began to work on his problems. During that time, the patient group had gone from being supportive to being confrontative over his denial.

Another example of patients who fell into this category was Gregory (Case #2) who, on entering the unit became socializer extraordinaire. Gregory listened to everyone's problems, told jokes and was the life of any gathering outside therapy for his first two weeks at the unit. He listened attentively in groups but never related any of his concerns, to the point where other patients said they thought he didn't have any. It was approximately two weeks into the programme before he stopped talking about already having been "cured" and being so very happy, and started working on his very real concerns.

Morgan (Case #3) walked into the unit and immediately began organizing pranks, told jokes continually, and laughed, no matter how serious the topic. He was, again, for about ten days the life of the party, confident and happy, and had no problems.

Curt (Case #4), from the beginning, not only denied having problems, but impressed on all who would listen, his tremendous charms and abilities. He told remarkable tales of daring, cunning and prowess, but fell asleep when in sessions dealing with problems.

Marcel (Case #5) was another who was delighted to be at the Unit, said that the programme was fantastic,

and how he thought it was wonderful that all these people were being helped by this wonderful staff, but denied that he was an alcoholic. Marcel amused social groups with his stories, but shared problems and concerns with no one for about the first two weeks of his stay on the programme.

In Marcel's case, the patient group was supportive for approximately four days, after which there was growing concern about and hostility toward him. Marcel withstood a great deal of pressure from the group, until one day in a large group discussion on alcoholism, one of the group members who was raising a rather pointed issue about denial, asked everyone in the group who was an alcoholic to stand up. Everyone except Marcel immediately stood up, and after about a ten second pause, he too stood up with the rest of the group. While Marcel was no longer the life of the party at the unit, he became a patient who was willing to work on his problems.

Morgan's (Case #3) attitude changed after being on the unit for about ten days, at which point the group was putting a fair amount of pressure on him. In response to the growing pressure, he withdrew for a time, and only after another period of time could he respond to the group.

Curt (Case #4) too, was confronted by the group, and finally gave up his mask of bravado after a relatively brief time.

The bravado of this group was obviously an attempt at denying either that they had problems or denying the gravity of those problems. Each in this group was cooperative, ingratiating, and willing to help and amuse others. Their withdrawal techniques were usually passive and non-challenging, making it difficult for the patient group to challenge their motivation. This attitude rarely was accompanied by overt hostility, but covert hostility was brought to the surface when they were challenged as to the honesty of this attitude by either staff or other patients, as in the case of Morgan (Case #3). This attitude, as illustrated often faded after a period of support at the unit or under pressure.

A second category of behavior seen regularly at the unit were those who were actively hostile on entering the unit. Those individuals tended to act suspicious and withdrawn, actively rebuffing both staff and other patients. Hostility in all aspects of daily living was the hallmark of this type of patient, from complaining about all aspects of the programme, to being

disruptive in therapy to mocking those who were working on their problems.

Sarah (Case #6) was an example of a person who was openly hostile on entrance to the unit. Sarah had referred herself to the programme and, prior to entering the unit had been very nervous and anxious. On entering the unit, Sarah spent much of her time criticizing the facilities, the staff, the programme, the food, and the other patients. Patients who tried to help or show concern were met with cutting remarks, or were subject to a barrage of complaints which ended in criticizing them. This attitude was initially met with sympathy, albeit rapidly distant sympathy, and when it did not abate, the group began to ignore her. Finally, the group began to be progressively more confrontative with Sarah about her attitudes and her lack of work on her problems, however, Sarah never gave up her attitude toward the patient group, nor her public stance.

Christian (Case #4) spent his first period at the unit in almost complete silence except for occasional sardonic replies to direct questions. He physically isolated himself from the other patients, and rebuffed all attempts to make light conversation. He attended all sessions but made no spontaneous remarks and spent

much of his time staring out the windows. The patients, after making initial overtures, left him in isolation until he came out of his own accord. An important feature about Christian was that he never denied he had problems, he simply did not communicate.

Owen (Case #8) entered the unit and immediately began to challenge the most simple of procedures; mealtimes, group times, the way the coffee was made, et cetera. He tried to involve other patients in his challenges, however that proved successful on a very limited basis and for a very brief period of time. He succeeded in recruiting one other patient who had arrived with him at the unit, and who was less hostile in attitude. This dyad broke down when the other patient found he wanted to be involved and left Owen on his own. After a very brief period and with minimal group pressure, Owen dropped his hostile stance.

Ian (Case #9) and Jeremy (Case #10) came into the unit at the same time. Ian spent his first days at the unit sitting back, watching and mocking those who were involved. Ian was open about his distaste for being at the unit. Jeremy was anxious and nervous when he entered the unit, but under Ian's care grew progressively stronger and more hostile. Group pressure was mild toward this dyad, in part, seeming to respond

to their increased aggressive behavior by isolating them from the rest of the group.

If attempts to bring the hostile person out and into the patient group failed, the group often isolated them, as in the cases of Sarah (Case #6) and Christian (Case #7). People in the patient group often commented about such patients that if they were given time they would come around. The exceptions were people like Ian (Case #9) and Jeremy (Case #10) who formed a very powerful and aggressive dyad and for whom the initial efforts at confrontation only seemed to strengthen their hostility. The isolation of Ian and Jeremy finally seemed to be a protective measure on the part of the group. Generally, the isolation of an individual seemed to help them to make a decision without obvious pressure, and, in most cases the response was positive. Confrontation seemed to work most effectively on those whose hostility was weak to begin with, such as Owen (Case #8); without his weaker partner, Owen could not or did not desire to continue outside the group. If a person was disruptive and hostile, the patients often returned the hostility openly after attempts at support, confrontation and isolation failed.

One of the problems with this attitude was that even if the person finally resolved their hostility, it

seemed to be very difficult to backtrack and overtly change behavior. In some cases it did happen that an openly hostile person changed his or her view and was able to translate this into behavior and find acceptance in the group. However, if the person had taken hostility too far by making enemies of the leaders and those who might have been intimates in his or her incoming group, moving out became far more difficult without extraordinary peace-making efforts, and even those, in some instances failed to gain them acceptance.

A phenomenon which was illustrated in the case of Ian (Case #9) and Jeremy (Case #10), was the formation of a supportive dyad, and in some cases these groupings were larger. In such cases, the individuals gained strength in their hostility, and the breaking down of such attitudes occurred far less frequently. In addition, even if one did want to change, the peer pressure from this subgrouping became intense. Because hostility was the *raison d'etre* for this group, a traitor was treated with especial hostility. The fact that breaking away was difficult and moving into the mainstream took special efforts, made this particular transition rare.

The third category of behavior which was seen fairly often were those who entered the unit in a state

of overt anxiety. While it is reasonable to suggest that anyone entering treatment and a new social grouping would be anxious, those who expressed it directly, verbally or by their demeanor, were fairly common. The fact that anxiety was the dominant expressed state did not mean that other emotions such as hostility could not underlie the anxiety, but simply that it was the presenting behavior. Those people in this category tended to be cooperative and quiet, watching all that went on around them carefully for signs of danger. When asked, they often admitted to minimal discomfort, while showing signs of high tension and anxiety.

An example of a patient who fell into this category was Marge (Case #11). When Marge entered the unit, she spoke to few people except when they made direct, friendly overtures. Marge spent her first few days alternately crying in the bathroom or sitting in groups looking as though she was ready to cry or run. This pattern changed as the group offered support and warmth and Marge responded. Gradually she became more confident and comfortable.

Jorge's (Case #12) anxiety was presented in a far more subtle way than was Marge's. Jorge was friendly in a fairly distant way to the group when he was approached. If left by himself, Jorge spent much of his

his time watching. In groups if asked a question, Jorge became extremely nervous and almost tearful. Jorge spoke several times of leaving the unit because he "couldn't take the pressure". The group responded to Jorge by giving him support and encouragement. While Jorge never seemed to become completely comfortable, the obvious signs of anxiety and talk of leaving faded.

People who arrived at the unit showing signs of anxiety and tension tended to elicit great support and care from the rest of the patient group. A possible explanation for this was that the group could easily understand and sympathize and were able to actively affect the outcome. The anxiety which was overt in these cases also allowed entree to greater intimacy and also allowed others to be in a position of being both comforter and strength to the overtly weaker individual.

The final group consisted of those who entered the unit expressing comfort with the situation and expectations of great gains. While certainly not obviously threatening to those already in the unit, this group tended to produce discomfort and sometimes hostility in those who were entering the unit with them. Patients in other weeks tended to express disbelief at this expressed comfort in what was seen as essentially an uncomfortable

disguised before, after the group had exerted pressure on him.

Derek (Case #15) was quiet but communicated easily with the other patients when he arrived at the unit. He said often that he was glad to be there and expected that it would help him a great deal. Derek however did not share problems until about ten days into treatment, the group having exerted no pressure. Once he began to open up fully, the group was supportive where they had been skeptical before.

People in the described group tended to settle in fairly well after a few days and come to terms with the emotions which had been so difficult to deal with at entry. They sometimes seemed to have simply felt a lower level of anxiety or were quite genuinely relieved to be getting treatment. However, many simply could not express what they were feeling, and covered this with a facade of comfort. If they were seen by the group as settling in within a reasonable amount of time, they were treated with normal courtesy, while the group waited for the impact to hit. When a person opened up as with Derek (Case #15), the group was quite supportive. If the group never saw an expression of this impact, or the person never began working on problems, then questions arose as

to his or her honesty, and pressure followed. If the person responded at any point he/she was able to assume a normal place in the patient community. If the person never relented several things often took place. The person might have been able to achieve a modicum of acceptance based on personal qualities if an effort was made. Secondly, the person might have become subject to increasing pressure to admit to "normal" group emotions and if no response was made, the group sometimes rejected the person as a phoney. Finally, the group sometimes simply ignored the person, treating him or her neither as a group member nor as an outsider, simply tolerating them. The obvious exception was in the case of people like Sean (Case #13). People like Sean presented the group with an extraordinary situation, as they were few and far between. Sean and others were able to combine all the qualities necessary for the group to understand his/her sincerity and for the group to be comfortable in his/her presence. Like Sean, these people often became patient leaders and well trusted by all.

As was seen by the foregoing, there seemed to be a very strong ethos which demanded a degree of conformity at least in the expression of some feelings regarding being an alcoholic and being in treatment.

This classification system was based on observations of approximately 300 patients to greater or lesser degrees and is intended for use as an illustrative tool. There were patients who did not fit neatly in any one category, and some who defied any classification. However, the majority of patients seen fit generally into these categories, and the majority of patient groups reacted to these individuals in the ways which have been illustrated. The subject of therapist intervention and facilitation has not been broached because these examples were used to illustrate patient relationships with one another.

Social Relationships

A patient entered the unit after the assessment and sometimes a several week waiting interval, for two days of orientation before entering the regular routine of the programme. It was always a source of interest and speculation among the "old" patients as to what the new patients would be like, and how they would fit into the present group. It was not unusual either for the patients to approach therapists in an attempt to ascertain details about the incoming group. This interest peaked on the morning of intake when the old patients would watch

for the new ones coming in and the relations officer from the patient council greeted them. There were often jokes about trying not to frighten them and sometimes the patients reminisced about what they had seen and felt that first day. Even though the new patients' time was basically taken up with orientation with staff, often, patients went out of their way to quietly seek out a new patient and welcome him or her. The majority of patients however, while friendly and interested, kept their distance from the new group. This distance had much the same feel to it as that distance kept from someone who came in for assessment; almost an unwillingness to intrude in what was perceived as a difficult and frightening time, a time when one could easily be overwhelmed or sent fleeing.

Chester (Case #14) spoke about his first day and said he came into the unit and looked through the door of Conference Room I at the patients involved in therapy. He said he was scared and wanted to run before it was too late. He said the people all looked happy and comfortable and he was sure that he would never fit in with them. Another patient, Dee (Case #16), remembered feeling that she did not belong in that place with alcoholics. She said she too went to the door, but it was to see what they looked like. She remembered being surprised that they

didn't look like alcoholics. Edgar (Case #17) remembered feeling sick and exposed but said he was determined not to show his weakness to a bunch of alcoholics. Merv (Case #18) said he drove up to the unit twice before he could get out of his car, he said he wasn't sure he could force himself out of the car and through the front door he was so scared. He said he wanted treatment but he was afraid of what the others would do and say, and afraid of what others would find out about him.

This newly arrived group often tried to form relationships among themselves, much as any diverse group in a difficult situation; struggling to find common experiences to lend cohesion and safety to their situation. Often, these groups formed at intake became highly cohesive, lasting far beyond their four weeks together at the unit. While other and lasting relationships were formed at the unit, this group tended to occur most often.

Brent (Case #19) and Ward (Case #20) were an example of this bond which was often seen. They entered the unit together and during their orientation together began to talk. They found they had many things in common, and over the course of the next few weeks their friendship grew. They supported each other through difficult periods, and encouraged one another when motivation or

energies flagged. On their last day on the unit, both expressed how difficult it was both to leave the unit and the people there and especially that they knew how difficult it was going to be to continue their friendship on the high level it had been on at the unit. They both also said that they had never had a friendship of such intensity.

After two days of orientation, this new group then entered the regular part of the in-patient programme, joining, for most therapy groups, people in their second, third and fourth weeks. However, this group was occasionally reformed when groups were split and special information was presented to people at various points in their time in the unit. Thus, even by the makeup of the schedule and the dissemination of information, this cohesiveness was reinforced at various points in the programme.

Another type of relationship which was formed at intake or shortly thereafter was that of a mentor and student. It was not unusual for a third or fourth week person to adopt an incoming patient and help them through their first period on the unit. In most such relationships, this helped to smooth the new person's way into therapy, and ensured their early and eager participation in all aspects of the programme under the watchful eye of their mentor.

Jake (Case #21) adopted Mickey (Case #22) on the second day Mickey was in the programme. Jake was in his third week when Mickey entered the programme and was gradually gaining comfort and confidence. Mickey was young and frightened and seemed to be in a state of constant confusion when Jake came along. Jake made sure that Mickey knew where he was supposed to be, that he was there and that he participated in everything that went on at the unit. At the end of Mickey's second week, Jake finished his in-patient sequence and went home. During those two weeks, Mickey had gained confidence both socially and in therapy, and had been constantly under Jake's wing. When Jake left however, Mickey suddenly seemed lost and confused, and for about two days he seemed to have difficulty with everything, both socially and in therapy. He seemed finally to resolve this, and began to do things on his own.

This mentor relationship seemed to both provide comfortable entree and to prevent the student from finding his or her own way and from developing his/her own resources. As in the case of Mickey, once his mentor left, it seemed necessary to reorient himself to being on his own and developing his own resources.

The tightest groups formed however, appeared

to be those patients entering together who were assigned to the same therapy team. These people, along with those in later weeks assigned to a particular team, had the most intimate contacts with one another.

One such group consisted of Howard (Case #23), Vaughn (Case #24) and Tina (Case #25). They entered the unit together and were assigned to various therapists in one of the therapy teams. While at the unit, this trio was inseparable, spending all waking time together, sometimes talking late into the night. The bond was so strong that the members of this trio tended to socialize with each other to the exclusion of all others. The three supported and protected each other through the stay at the unit, and again, expressed great sadness when they finished their in-patient time.

An obvious potential problem with such a grouping was that their very intimacy could be used for or against their progress in the programme. They tended to protect each other from all discomfort, and on occasion, this discomfort included therapy.

Four days a week, for an hour and a half each time, the small group assigned to a therapy team met and discussed their personal lives and problems together. This group had the responsibility, ideally, for acting as

a catalyst for helping the person to look most deeply at his or her problems and to seek ways to achieve a new life style. Under the guidance of one or more therapists, the person probed deeply into themselves and one another. The group sometimes took a supportive role if the person was working hard, and was sometimes confrontive, if the person was evading or sitting back. There were absolute rules of confidentiality for this group, and when, on occasion, a patient broke this trust, he/she was heavily censured by their therapy group.

Gus (Case #26) was a person who broke this rule and found himself ostracized both from socializing with those in his therapy group and those in the larger groups; both groups reacted angrily at his breach of trust. It took a great deal of work for Gus to regain even a modicum of the group's trust, and even when he had been accepted again, his social relations did not have the intimacy that others enjoyed. This however may have been due to other factors such as his denial of alcoholism and hostility during his initial time at the unit.

This bond then, in addition to the original grouping, sometimes helped to form very close subgroups. Within this subgrouping, on a number of occasions, patients were able to relate events which would, under

normal circumstances, have been shocking, disgusting or frightening to a peer group. However, in these groups, such revelations were normally met with understanding and support, further cementing the bonds.

The exceptions to these bonds usually occurred when a particular patient showed no effort toward improvement, refused the group's interest but worked on his or her own, or was not felt by the group to be capable of functioning on that intimate, comrade, level. In the first case, a variety of reactions were seen. On occasion, open, verbal hostility was expressed toward the person after a period of support. If no response was gained, this response often alternated with shows of concern which if again met with no response, often quickly degenerated into frustration, then anger, and finally rejection of the person. This was not an immutable pattern, but one which was seen most often.

Gus (Case #26) again was a good example. The group saw him as not working, hostile and dishonest, even before he broke confidence. Their reaction initially was concern and support, then growing pressure to get him to work, and finally anger and frustration with his lack of response. It was during this last stage that Gus broke confidence, and after the reaction of the group to that, he worked most hard.

This same pattern was sometimes repeated if the group felt that the person was faking working to satisfy outside pressures or the therapists. This most often occurred when a patient bragged that he or she was not an alcoholic and didn't really belong at the unit, but was going through with it to assuage someone else. The feelings towards the person became especially intense if the person flaunted this lack of association to the other patients but acted as a cooperative patient when staff was present. Most people seemed willing to accept that another could still be having some degree of denial about the gravity of their problems, but tolerance for total denial and for those who were hypocritical about what others saw as grave issues, was very low. In addition, the reaction paralleled a loss of trust reaction; the person quickly became an outsider, an intruder, and, worst of all, a person who had taken their trust under false pretenses. Bart (Case #27) was seen by the group as doing precisely that. In groups, Bart participated appropriately, but outside groups he told people that he wasn't an alcoholic, that he had been forced into therapy and didn't belong, but had to stay. The group was supportive for the first week, but when, in the second week his attitude had not changed, they confronted him. They

listed off various problems associated with alcoholism and demanded to know with each, whether or not he fit. At the end of the questions, with no further pressure, he decided he had to be an alcoholic and he did have problems on which to work.

The second situation, where a person refused the group's interest, but worked, presented a specific problem for most groups. The reaction usually was one of some distance, but not often of hostility. There seemed to be a respecting of this decision, and either a friendly but careful attitude, or simply distance, tinged with some of the same avoidance shown to those at the unit for assessment or at intake. If, at a later time, the person became more involved with the group, then a closer relationship was sometimes achieved, however, due to a time element, it rarely was able to match the intimacy of the relationships which formed early in the programme.

Neville (Case #28) was seen by the group as working but kept his distance socially from the group. He spent his time by himself but was not seen as disruptive or aloof, simply his own person and contented with being such. The group at first was puzzled and somewhat irritated by his attitude, and showed this by throwing small, cutting remarks at him about his lack of socializing. When he

reacted pleasantly to this and reaffirmed his comfort with the situation, the group gradually came to accept and respect his decision. Trent (Case #29) began his relationship to the group in much the same way, and their reactions were similar to Neville's (Case #28) case. The major difference was that Trent finally decided to become part of the group on a social level, and while he never quite became a comrade, he was seen as a leader by the patients; as one who was strong and thoughtful.

The third situation where the group felt that the person for a variety of reasons was unable to understand or respond appropriately, evoked a variety of responses. In cases where language was a perceived barrier, there was usually simply a distance, and few relationships of the depth previously described were formed. Such was the case with Mario (Case #30). Mario understood what was being said to him, but his responses were slow and sometimes garbled. Other patients at first tried to make casual conversation with him, but the effort involved seemed to be too great and they soon left him to himself; neither insider nor outsider, just there.

If a person was perceived as being slow or stupid, often he or she would be ignored, however, if the person was vocal, the reaction on occasion changed to

anger or ridicule. This seemed to be an awkward effort to let the person know that he or she was being inappropriate. On some occasions, a mentor relationship was set up with such a person, and if they responded well, they were able to achieve limited acceptance.

Dirk (Case #31) fell into the latter category. Dirk had trouble with writing and with full comprehension. Frank (Case #32) took Dirk under his wing, sat with him in groups, took notes and explained anything to him that he did not understand.

Clyde (Case #33) was seen by the group at first as being unwilling to involve himself. They tried to help him to become involved, and when he could not respond in a way in which they wanted him to, their concern turned to mild irritation and finally to indifference. With Bart (Case #27) however, the situation was different because the group perceived him as being unwilling despite their efforts, and in addition, they felt he was disruptive. Bart was vocal in his being different and the group could not accept that. The reaction to him after initial efforts was one of hostility when ignoring him did not keep him quiet.

Dirk (Case #31) appeared to the group as being, from the beginning, as they described it "out to lunch";

his behavior was seen as idiosyncratic, and following a brief testing period, the group simply left him to his own devices. There was little hostility nor even much feeling about him following the initial period. This continued until Kevin (Case #34) was admitted shortly thereafter. Kevin too was seen as unable to respond, though for different reasons. The reaction to Kevin was one of frustration and anger which was directed not towards him or Dirk, but towards therapists. Several patients approached staff saying that they didn't know what to do with both of them. The problem was solved only when Dirk finished his time at the unit.

Benign neglect seemed to be the hallmark of most such group reactions when only one person was involved. More than one appeared to change the situation dramatically. The final group, was those who were considered to be consistently inappropriate and the group considered such persons to have some sort of mental dysfunction. Depending on how dangerous (in all senses) or incompetent this dysfunction was seen as making the person, the reactions varied. Again, a testing period, during which this inappropriate behavior was challenged and others tried to help the person modify their behavior, sometimes ensued. If the dysfunction was seen as unalterable, then a benign neglect was again practiced. If

however, the dysfunction was more subtle, as in some personality disorders, then the testing period often extended for some time, and ended only when it was decided that the person could or would not change. The attitude in these cases reflected those of earlier examples. However, this situation was extremely rare in the year under study.

While none of these situations occurred repeatedly, the group's reactions were clear enough to be important in suggesting their parameters of acceptable behavior and attitudes. This was not to say, for example, that some resistance to therapy was not tolerated by the group, but that resistance to the group's established norms was not. The norms, often unspoken, but nevertheless clear were that, one: All patients had to have passed through or be approaching the rite de passage of admitting to a drinking problem, and two, that there were normative behaviors and those who could not or would not behave appropriately could not be included in the group.

There were distinct phases to treatment at the programme for each individual, which were general to most patients, and which the patients recognized and related to new patients in order to reassure them that

their feelings were normal. When and by whom these phases were identified among the patients is unknown, except that they seemed to be a matter of general knowledge. The phases as described by the patients were roughly: the first two days were orientation, which was a time of anxiety; the first week was characterized by confusion and again, anxiety, much like being dropped into a foreign country and expected to master the language and customs quickly; the second week was characterized by pain, as the confusion cleared somewhat and people began to take inventory, but lacked enough tools yet to effect major changes; the third week saw the pain eased and the pieces of the puzzle began to fall into place, tools began to work, strength began to be felt; the fourth week, strength consolidated, feelings of power over their fate, and comfort with the changes they had made, and finally anxiety over leaving, but eagerness to reenter the community and be with their families. It was interesting that these phases as described by the patients are analogous to those expected in therapy; orientation, testing and resisting, trusting and working and finally separation. These phases reflected the way in which patient relationships were formed and developed at the unit, and, as will be shown, the relationship with therapists.

Leadership

Leadership at the unit fell to a variety of people within the patient group. This leadership did not always coincide with the leadership of the patient council. Leaders tended to be people who were socially relatively intact when they entered the unit, and were able to offer support and encouragement to others from the beginning. They tended to be solid, well reasoned people whom others instinctively turned to for advice. They also tended to be able to articulate others' concerns, and to mediate fairly in a disagreement. Angus (Case #35) was such a person. He was a solid, slow talking, pleasant man of about forty. From the time he arrived at the unit, he tried to help other patients as well as working on his own problems. He took special pains to relate his experiences to the younger patients. When problems came up that he could not help with, he quietly approached staff for help and advice or to offer information. There was never any suggestion that he was trying to gain directly out of the confidence shown in him.

Other types of leaders did arise at the unit, however, and they tended to arise situationally, that is, to articulate a particular set of concerns, and with the resolution of those concerns they lost their roles in

most cases. If the issues persisted, one of two things usually happened; the person's leadership sometimes persisted until the situation was resolved, or if they were seen as no longer being capable of articulating the group's concerns, their leadership ended. Aaron (Case #36) rose briefly as such a leader, to articulate group anger over a situation. When the situation was finally resolved, Aaron's leadership ended. Aaron was useful to the group to articulate that single issue because he was angry, but once done, he was not seen as being trustworthy for other issues.

The Patient Council

The patient council began with the beginning of the programme. The intention of forming a patient council was to have the patients govern the detail of living and getting along in a community. The council appointed people to see to dishwashing, coffee making, emptying of ashtrays and the like. The original meetings of the patient council occurred once a week with both patients and staff in attendance, and were a time when community issues were discussed, and problems, if possible, resolved. The council functioned in this manner for approximately the first third of the year under study,

after which, drastic changes took place. The first major change was that as staff took on more responsibilities outside direct patient contact, fewer therapists attended the meetings. A second change was that a group of patients got together to write down the functions of the council so that each week people would be clear as to what their responsibilities were. During this formalizing period, small but important changes were made, and functions were added which had never been responsibilities of the council before. The offices and duties which came out of this formalization by the patients follows. These descriptions have been taken directly from the form used by the patient council.

Unit Commander: One person in fourth week, whose duties included: Being spokesman for the patients; making sure all other jobs were carried out; putting the thought for the day on the board; making sure all patients went to meals; making sure patients were responsible for activities, i.e. being on time for lectures, etc.; "running the unit to the best of his ability".

Executive Officer: One person in fourth week, whose duties included: recording of new officers, ordering food daily and regulating food. This person was also expected to pick up the commander's responsibili-

ties if the commander for any reason was unable to lead.

Relations Officer: One person in third or fourth week, whose duties were the following: welcome all new patients and answer questions they were concerned about; inform patients of all the rules of the unit (what rules were being related is unknown.); making sure that the guest book was ruled up with a pen available and that guests signed the book.

Boiler Engineers: Two people in second, third or fourth week whose only duty was to make coffee.

Utilities Officer: Three people in second, third or fourth week, whose duty was to wash dishes.

Horticulture Officer: Any week, one person whose duty it was to look after the plants.

Flame Control Officer: One person, any week whose duties were to empty ashtrays as well as to make sure that all patients knew where fire exits and equipment were.

Visual Perception Officer: One person, any week, whose duties were to clean boards after lectures and arrange chairs.

From the boiler engineers down, there were no new duties, simply a formalization of the expectations and the names. The names were decided upon to make some

of the rather mundane jobs sound fun and important, and the first few weeks after the change, the names were a running joke among the patients.

The most important changes were in the creation of the top three jobs, and in the description of their duties. Suddenly, there was a single person who was expected to make sure that everything ran well and that everyone did what was expected of them. And secondly, this person was endowed with the right and expectation of articulating patient concerns. Suddenly one person was expected to accept responsibility for what had, to that point been the responsibility of each person, and that should he or she be unable to do that, a line of succession was formalized, so that it would not revert back to the individual. Implicit in this seemed to be the need to have a powerful spokesman to articulate concerns which had previously been resolved on an individual basis. According to the authors of the original document which formalized these positions, the intent was to save time and energy and to make sure that everything ran smoothly. The consequences over the ensuing months were, in fact, far different. Within a few weeks of the formalization of the patient council, the council meetings were separated from the community meetings, to save staff time. Within

a few weeks of that change, the meetings of the patient council saw fewer staff members in attendance, and within a short time, staff was made aware that their attendance at meetings would be inappropriate and unwelcome.

It becomes fairly clear that below the position of relations officer the duties were fairly mundane, and the level of finesse necessary was minimal. However, with all offices filled, better than half the patient population was involved in an active way in the functioning and maintenance of the unit. These jobs aside from their obvious benefits in terms of the smooth functioning of the unit achieved two purposes. The first was to involve as many people as directly as possible in the community of the unit. This sense of community helped in forming the necessary trust which was required for groups to be as comfortable and as effective as possible for everyone. All these functions were being met prior to the formalization and the addition of jobs and responsibilities. The council after the formalization functioned almost as a para-structure to the staff structure. This allowed the patients both a sense of responsibility as well as control over their environment and condition through the use of the group and the structure. This sense of control in what was in many ways a powerless situation

for many, was achieved prior to the formalization on an individual basis. Progressively, following the formalization, patients tried to use this structure to present concerns, only to be thwarted by staff who insisted on individual responsibility for resolving concerns. Thus, the patients had a structure which looked as though it had power, however when they tried to utilize that power, they were struck with the fact that its power did not function in that situation. This also had the effect of formalizing an opposition between the structures which had not previously existed; the formal terms of reference between staff and patients had been different and so there was no formal venue for power in the situation.

An example of this was when the Unit Commander approached a staff member to say that some people had been uncomfortable with what had been presented in a particular lecture. The therapist said that he would be more than happy to talk it over with the individuals involved, and that if they were uncomfortable, it was up to them to take the responsibility to voice those concerns directly. The unit commander went back to the group, frustrated, he had pressure to resolve the issue from the patient group since that was his job, but he was unable to do that. He was, in addition, angry with

the therapist for not allowing him to do what was expected by the patient group.

Leadership of the patient council often reflected the values found in leadership generally at the unit; there were notable exceptions to this however. In addition to sometimes electing a person who was capable of articulating a single concern, there were several occasions when the patient group elected a Unit Commander who was clearly a person whom the patients saw as falling into one of the inappropriate categories. On enquiry, the reasons for these choices were that the patients felt that by showing trust and giving responsibility that the person might respond and improve. Oscar (Case #37) was elected Unit Commander despite the fact that he had earned the patients' wrath on several occasions with his behavior and despite the fact that he had not become close to anyone on the unit due to his continued inappropriate behavior. His week as unit commander reflected the first three weeks of his stay. By the end of his week as head of the patient council, the patient group was angrier than ever with him. This pattern was common when a person who had previously been inappropriate was elected. The expected positive response to this show of trust rarely followed, and when it did not there was a sense of betrayal and hostility increased.

Women on the Unit

Women patients at the unit were always grossly outnumbered by males, a fact which gave some women pause on entering treatment. Georgia (Case #38) delayed entering treatment until she was ensured another woman to begin with at the programme. The ratio of men to women was often ten or twenty to one. There were often fears expressed by women at the beginning about being with so many men and about how they would be treated. One woman, Marie (Case #39), was so frightened that she ran to her room between groups to keep away from the group. After a day or two and some gentle persuasion by various members of the group, she began to socialize with the men. The concerns of the women, in all cases, turned out to be unnecessary. Instead of being subjected to harsh language and disrespectful treatment because they were female and alcoholics, the women were treated in an exceedingly gentle and respectful manner. The women were often catered to, receiving special treatment and attention, and protected by members of the group from those who used profanities. In fact, there was often active censoring and censuring of those who made dirty jokes or off colour remarks in front of the women. For some women, this enabled them to keep a distance which made

them more comfortable and secure, but in many ways, denied them access to the group fellowship. Becky (Case #40) was one woman who at first appreciated and encouraged the special treatment, but soon found it stifling. She first told the men that she did not mind the language, however this did not change their behavior. It took Becky some time and active insistence before the men could accept her being there when jokes were being told or harsh language was being used. Once they had accepted her presence in that situation, Becky was involved in far more of the socializing. In a very few cases, women were able to achieve the best of both; winning acceptance and having special treatment and benefits at the same time. Caroline (Case #41) was one of the few women who was able to sit through an off colour joke and laugh with the rest, and at the same time retain what the men saw as vulnerable, feminine qualities which meant coffee was brought to her, her cigarettes were lit, etc.

Whether or not a woman achieved full acceptance, in therapy groups she was expected to work, and if she did not, much the same treatment was accorded her as men in the same position. Alice (Case #42) was a woman who tried to extend the protection afforded her in socializing to the therapy situation. She was told by the men in the group that they expected the same from

her as they expected of each other. When she resisted this, the group became irritated, and for several days she lacked the special benefits she had previously enjoyed.

The only obvious exceptions to these expectations were when a woman fell into any of the perceived incompetent categories. Rarely did a woman become a focus for overt hostile attention unless she was disruptive or abrasive; again, there was a tendency to protect except in the most dire situations. The case of Olga (Case #43) was an exceptional situation. Olga was hostile, flaunted her lack of association with the group and often was disruptive and/or inappropriate in groups. For about a week this situation was tolerated quietly, but with growing tension. At the beginning of the next week when the behavior continued, the group confronted Olga. They demanded that she participate appropriately, and that she come to groups on time. They also told her that her behavior had been tolerated but that she was quickly a making enemies. Following this confrontation, Olga became far more appropriate in groups, however, she was never able to achieve total group acceptance.

Ethnic Relationships

People who were distinctly perceived as foreign at the unit, like women, had to make special efforts to achieve acceptance. Contacts were often friendly but distant and patients generally seemed to have a difficult time achieving the same level of intimacy with one they considered to be very different. Even where language was no problem, a person born and raised outside English custom had a difficult time. Again, as with the reactions to women, there was rarely overt hostility, but usually simply different treatment which made the distance pronounced. The response to this often occurred in one of two ways; either the person made special efforts to relate to and become one of the gang, or they accepted their distance. This distance normally carried into therapy only if there was a language problem, and in that case the treatment was one of benign neglect. Alfredo (Case #44) did not have a problem with the language, but simply came from outside the cultural background which was predominant. Alfredo found himself at a distance from the group when he first arrived at the unit. He began to tell jokes, and soon was accepted by the group for his sense of humour initially and later for other qualities. Jacob (Case #45), on the other hand, was in essentially the same position as Alfredo, but did

not seek acceptance, and the distance was maintained throughout his stay.

Conclusions:

A continually changing group of twenty people were brought together to work around problems whose hallmarks were anxiety, hostility and lack of self confidence. This presented at best a very difficult situation in group interaction. That patients normally got on well with each other, had norms which were enforced, rejected those who did not conform if they could not be induced to change, and were fearful and suspicious of those with whom they could not deal, reflected, in many ways the functioning of a normal community. The fact was that this was a voluntary, intentional community and that relationships were compressed and intensified due both to the physical setting and the duration. The fact that formal structures arose is not in itself surprising in this context, however, the ramifications of the rise of this structure on therapist-patient relationships are perhaps the most important. Changes in relationships among patients (i.e. greater solidarity, formalization of the patient council with the subsequent change in status and responsibilities of the top officers to the rest of the patient group, and perhaps some increased rigidity in

expectations of behavior) occurred concomitantly with changes in the relationship of patients to therapists. These changes and the expectations which underlay therapy are described in the next chapter.

VII. Staff-Patient Relationships

This chapter presents an explication of the expectations with which therapists and patients approached one another in therapy. In concert with the descriptive material which has gone before, this should provide an explanation of the movement of relationships, i.e. greater formalization of contact outside direct therapy and greater complementary functioning between the two groups.

The forces which helped to provide the basis for this process such as the divergence of expectations as to the nature of the therapeutic relationship and therapy and loss of opportunities for casual communication, will also be cited and discussed in this chapter. The potential for future movement of these relationships is foreshadowed by the material presented.

At the unit, the ideal patient-therapist relationship was seen by staff as a partnership working towards a comfortable sobriety for the patient. This relationship ideally required both partners to be equally responsible for working towards the patient's goals and to be working toward these goals with equal enthusiasm. It required that the patient trust that the therapist wanted to help and would not harm him or her and that even

when the benefits of a particular therapy or intervention were not tangible that they be undertaken fully. It further required that if the patient had problems, concerns or misgivings that these be shared with the therapist.

The ideal required that the therapist be professional in every aspect of patient care. That meant that personal problems or concerns never entered into dealings with patients. It further required that all prejudices or preconceived notions be left outside the therapy situation. The ideal barred therapists from socializing with patients with the rationale that to become too close was to lose perspective and become vulnerable to the concerns of friendship and not therapy. The ideal required that the therapist engage themselves fully in working as hard as the patient was willing to work, and to help those unwilling to work to realize the necessity. It further required the therapist to be honest with the patient as to perceived progress and problems. Another facet of the ideal was that the therapist have no ego or emotional stake in the outcome of therapy in order to be effective with each subsequent patient, and to be able to continue to give effective intervention in the face of resistance, hostility or apathy. It required that the therapist's final goal for

the patient be comfortable sobriety and a detachment from therapy, and to attain these goals often meant making a patient uncomfortable to achieve long term comfort. Lastly, it required that the therapist be an example of those skills taught at the unit.

This ideal dictated that the patient be eager and responsive to therapy, that he or she be working partners with a hardworking, responsive therapist, who wanted him or her to reach a mutual goal and would work to ensure that he or she became progressively more independent of treatment. In addition, the ideal dictated that if there was any failing in working toward this goal that the therapist would not be hurt or upset nor even sympathetic, but would help him or her to analyze the problem and continue towards the goal.

This ideal in its entirety was never enunciated by the therapy staff, but seemed to arise from a variety of sources and seemed to become more formalized after approximately the first three months. What had been a developing role gradually became a set of expectations on therapists by therapists which were adhered to virtually universally from then on. The sources of these expectations included the training of various therapists, common concensus on what seemed to be the most appropriate tack to achieve the best therapy and the long term health

of both patients and therapists. The exception to this was that an expectation that therapists would exemplify all the skills which were taught at the unit developed over the course of the year under study, and seems to have emanated from the patients. This last expectation seemed to arise out of what was taught at the unit in terms of life skills. Patients were taught to strive for a model way of life; honesty, caring and hard work being the ways in which to move towards this model.

This model way of life revolved around being involved and comfortable with others, being emotionally open at will and being able to set and achieve realistic goals. In addition, the model suggested that an individual should deal with irritations and problems before they became too large to deal with and that by dealing with problems the person would be more comfortable in the end. The thrust was that people could take control over their lives and be more comfortable, but that it might mean giving up short term comfort for the long term goal. The problem appeared to arise in the interpretation of the model. The staff perceived the model as that towards which one strove, the patients perceived the model either as a reality or as a fiction. In either case, the patients seemed to expect the therapists to live this model, either to be a role model or to prove its exis-

tence. When this became a compelling force is unclear, however it was clear that as the year under study progressed there was increased perceived pressure for staff to act in these model ways. This pressure was reinforced for staff when a therapist would cite a personal failing or would become momentarily weak or impatient. In the first case, there seemed to be a sense of disbelief that these personal failings existed and a belief that the examples cited were to make people more comfortable. For those who used the therapist as a role model, such weaknesses elicited shock and disbelief, and for those who believed that striving for the model was useless, there was a sense that the hoax had been confirmed, and with that a sense of disappointment.

On one occasion, a therapist cited her difficulty in learning to be an assertive person and a patient immediately responded emphatically that he simply couldn't believe that. On another occasion, a therapist used a minor marital problem he had been through to illustrate a particular point in a lecture. Two patients talking after the lecture commented that they didn't believe that the example was real. In another situation, a therapist who became irritable was met with shock and disbelief by a patient who had seen her. In teaching life skills, several therapists were told that no one

could be like that, not even therapists. One patient commented to a therapist who was trying to quit smoking that he didn't believe that the therapist should have any trouble, even though the therapist was having difficulty. The implication was that a real therapist shouldn't have any trouble or that the goals were not attainable, and if they were then the therapist would not have any problem.

A part of the problem as described seemed to be a function of the therapeutic ideal. Because of the distance required to remain therapeutically effective, few patients knew more about a given therapist than his or her name, profession and how they conducted themselves on the unit. There was a pervasive sense of mystery about therapists partly because of this, which patients could not penetrate. There were often half kidding questions about how therapists lived when they were not being therapists, and how the spouses of therapists survived. There were also direct questions about therapists, and about who was inside the therapist. On several occasions a patient asked a therapist to talk to them and to stop being a therapist for a while. On other occasions, patients asked about family, children, hobbies, background, etc. Patients who sought personal details about a particular staff member found themselves politely but firmly

turned down. A full explanation when it followed such a request often met with one of two responses, one accepting of the situation and the second "it was only a casual question and I really didn't want a twenty minute answer". Even when there was understanding of the rationale behind not giving out personal details, there was a sense of rejection. Some patients offered arguments as to why the therapeutic relationship would not be damaged by a casual association, as in the case of Garfield (Case #46). After receiving a full explanation from his therapist as to the problems and the reasons, Garfield agreed that could be a problem in many cases and that it certainly was an understandable policy, however, nothing like that could ever happen with him. He finally seemed to accept that during the course of therapy and out-patients that such a relationship would not be possible. Other patients left with remarks suggesting "well, if that's the way you want it, I don't want to know you either". However, most patients seemed contented not to know more than was offered, and seemed to understand without being told why it was important. On one occasion, a therapist who was approached in group by a patient wanting to know more did not have time to reply before other group members were explaining carefully the problems.

At the beginning of the year under study staff spent a great deal of time with the patient group. Staff ate lunch in Conference Room I, and played cards with patients when they returned from lunch. In the evenings when groups were finished staff members often spent casual time with patients simply chatting when their work was finished. This pattern continued for approximately the first three months of the year. Staff members began to have greater responsibilities outside of direct patient contact and so time actually spent with the patient group became less. Lunch for staff was moved to Conference Room II at about that same time so that staff could discuss patient problems and so the casual contact at lunch was discontinued. Also, at about that same time, the first out-patients were forming groups, and evening time was occupied with groups and charting more and more. There seemed to be gradual attrition of the time spent with patients except in groups and in individual interviews over the year, and staff became less visible.

Patients generally found staff to be consistent in approach to problems, and this seemed to obviate many potential problems. On many occasions, several staff members were approached with the same questions, when the responses were found to be the same in substance, it

seemed to have a reassuring effect for most. In some cases however this consistency elicited hostility, the patient charging that the responses were not necessarily good or honest or helpful but that all staff simply mimicked what they had been taught. Oscar (Case #47) brought this out in group one day when he said that all therapists were taught to remember names to make people feel good. He also said that therapists were taught to give people compliments whether they deserved them or not to build them up. Again, before the therapist responded the group responded citing their own experiences which were opposite to his. Staff cohesion in the last two-thirds of the year seemed to be increasingly a double edged sword; it gave many patients a feeling of solidarity of staff and approach, but it also seemed to threaten others.

Patient's perceptions of staff became especially interesting in view of average education and social backgrounds of both. While in fact most therapists were more highly educated and from a higher socio-economic background, these differences seemed to be exaggerated out of proportion to their reality. This perceived dichotomy extended far beyond social status to perceived life experience. The correlation seemed to be that if one came from a particular background, one could not have life experience. A common retort when a particular approach

was suggested by a therapist was that it wouldn't work, or it was too difficult. If the therapist replied that they understood that it was difficult but that it was important to try it, the retort was "how do you know it's difficult, you don't know what it's like". This perceived dichotomy seemed to also tie in with perceived status as a therapist. Many patients approached the idea of being a therapist as almost a mystical function. Many people seemed to believe that a therapist could answer all the important questions of life, if they could only get the therapist to tell them instead of asking questions of them. Often in therapy, patients asked the same questions three and four different ways, asking the therapist to give them an answer. The therapist always explained that first there were no right answers to most questions, and secondly it was better for them to find their own options and make their own decisions. It was also explained that an answer which worked for one person might not be the answer for another. The therapist said that they would be happy to help the person to look for options or for different ways of viewing the situation. However, for some there persisted a belief that there were right answers if they only asked enough questions. One patient, having gone through the entire explanation said, "okay, that's fine, I'll remember that for the future,

but how about giving me just this one answer".

Over the course of the year the response of the group to a patient seeking answers rather than working changed. During the first few months, the groups were often willing to demand a high level of participation and work of one another. As the year progressed, this role was given over more and more to the therapist.

However a particular patient responded to the idea of entering an alcoholism programme or the idea of therapy and therapists, once in the programme, there developed, for most, a sense of solidarity with the other patients. At the beginning of the year under study, this sense of solidarity seemed to extend to staff much of the time. However, the sense of solidarity with staff seemed to slip away as staff contact became less, and was gradually replaced with a rather formal distance. The change was seen not only in the number of contacts between staff and patients but also the kind of contacts. Where information had been given freely to staff during the first third of the year, during the last two-thirds, the receiving of free information became less frequent. It was not uncommon during the first third of the year for a patient to approach a therapist and tell them about a problem another patient was having. With that information, therapists could watch situations more closely or effect inter-

vention earlier than would have been possible otherwise. A patient approached a therapist in the last third of the year and asked quietly if he could see her in private. Once alone, he said, "I don't want to be a fink, but I've got to tell you that Merv (Case #18) is having a problem..."

On another occasion a patient inadvertently revealed that another patient's serious problem with a family member had reached a crisis that evening, and in fact they were thrashing things out at that moment. When asked how long that had been going on, he replied about two hours. He then said "I was sure that you knew what was happening and were in control of the situation". In another situation, the comment was "you always seem to know what's going on, I didn't think you needed to be told". As the omniscient image of therapists grew, what point was there in telling a therapist what they must already know? With this factor added to the gradual reinforcement of the expectation that therapists must be role models, casual communication became more and more difficult. The process was one of moving away from the patient group. This process, at the end of the year, had proceeded to the point that in many cases, a therapist was not well known to the patient group. Patients saw therapists in many cases as one who either must not be told about what was going on because it might mean trouble, or one who didn't

need to be told. Again, due to a lack of direct contact in a casual sense, patients lacked a feel for the humanness of the therapist; they saw only the image of the therapist, which had been pushed closer to the image of the role model during the course of the year.

It was interesting to note that throughout the year, no matter what the relationship with staff was during the in-patient phase, the out-patients (those who had been through the four-week in-patient sequence) were very different. Out-patients seemed generally comfortable in communication with any staff member. In the out-patient sequence, patients seemed very comfortable in stopping an unfamiliar therapist to chat and pass the time of day. It was as if a barrier had been broken at the end of the in-patient sequence. Patients no longer felt as though they needed to "act like patients" and therapists could be people. The change for most was so dramatic that it suggested that the perception by the patient of both him or herself and of therapists in a complementary relationship was limited to the in-patient time. Patients were perceiving rules and roles where in some cases there were none, in other cases ascribing varied interpretations where there were rules and roles, even when those rules and roles had been clearly delineated.

Conclusions

It has become clear in this chapter that there were obviously some differences in the perception and expectations of the role of therapists, between therapists and patients. These differences were reinforced and increased by the patients over the course of the year and there was a gradual response by staff moving closer in appearance to the model. In addition there were differences in the expectation of the role of the patient in this relationship which, over the course of the year became more pronounced. These problems in definition and expectations seemed to be time/change limited on the part of the patients, gradually disappearing as patients reached the third and fourth weeks of the programme. In addition, out-patients (those in the fourteen month follow-up sequence) obviously had a very different picture of those relationships. However, as patients were moving through their four weeks, there was a continual influx of new patients at the beginning of the sequence. Thus, the cycle began over again for the therapists and the expectations of roles appeared to be changed however minutely, by each group.

There was also increased formalization of contact between staff and patients outside of direct

therapy due both to increased pressure to adhere to the role and the model, and increased responsibilities of therapists outside direct patient contact. With this increase in formalization of contacts there seemed to be a concomitant rise in the expectations by patients of a tutelary or complementary relationship of staff to patients, and increased resistance to symmetrical functioning within that relationship.

VIII. Discussion

Throughout the descriptive material, the group and the individual have been freely interchanged which may have seemed to be a confusion of levels. However, the individual examples cited were used to express the prevailing moods and attitudes of the groups involved. This transition from individual to group may be justified on several grounds. The first is purely a technical consideration, that is, the possibility of depicting the complex interactions among individuals, with groups continually in transition and over the period of a year without recourse to representative sampling, is simply staggering. It is also likely that even if this had been attempted, clarity and brevity would have been lost in the pursuit of greater obvious verisimilitude. The second consideration was that the subject under study here was the change in norms of behavior. Behavioral expectations are only reified in the context of a group, and group norms only change as individuals change, therefore the use of selected individual cases to suggest group norms is not as illogical as it may at first seem. This approach also brings the discussion full circle to

Bateson's methods, i.e. defining the group's norms by the behavior of the individuals within that group, and their concurrence with that behavior.

Through the descriptive material presented, it has become clear that changes both in the structure and functioning of the relationships under study have occurred over the year. To delineate the nature of the changes, their etiology and the potential consequences of those identified changes will be the purpose of this discussion.

It has been clearly stated that those who came to the unit had a particular kind of problem, that is alcoholism. It was shown that with that problem came a constellation of social and emotional problems, beyond the abuse of alcohol. The social problems included potential breakdown in health, family relationships, social relationships and in the area of employment. The emotional problems most often seen and also identified in the literature included two broad typologies of personality characteristics. One typology was associated with patients who were anxious, overly sensitive, had poor self-concepts and an inability to deal with emotions appropriately, especially anger. The second included those who were hypomanic, "...socially at ease, and indifferent to conventional morality and/or social controls" (Rosen: 1966:

1286). Those common emotional and social problems as suggested, may have been exacerbated through the confrontation of their problem and the manner in which they decided to attend treatment. Further exacerbation of emotional effects were often prompted by actually entering treatment which involved a new social situation, a new physical situation and potentially the anticipated pain of change from a habit and lifestyle.

The physical setting, although essentially unchanged over the year, was austere, formal and perceived as extremely limited in terms of free patient access areas. This produced an enforced intimacy among the patients. Robert Sommer suggested that "Under crowded conditions, social norms for maintaining privacy partially substitute for the lack of physical devices." (1969:41). These norms at the unit, dictated that areas "owned" by a person or group were respected, and that this also extended to staff areas. These techniques for maintaining a semblance of privacy and respect of personal territory seem to have developed over the course of the year. Sommer suggested that people in restricted situations such as prison, seemed to understand innately that control over emotions was necessary for the survival of all. This was especially true due to the limited movement possible and

the length of enforced contact. (1969:42)

The possibilities for avoiding other patients at the unit for any period of time were distinctly limited without physical withdrawal. Therefore, norms of acceptable conduct seemed to have been formulated or were innately understood to be essential for the comfortable survival of all and over the course of the year they appeared to be followed consistently. During the course of the year very few even potentially explosive situations occurred despite those problems suggested as common to this group. It seems reasonable to attribute this, in part, to the strength of maintenance functions.

The physical setting, which provided limited perceived free access areas for patients, might well have been expected to be a potentiating factor for explosive behavior at the unit. Instead, in response to the situation, social norms were developed and enforced which ensured that such situations did not arise. Those normative behaviors became clear on review of patient relationships with one another and with staff.

The expectations of relationships among patients set out clear cut criteria for membership. Those norms not only made for comfortable social relationships, but were essential for the harmonious functioning of the patient group. A patient who showed inappropriate

behavior, as determined by the rest of the patient group, could create stress which could be ill afforded in tight quarters. In addition, taking into account those problems which were often characteristic of incoming patients, the degree of social control necessary for the maintenance of the group in such a situation was high. This situation also provided a testing ground for restructuring of social skills and a structure for self discipline in an ongoing social situation. It further ensured swift feedback for inappropriate behavior, potentially reinforcing appropriate behavior through group acceptance and support.

For those patients deemed inappropriate by the patient group, the situation seemed therapeutically to have both good and bad elements. Support was given for a change in behavior and participation. For those who chose inappropriate behavior, the situation made the decision fairly clear cut; be appropriate and be accepted, or be inappropriate for a long enough period of time and be rejected. The unfortunate element from a therapeutic stance occurred when a person needed to be rejected to fulfill their image of themselves or to be able to shift responsibility for rejection to others.

There were situations during the course of this study when all three outcomes occurred. The cases cited earlier, such as Case #5, Marcel, demonstrated the

pressure to act in an appropriate manner. When he acted appropriately, he was rewarded with acceptance.

Sarah (Case #6) never responded to the pressure of the group to behave appropriately, and was finally rejected by the group; she unfortunately may have also fit into the category of those who needed to be rejected.

In speaking about what he termed "the need for affiliation", Schachter described an individual's desire to "...associate, cooperate and reciprocate with others like themselves, or others who are undergoing similar experiences." (1959). He suggested that an individual needed to be able to perceive similarities of some sort to experience this bond with another individual or group. If this idea is applied to the group(s) under study, several things become immediately clear. First, given the problems which many patients had experienced prior to entering the unit and the emotional problems in terms of needing to be accepted which were suggested, it would seem probable that this need may have been heightened in the group under study. This may offer a partial explanation for the degree of solidarity which was developed in most patient groups. In addition, it may to some degree explain why, for the most part, patients adhered to the behavioral norms with little dissension.

Secondly, it seems equally clear that patient's perceptions of therapists were not necessarily conducive to such an affiliation between patients and therapists. If we accept that, then it is possible that if the norms of the two groups were in conflict, the need for affiliation could be a determining factor in choices of affiliation. That is, a given patient may have felt that he/she had to decide between therapy and therapists and the patient group.

Patients generally got on well or at least tolerated each other with a fair amount of good humour and mutual support. However, it was not surprising that the censuring of those who declined membership was fairly strong in light of the need for affiliation, which may have been exaggerated under stress. Those who rejected their membership presented several either real or perceived messages to the patient group. First, "you may be an alcoholic (with the stereotype in mind) but I'm not". This message was characteristically delivered either in taunting tones or with a patronizing air towards those who had admitted such a problem. In a group whose comfortable existence together was based on cohesiveness and solidarity based on mutual experience, this type of statement was tantamount to heresy. Case #27, Bart, was a good example of such denial and the group's reactions. It

further provided strains in living together on the unit if staff were not privy to this person's attitude, and this fact was flaunted to the other patients. Anger was not only directed toward the patient but toward staff for not knowing. The second message often was, "since I'm not an alcoholic, none of the rules apply to me". The sometimes covert message along with this was, "none of the rules apply to me except when staff are around", thus presenting other patients with yet another problem. If the person did fulfill expectations when staff were present then staff would not necessarily know about this attitude. If a patient told a staff member, it was, in the latter part of the year, a breach of expectations on the part of the other patients. The final message was, "since I'm not an alcoholic, I don't need to change". This too infuriated those who had made a commitment to change; if they worked, they were suckers according to the other, or pitied by the other as being weak. If they did not work, they were missing out on a chance to work on their problems. Thus, the heavy censure was not only help and support for the patient in denial of alcoholism, it was an affirmation that what the others were going through was important and necessary, and that they all were, in fact, in the same situation.

Those whom the patients felt were incompetent after the period of testing and support and who were denied membership in the group seemed to have provided the patient group with special problems. Firstly, how to enforce the group's expectations if the person was not competent, and if expectations could not be enforced, how to deal with inappropriate behavior. Benign neglect was the response of choice to non-disruptive individuals. However, if a person was disruptive, the group, after a period of attempting to control this behavior, expected staff to control the person. If this behavior was not curtailed by staff, staff became the object of the anger. There also seemed to be anger over the fact that this person could not (or would not) participate fully both in therapy and in the social situation; that they did not understand the gravity of what was going on, that they could not affiliate, such as with Case #31, Dirk.

The group seemed to be able to "carry" only one individual in either non-associative category at any one time. If this capacity was exceeded for any length of time, anger towards both the affected patients and staff became far more obvious. The group's resources seemed taxed beyond their limits in this situation, and extraordinary behavior was allowed. It was at these times, among others, that the rules which seemed to exist toward

the end of this study regarding not informing therapists could be broken. This was well illustrated in the cases of Dirk (#31) and Kevin (#34). Therapists at these times were informed as to precisely how people felt and what was the problem. This situation also seemed to allow people to vent a disproportionate amount of anger about anything around therapy and the unit. This seemed to justify the expression of discomfort focusing on the other, perceived incompetent patients and therapists.

All of this seemed to support the importance of normative behavior having been essential to the comfortable functioning of the patients who were at the unit.

Thompson spoke of socialization as teaching the individual

- 1) survival skills...
- 2) rules and regulations governing social interaction and the allocation of pertinent social and material resources,
- 3) principles defining the self and the place of the individual in the group, and
- 4) a general conceptual scheme for the attribution of meaning and significance to the world. These were termed the major elements of a cultural design for living.

(1975:40)

The patients evolved a system for socializing those who came to the unit and for censuring those who resisted eventual socialization and threatened the social order. There were rewards for those who joined and associated, and indifference or anger towards those who could not or would

not adhere to the rules.

During the year under study, little of an essential nature [that was evident to the author] changed about basic relationships among patients except a greater sense of solidarity.

Staff-Patient Relationships

Relationships between therapists and patients were always characterized by some distance, strictly as a function of the normative relationship. However, pragmatically, over the course of the year changes occurred on both sides which seem to have affected the overall quality of the relationship. From the outset, it should be understood that this refers, so far, only to relationships other than direct therapy. This analysis will deal with "the patient group" and "the therapists". An opposition has been deliberately created which will be supported in the analysis.

The relationships between therapists and patients seemed to undergo a progressive change over the course of the year, characterized by an us and them mentality on the part of the patients. The signs and symptoms of this change included progressive exclusion of staff from patient areas and from free perceived access to social groupings and a progressive deterioration of

direct, casual communication. In addition, there was increasing pressure for the therapists to live the model which was being taught.

There were some obvious reasons for this perceived change in the quality of therapist-patient relationships. Some of those reasons may have included therapists being progressively less visible over the year with increased roles in work not directly with patients. A lack of clear understanding of expectations and relationships on both sides might also have occurred and helped to bring about this change. The nature of the problem being dealt with may also have been a factor in producing such changes. However, these reasons may explain in part the etiology however they do not explain the process by which the changes came about, were perpetuated and escalated.

Perhaps an oblique approach to the problem of changes in therapist-patient relationships will do most to illuminate the process and its possible future progress. Through the use of a specific model, we may discern patterns which are applicable to the group studied. In this, it is important to keep in mind that we are dealing with two separate groups, whose views of themselves and each other may be distinctly at odds, and whose purpose may or may not be uniform and understood by

both groups. This purpose and its understanding will be an important focus in what will follow.

If we begin by looking at the nature of the ideal therapeutic relationship as detailed earlier, in light of both Gregory Bateson's works (1958, 1972) and Paul Watzlawick's and others' works (1964, 1967, 1974), on communication theory, we may gain a new perspective on our subject. The authors suggested that there are two basic forms which relationships take, subject to a variety of subforms. The first form is that of a symmetrical relationship, characterized by attempts to establish and maintain equality. "...partners exchange the same sort of behavior, or in other words they demand equality through the message character of their behavior."

(Watzlawick, et al., 1964:7). A healthy symmetrical relationship was described as one in which partners share behavior, neither being superior, providing for mutual respect and trust even in their differences. (Ibid.) Potential dangers in such a relationship include the possibility of escalation of positions, finally resembling an armament race; each struggling to maintain position as the other moves. The second potential danger is that one partner may be seen by the other as being more equal. (Watzlawick 1964:7).

In the complementary relationship, partners exchange behaviors which presuppose the other's response and provide purpose for it. These exchanged behaviors confirm the positions of the partners. Examples of such relationships are mother/child, teacher/student, etc.

(Watzlawick 1966:7-8).

A typical problem arises in a complementary relationship when P demands that O confirm a definition of P's self that is at variance with the way O sees P. This places O in a very peculiar dilemma: he must change his own definition of self into one that complements and thus supports P's, for it is in the nature of complementary relationships that a definition of self can only be maintained by the partner's playing the specific complementary role.

(Watzlawick et al. 1967:108)

Watzlawick et al. also noted that change must be allowed to happen within a relationship or it will become disturbed if growth was not allowed. The authors also emphasized that both types of relationship are neither good nor bad in themselves but that pathologies of either may occur, and that in most relationships both forms occur as needed. Switching from one form to another may restore stability when either system threatens to overload and become "runaway". A runaway in a symmetrical relationship leads to escalating competitiveness, while in a complementary relationship to rigidity and exasperation (1964:9).

With all the foregoing in mind, it now seems appropriate to turn to the description of the ideal therapeutic relationship and to analyze the possible modes of relationships involved and then the pragmatic situation.

The Therapist-Patient Relationship

From the outset, the ideal was described as a partnership. This descriptive word would suggest a symmetrical relationship, an equality of responsibility for outcome. The description went on to say that this relationship ideally required the partners to be equally responsible for working towards a given goal and to be working toward a common goal with equal enthusiasm. In the ideal, this presupposed that the patient was a willing, capable partner who wanted to form such a relationship. It also presupposed that this was the form of relationship which the patient envisioned.

If we accept for the moment that on an experiential level these two patterns are "known" to each person, what ever pathologies of them may have occurred in any given relationship, then a pattern of expectations may be set. This pattern is then, that if the patient was willing to accept responsibility for helping themselves, so was the therapist; if the patient refused to help him

or herself, then there was nothing to be done, i.e. we cannot function unless we both function; that is, a symmetrical pattern.

In a complementary relationship, i.e., doctor-patient, mother-child, etc., the expectation is of opposite forces; if I am sick you will make me well, etc. This idea was also carried through in the therapeutic ideal in that, if a patient was not working, then the therapist's role became one of helping them to realize the necessity, to give guidance and direction, to give lectures and therapy sessions. This model was reinforced in many cases by patient expectations about therapy and therapists. Patients often referred to sessions as classes and spoke about what was being taught, suggesting further, a complementary set.

In a therapeutic relationship, as in other relationships as mentioned before, neither mode was necessarily good or bad, but might change to fit the needs of the situation. However, if these modes conflict with the expectations of the patients, what may be the outcome? If we go back to patient perception of therapist status and function then there was clearly a conflict for many in the formation of a symmetrical relationship. Therapists were well educated, patients were less well educated; therapists were therapists, not alcoholics (keeping in

mind the pejorative set for alcoholic); therapists were generally middle-class; patients were not; therapists were in their own territory, both physically and in terms of skills, patients were not. All of this would suggest that for most, clearly, the expectation was, at least for the initial time, that the relationship with therapists would be a complementary one, with the patient as a relatively passive partner being "worked on".

The ideal relationship on the other hand, required that both modes situationally exist in the relationship, and that the ultimate goal of therapy and a healthy therapeutic relationship was a complementary kind of disconfirmation, culminating in a basically symmetrical situation. This would mean that the patient would reach a point where he/she no longer needed to be a patient, therefore no longer needed a therapist; that is, would be fully equal and functional in a symmetrical relationship, to which both must agree. The peculiar nature of the therapeutic relationship also dictated however, that no progress could be made toward this final, symmetrical relationship until the patient and therapist disconfirmed one another's roles. That is, since there could not be access to the therapist as would be expected in a "normal" symmetrical relationship, so long as they were patient and therapist. It is not surprising then, to have found that among those

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who seemed to expect complementarity, fourth week and out-patients were rarely represented.

In light of the foregoing and the general life position of incoming patients, that is, not a position of strength, it is not particularly surprising to have found many expecting a complementary relationship with therapists and being uncomfortable when these expectations were not fully met.

In the natural history of the living human being, ontology and epistemology cannot be separated. His (commonly unconscious) beliefs about what sort of world it is will determine how he sees it and acts within it, and his ways of perceiving and acting will determine his beliefs about its nature. The living man is thus bound within a net of epistemological and ontological premises which - regardless of ultimate truth or falsity - become partially self-validating for him.

(Bateson 1942:314)

The self-validating premises in this case may be that the therapeutic relationship could only be a complementary relationship in view of life position and self image, and if one treats it as such it may become so. Therefore, as described in therapist/patient relationships, the move to a symmetrical form was often met with great resistance. Examples such as the denial of a weakness in a therapist by a patient, an expectation of omniscience, an expectation of living what was an ideal.

Even when symmetry was accepted, it was often reinterpreted by the patient so that therapists were "more equal", i.e. a weakness was temporary and there was probably a good reason for it anyway which was beyond the therapist's control. Again, in view of life position, this resistance was not especially surprising, especially in view of poor self images; if the therapist is weak also, we are all lost. Remembering that this form of resistance to the therapeutic relationship was usually time or change limited, we may enquire as to the purposes served by limiting the relationship to a complementary form.

A complementary relationship dictates a power relationship; there is a sick person and the one who can fix the sick person, if they will. The active/passive components of this relationship may serve several functions. Firstly, it may reinforce the weak position of the patient, which may be, for that person, an acceptable position; "don't put too much pressure on me, I'm ill", or "I am too weak to be in control of myself or anything else". It is a position of justifiable weakness. Secondly, it by its nature, limits the level of active commitment possible for the partners. Thus, someone who was ambivalent about the nature of their problem and the possibilities for movement may have found this

position especially comfortable. Especially for people whose motivation to seek help may have been forces external to him or her, this position allowed the person to maintain a lack of commitment and allowed others to "work on" him or her, not resisting precisely, but not an active partner. Thus resistance to any movement to any symmetrical functioning would not be especially surprising. In addition, those who felt genuinely powerless to help themselves may have found this a comfortable position and thus have resisted any movement toward symmetry. Another factor in this resistance to a move to symmetrical functioning may have been that this relationship gave the person time; time to adjust, time to feel out the situation, time to make decisions without any demands.

A symmetrical facet might also demand rejecting the omniscience ascribed to the therapeutic role which might then imply that if no supernatural acts are taking place, then the process must have been natural. If the process was natural then either "I am too weak to be able to work through it", or "I should already know how to do it if it is natural". "Since I don't know how to do it, either they are telling me I don't know anything, it's supernatural, or I really am weak." Even in the partial acceptance of a symmetrical role this could be achieved with "therapist's more equal" stance.

An additional factor in the initial rejection of the symmetrical form was that it dictated mutual trust and respect. The life position of many people who entered the unit dictated that trusting others was a dangerous activity at best and to be trusted or respected, belied the pejorative implications of their perceived position, which in many cases was a known position if not optimal.

A final factor in this rejection of symmetrical functioning may have been the type of change required. Many patients entered the unit expecting that the object of treatment was sobriety, and that simply being sober would create a comfortable life situation. It was often expected that this transition was, in and of itself a "cure". The discovery that sobriety was viewed as only a beginning, proved startling to those who had not expected to make major changes beyond that sobriety.

Both Bateson and Watzlawick spoke of levels of change and learning. "Learning I is characterized by specificity of response, which - right or wrong - is not subject to correction." (Bateson 1972:293). In this case, simply not drinking might be seen as a form of Learning I. "Learning II is change in the process of Learning I, e.g., a corrective change in the system of sets of alternatives from which the choice is made, or it is a change in how the sequence of experience is

punctuated." (Ibid.). Punctuation in this case meaning whether the person viewed his or her behavior as a response or as a stimulus; "I drink because I am unhappy or I am unhappy because I drink". In fact what was being asked of patients was Learning II, not a simple, new learned response, but learning to view themselves, their situation and the world in a very different way. This required the patient to step outside his or her assumptions of sets and challenge their ongoing, never changing validity. Again, this was an exceedingly challenging expectation for a person in the life position and situation as described, and could only be achieved in an active position. Watzlawick, et al., described many ways in which communication could be avoided or thwarted, thus avoiding the necessity of Learning II. They suggested that "Conceivably the attempt not to communicate will exist in any other context in which the commitment inherent in all communication is to be avoided." (1967:75). One method of avoiding communication was using the symptom as communication.

I would not mind talking to you, but something stronger than I, for which I cannot be blamed, prevents me...the communicational "play" becomes perfect once a person has convinced himself that he is at the mercy of forces beyond his control and thereby has freed himself of both censure by significant others as well as the pangs of his own conscience.

(Watzlawick et al.: 1967:78-79)

As well as relieving him of the necessity of communication, it has implications for the nature of the expected relationship with others if they accept the situation.

Thus, we have disagreement in many cases on two levels: one, on the relationship level, and two, on the content level. In order to break through this disagreement, the therapist had to be consistent in his/her expectations of strength and motivation toward change, and the patient, having run into this disagreement had to decide to respond to the expectations.

As we have seen, especially in a patient's initial time at the unit, there were fundamental differences of definition of relationship and expectations between many patients and therapists. These differences were normally rectified as the purpose and content of the intervention became clear and the testing of the relationship proceeded. However, that the unit functioned on an open group basis meant that the players in this initial time were continually changing. It would be perhaps logical to assume that any effects of this initial problem would be transitory since the problems themselves were resolved in most cases. This however, misses the fact that changes in the responses, however slow, may have taken place. The suggestion that changes

in responses had indeed taken place, came from the descriptive material. The response of therapists to patient expectations of fulfilling role models progressively took place; communication with patients became more distant on a casual level and patient solidarity on an organized level became more pronounced.

The Therapist-Patient Group Relationship

In speaking about relationships, Bateson wrote:

"It is at once apparent that many systems of relationships, either between individuals or groups, contains a tendency toward progressive change." (1958:182).

Schismogenesis as Bateson defined it is "...a process of differentiation in the norms of individual behavior resulting from cumulative interaction between individuals."

(1958:175). Bateson also spoke about cultural contact between groups. He suggested that the potential outcomes of such contact were: 1) complete fusion of the two groups; 2) the elimination of one or both groups; 3) the persistence of both groups in dynamic equilibrium as differentiated groups in a single major community.

(Ibid.:184). Bateson refused to consider the first two alternatives as viable and would only consider the third alternative, but if we are to apply this to the group of patients and their subsequent resocialization, then we

must consider the other forms. Fusion would only be possible if the systems were to be compatible and in the case in study, they were incompatible. The second possibility, the elimination of one or both groups, is in fact what was being sought. Therapy is intended to eradicate those characteristics which made that group incompatible to the norms of the dominant society, and to achieve this required Learning II and the elimination of old, perhaps comfortable behaviors. The third possibility would require only first order change, or Learning I, but would not be considered to be an appropriate therapeutic goal.

Spinoza suggested that "Each thing insofar as it is in itself, endeavors to persevere in its being." (1949:135). Thus, as has been described, the stage was set for a battle for survival between the therapists on one side and the patients on the other. That some resisted is not surprising, and that change occurred on both sides is not surprising either. The form of those changes, and their potential ramifications is however a matter of concern.

Bateson suggested that once a split begins, certain outcomes may follow. Schismogenesis may promote disharmony as each partner seeks to confirm higher position and to maintain control. With the widening of the split,

"...we find the development of structural premises which give permanence and fixity to the split." (1958:136).

Bateson further suggested that if the process were to continue long enough, hostility, jealousy and an inability to understand each other could occur. (1958:187-88).

Bateson went on to suggest that:

It is likely that the further apart the personalities evolve and the more specialized they become, the more difficult it will be for them to see each other's point of view. Finally, a point is reached where the reactions of each party are no longer striving after the answer which was formerly satisfactory, but are simply the expression of distaste for the type of emotional adjustment into which the other party has been forced. The personalities thus become mutually contra-suggestable. In place of patterns of behavior which were perhaps originally adopted in an attempt to fit in with the other party, we now have patterns of behavior which are definitely a reaction against the other party. Thus the schismogenesis takes a new form and the relationship becomes less and less stable.

(1958:189)

Applying these ideas about relationship between individuals to the interaction between staff and patients as members of opposing groups, it is apparent that the situation under study bears little relationship to this final product of schismogenic change. That in turn suggests that the form of schismogenesis seen has not yet reached that stage and that there are mitigating factors preventing escalation. If in fact the split has simply

not reached the final stage can only be seen over time, and cannot be known from some middle point. However, there were factors which may be seen to have mitigated against the relationships moving apart unchecked. The first factor was the persistence of the ideal which dictated that a purely complementary relationship was not appropriate for the type of intervention being offered; that precludes, to some degree, a runaway complementary situation. A second factor which would mitigate against this situation escalating rapidly is the fact that the relationships do change form. Thirdly, there was great tolerance of new patients by both staff and patients, however pressure from both groups dictated a time limited, predominately complementary relationship. Fourth, most people who came to the unit, despite the problems described, took an active role in their treatment following resolution of conflicts. The fact that the conflict was time/change limited also would seem to mitigate against its rapid escalation. A final factor, one suggested by Bateson is that "schismogenesis may be checked by factors which unite the two groups either in loyalty or opposition to some outside element." (1958:194). In this case there were several obvious points which united the two groups; one in opposition to alcoholism and its concomitant

problems, and two in opposition to the society's views of the alcoholic.

Bateson spoke about "...the development of structural premises which give permanence and fixity to the split." (1958:136). Through the descriptive data, several factors were shown which might be seen to lend permanence to the division. The first was the clustering of staff areas, lending perhaps unnecessary solidarity and distance to an already perceived somewhat distant and formidable group. As was suggested in the physical setting section, approaching a therapist's office may have been akin to running the gauntlet.

A second structure which may lend permanence to this division was the patient council. As illustrated, over the year under study, the council grew in size, duties and secretiveness. Increasingly, patients attempted to use the patient chairman to voice problems and seek solutions. The problem was however, that this council was originally established as essentially a non-decision making body, to deal in a town meeting fashion with the maintenance problems of a community. Its beginnings and workings were informal and included therapists. Over the course of the year, its internally devised duties grew far beyond their original parameters. The types of material dealt with directly did not seem to change drastically over

the year, however, the use of the council and its officers by the patient group did. Where at one point problems were brought up directly by the affected parties, more recently there was a channeling through the patient leaders to enunciate the problems. In addition, in some cases pressure was put on the chairman to resolve problems. This development seems to have created a whole new infrastructure for communication, which did not exist at the beginning of the year. The problem with the structure was that it was a chimera; essentially lacking power, possessing only structure. It had power however in its potential for lending greater strength to the split and reinforcing non-symmetrical functioning. Unlike other possible situations where problems might be worked out on a representative basis, the therapy situation may not presuppose simple problems. Problems must first be dealt with on an individual basis and not through a representative. This structure attempted to establish a basis for mediating problems on straight forward, simple terms, where the communicational bases may have been far more complex. The extended problem then is that these efforts to mediate at representation in most cases had to be frustrated to deal directly with the problem. Even by these attempts, the council may have had the effect of suggesting further solidarity to the

split, and perpetuating the maintenance if not the movement of schismogenesis.

Therapists' response to patients' expectations may also have lent permanence and fixity to the split, by responding with behaviors which maintained the more than equal status demanded by patients. A potential mitigating factor was the refusal of therapists to respond to patient expectations of a totally complementary relationship.

IX. Conclusions

As was seen in the descriptive material, in all aspects of structure and relationships, patients had expectations which they placed on the world they were entering. Those expectations showed them clearly expecting to be in a position of weakness in a system of hierarchies and strength. They found instead a situation in which strong expectations of the ability of the patient to reassert or develop strengths was the dominant ethos. To subscribe to that ethos however meant giving up the basic comforts of a weak position. Those comforts included not having to take responsibility for outcome, avoiding a commitment, and avoiding the risks of change.

Resistance to the expected patient-therapist relationship took many forms, but most individual efforts at resistance were time/change limited.

Patients developed and enforced norms which dictated positions and relationships. These norms helped to maintain a comfortable situation in a physically constricted area for people with extraordinary problems in an uncomfortable situation. These norms however also helped to dictate position and the possibility for movement within relationship types. These norms were

reinforced by the development of a structure which further obviated movement towards individual strength.

The response to these expectations was a gradual movement by therapists closer to the more formal, complementary role of therapists seemingly demanded by patients.

While there were no changes in the conception of the ideal relationships between therapists and patients, there were changes in the behaviors of both partners. These changes in behavior suggested the early stages of schismogenic change. These changes were mitigated by other factors and were not seen as having affected the relationship between an individual therapist and individual patient. In addition, it is not possible to predict the movement of such changes as the outcomes could be diametrically opposed. One potential outcome could be that this division will continue to the ends Bateson suggested. A second, and equally likely outcome, may be that as patients are able to be more dependent and less challenged at the outset there may be a movement towards greater symmetry naturally as strengths are realized. However, there were indications at the end of this study period of some rigidity on both sides, which may suggest a possible path for this movement.

There is certainly the possibility that now that the large outlines of behavior have been delineated, that a more intensive and replicable study can be carried out to measure movement in the relationships described.

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