MORAL FACTORS INVOLVED IN PATIENT ACCEPTANCE OF TREATMENT AT A CLINIC FOR ALCOHOLICS

MORAL FACTORS INVOLVED IN PATIENT ACCEPTANCE OF TREATMENT AT A CLINIC FOR ALCOHOLICS

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SCOPE AND CONTENTS:

This thesis investigates the moral attitudes of patients towards alcoholism, and the relationship between these attitudes and the patients' attendance record at an out-patient clinic for alcoholics. Incorporated within the thesis is a discussion of the definition of alcoholism as an illness and/or the definition of alcoholism as morally wrong and stigmatized. This is reviewed through the pertinent literature and studies of public opinion, medical and social control agencies. A questionnaire designed to explore the attitudes of patients towards alcoholism as morally wrong and/or illness was employed. The results obtained from the questionnaire are compared against the patients' subsequent attendance at the clinic. Discussion of theoretical work and suggestion for further study are included within the thesis.

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Table of Contents

CHAPTER 1

AN OVERVIEW OF THE STUDY

The Empirical Problem

A man comes to an out-patient clinic for the treatment of alcohol addiction. It is his first visit. His chances of remaining in treatment beyond the first three visits are, at a conservative estimate, that of one in three. The high "drop-out" rate of patients within the initial period of contact with the clinic is thought to be a problem of considerable importance because of the loss of possible rehabilitation for some of these patients, and because these are persons who have contacted the clinic and therefore the assumption is that in some degree or fashion they were motivated to do so. Further, the Foundation has an "education" branch which publicises and attempts to locate clients, therefore the loss of those who have already made the first step is considered a set-back.

The clinic, at which this study was conducted, was anxious to locate any areas of practical help and usage to their organization, and which might be implemented, in an attempt to maintain their patient population. Therefore, critical analysis, evaluation and suggestion were to be incorporated into the study.

Location of the Study

The study was conducted at a clinic which is a treatment

branch of the Drug and Alcohol Addiction Research Foundation - a Provincial Agency.

The aims of the clinic, as stated in the annual report in December, 1965, include:

> Out-patient treatment for the acute and long term aspects of alcoholism which is available during the daily clinic sessions.

There are twenty people employed at the clinic, of which six are medical doctors - two on a consultant basis; five nurses; seven clerical staff; and one social welfare worker.

New admissions in 1964 numbered 275. The male/female ratio was 6 to 1. The estimated "drop-out" rate of patients was 1 in 3. The patients came mainly on a voluntary basis, but percentage referrals, in 1964, were:

legal-professional and courts	10
physicians	18
industry	9

The employment status showed, in a one year survey, that 70 per cent of all patients were gainfully employed.

Empirical Problem into Research Problem

We could find no sociological surveys that had been made in this particular problem area. Review of studies made in other disciplines revealed little of a positive nature. However, studies which had been made into different problems but which had *en route* touched on the difference between the two groupings of

patients by attendance, did reveal some findings in the field of eliminating differences between the two groupings. For example, in a recent study conducted at an out-patient alcoholic clinic, similar to the clinic in which this study was made, it was found that the drop-out population of patients did not vary significantly from those who remained in treatment by the background variables of religion and education. In fact, the only significant differences found between the two groups were as regards attitude towards treatment.[1]

Another recent study, conducted at the Peter Bent Brigham Hospital, supported this finding of elimination of background variables as significant in groupings of patients who do, and who do not, attend.[2] The Bent Brigham study was a comparison of patients who kept their initial appointment at an out-patient alcoholism clinic and those who did not.

Those patients who kept their initial appointment and those wo did not were compared on nine socio-economic characteristics: sex; age; race; religion; marital status; occupation; employment status; residential area; and family income. In addition, the two groups were compared by the two additional

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[1] See an Evaluation of the Effect of Treatment on the Rehabilitation of Alcoholics. The Alcoholism Foundation of British Columbia, Vancouver, B.C., 1963.

[2] Joseph Mayer, Merrill A. Needham, David J. Myerson. "Contact and Initial Attendance at an Alcoholism Clinic" Quarterly Journal of Studies on Alcohol. Vol. 26, 3, Sept. 1965, pp. 480-485.

variables of source of referral and previous clinic contact. The findings revealed that none of these factors influenced initial attendance. To quote directly from the report:

> None of these eleven variables significantly differentiated between the two groups, nor did a separate analysis by sex... The absence of significant socio-economic differences between those who kept the initial appointment and those who did not is surprising. It was expected that some of the socio-economic variables would discriminate among these groups. If the groups do indeed differ, they differ in characteristics which are more subtle or of a different order than those investigated. [3]

Similarly this researcher found by a study of a past population of the clinic that there were no significant differences along the variables of religion; age; marital status; educational level and ethnicity, between the groups of patients who stayed in treatment beyond three visits and those who had not.

The finding was that the source of referral does not affect the patient's attendance patterns whether he is self-referred or under legal pressure to attend, the rates of attendance are not significantly different.

The findings of differences in the two groups by attitude in the Vancouver study was a possible lead, but the attitudes which that particular study mentioned were related to treatment and unrelated to any theoretical and explanatory base. The

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[3]Harrison M. Trice, "A Study of the Process of Affiliation with Alcoholics Anonymous." Quarterly Journal of Studies on Alcohol. Vol. 18, March, 1957, pp. 39-54.

attitudes were listed as: unrealistic, when the patient more or less was looking for an easy and rapid solution to his problem; neutral, when he had no specific expectations; and realistic, when he was willing to do his part in the treatment process.[4] Although there were found to be differences between the groups by attitudes, the question of a possible general explanation and underpinning of the different attitudes was not included in the aims of that study and therefore was not explored. A more fruitful finding, appeared to be that made by Harrison Trice in a study in which attitudes of "readiness to affiliate" with the Alcoholics Anonymous had been found to discern between those who had affiliated and those who had not.[5] We do not wish to assume that the vast differences between the affiliation with the organization of the Alcoholics Anonymous - involving a total "way of life" and philosophy - and that of affiliation with an out-patient clinic are not considerably different. Still, the area of cultural differences found by Trice appeared to be one with which a sociological study could profitably concern itself. Trice reported that differences among the groups - those who affiliated and those who did not - were by attitudes of the affiliates which represented "a value system which had more definite limits on what constitutes the

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[4] Op. Cit., "An Evaluation of the Effect of treatment on the Rehabilitation of the Patient".

[5] Trice. Op. Cit.

rewards of drunkenness...(they) had come to a fork in the road - they realized that they had to choose between home, job, community esteem and continued drinking". This can be interpreted as reflecting attitudes which might theoretically be considered as "anomic"[6] on the part of the non-affiliates, in that the way of life of drinking is not a culturally valued goal taken on a general level of societal values - although it may be valued in sub-cultural groupings, but as such would be considered as deviant by the over-all value system. Taking this as a starting point, this study decided to investigate the attitudes by cultural and social values of the incoming patients. It was hoped to discriminate the patients by their scores on a socio-cultural value scale. The further step of analysis was to be the comparison of the groups categorized by different scores and with their actual attendance pattern at the clinic we would expect the lower score (anomic) to be the more likely to drop out. The final outcome being that of comparing and discriminating the attendance pattern at the clinic by group values. This was to be a major aim of the research. Its limits were that we did not expect, by showing differences in values between the groups, to account for the total variation in attendance. If we could locate some differentiation between attenders and non-attenders it would be both promising and profitable.

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[6]"Anomic" to refer to normlessness or lack of cultural values.

However, the first aim of the study, would not provide the clinic with practical guidance for improvement in maintaining its patient population unless it could be interpreted within the clinic setting. For example, the patients' attitudes were prior to their entry into the clinic. We can assume that they had been socialized with reference to different groupings and that these were apart from the clinic organization. In point of fact, if we concluded that the patients who did not remain in treatment were anomic as regards their value orientation, then would this condition of anomie account alone for their failure to stay in treatment? In other words, what was the part played by the clinic in different acceptance of treatment by the patient? The nature of the drama really only begins to become clear when the two protagonists - the clinic staff and the patient population - meet. The socio-cultural values of the two groups - that of the clinic staff and that of the patients - must be determined, and their mutual effect discovered. This was done by a participant observation, outlined in detail in Chapter 2, within the stage and setting of the clinic. In this area the study can be considered to have explored the confrontation of the patient and the clinic. The study was tentative in nature and the possibility was that if it proved fruitful it might be developed and studied more extensively to a degree that was beyond the scope of this thesis.

In brief form the aims of the research can then be presented as:

(1) A strudy by questionnaire of the attitudes of incoming patients at an out-patient clinic.

(2) A comparison by attitudes of the patients with their (behaviour) attendance record at the clinic.

Subsidiary aims, to be explored tentatively:

(1) A study, by participant observation and by review of literature, of the attitudes of the clinic staff.

(2) The nature of the confrontation between the clinic and the patient seen in the structural[7] setting of the clinic. How this may be regarded as an intervening variable between patients' attitudes and patients' acceptance of treatment at the clinic - patients' attitudes being the independent variable and acceptance of treatment as the independent variables.

Empirical and Research Problem into Theoretical Base

A major decision to be made was the adoption of a rationale behind, and the determination of which, attitudes could be thought to be of significance in alcohol addiction and patient treatment. The attitudes towards alcoholism can be seen to rest on several levels of appeal. If considered at a "high" moral level we would expect to find alcoholism as regarded in itself as a vice or as a sin and to be subjectively held as "shame"; of if at the normative level of role obligations we would expect to find that alcoholism was considered as wrong

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[7] "Social Structure is a system of patterned relations of actors playing roles relative to one another". Talcott Parsons; Essays in Sociological Theory. Revised Edition: Free Press of Glencoe. Collier MacMillan Ltd., London, 1964, p.230.

because it interfered with "normal" role obligations of job and providing for family.

A questionnaire was designed to ascertain patients' attitudes towards alcoholism along a frame of reference which included questions directed towards both social obligations and cultural values - the latter to include questions of "morality". An example of the first kind of statement would be "alcoholism is wrong because of consequences to the social order"; and an example of the morality questions would be: "to be an alcoholic is to be ashamed".[8]

Incorporated into the questionnaire were questions regarding alcoholism as an "illness". This was felt to be an important area to investigate for several reasons. Firstly, the patients are patients - they are about to attend a clinic specifically designed as a medical clinic - and they do so as part of their treatment for their alcohol "problem". In other words, they are coming to a medical centre rather than say a penal institution or a voluntary association such as Alcoholics Anonymous. The medical perspective then is distinctive in this form of process. Secondly, the "illness" conception of alcoholism is of interest because of the re-definition of alcoholism as illness. Studies which have attempted to discern public acceptance of alcoholism as illness, rather than morally wrong, or as well as morally

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[8] "Shame" was taken to be an index, subjectively held, of high moral involvement. See - Helen Merrell Lynd, On Shame and the Search for Identity. New York; Harcourt Brace & Company, 1958

wrong, will be discussed in Chapter 3, as will the medical profession's view of alcoholism as illness.

Arising from these empirical concerns has been a parallel interest by medical sociology in the conceptions of deviance and illness as stigmatized - and therefore as including a negative moral evaluation - as developed by Goffman in his essays on Stigma.[9] Also the conception of illness as deviance if viewed from a functional viewpoint of the needs of the social system and as evasion from "normal" role responsibilities - as outlined by Talcott Parsons,[10] has been prominent in medical sociological discussions of deviance and illness.[11] This can be seen as a parallel to the current discussion of alcoholism as morally wrong or as illness, evident in lay and medical journals, for "stigma" is usually thought of as implying negative moral evaluation whereas illness is thought of as being a legitimate and non-evaluative condition. We would maintain that it is however a too simple dichotomy. Illness is evaluated, and evaluated negatively within our society, and is according to Parsons, only partially and conditionally considered to be legit-

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[9]Erving Goffman. Stigma, Notes on the Management of Spoiled Identity. Prentice Hall. N.J., 1963.

[10]See: Talcott Parsons. The Social System. The Free Press of Glencoe. N.Y., 1951 pp. 428-473. Also, T. Parsons and R. Fox, "Illness, Therapy and the Modern Urban Family". Journal of Social Issues, 8, 1952, pp.31-44.

[11]See: Robert N. Wilson. "Patient-Practitioner Relationships"; Stanley H. King. "Social Psychological Factors in Illness"; both in Handbook of Medical Sociology. Editors - Freeman, Levine and Reeder: Prentice - Hall, Inc. N.J., 1963.

imate - for the patient must strive to "get better" and his condition is denied permanent legitimacy. But illness does appear to be moving out of the sphere of being considered as a moral "sin" as being something of which to be ashamed - although the remnants of this state are still to be found in the social diseases such as syphilis. But by and large, these moral stigmata are falling from the ill changing attitudes towards the mentally ill illustrate this point. Still Parsons is clear in pointing out that illness is still to be considered as undesirable - even to be stigmatized as undesirable - because illness is deviant to the achievement values of society. However, the type of stigma which Parsons has in mind is the negative evaluation of a condition from a secular viewpoint - from the viewpoint of a cultural low evaluation upon the condition of illness. Illness has a low status; it is without prestige; it brings penalties; but illness within our society is moving from the state which included a stigma of moral shame. Remnants of the attitudes of moral shame which adhere to illness, and particularly to a social illness such as alcoholism, will be expected to be found in the attitudes of the patients attending the clinic studied. It will be expected that those patients who hold a secular view of alcoholism as illness will not hold alcoholism to be morally wrong or feel fear and shame connected with the condition of alcoholism.

Because the attitudes covered by the study have included

cultural values, morals, norms, role expectations; and because they have focused in two particular areas - that of alcoholism as morally wrong and as illness - and it was decided that the sum total of these attitudes be referred to as "ideology". This would be a general term which would eliminate possible incorrect labelling of attitudes discussed at different levels whilst still allowing for precise points of analysis which required exact reference.

A restatement of the previous discussion is that attitudes of patients will vary along lines of precise cultural definition of alcoholism, and will include attitudes characterized by a morality view of alcoholism as sinful and of subjectively held shame at the one extreme, and of attitudes of undesirability because of interference with role obligations, i.e. occupation, at the other extreme. These two extremes of attitudes will reflect current definitions and re-definitions of alcoholism within our society. Those patients who are characterized by a high moral concern are not likely to hold the illness conception of alcoholism as secular and without moral shame. Those patients who are <u>not</u> characterized by either of these two attitudes and values are to be considered as "anomic" - in that they do not hold the dominant cultural values.

As regards attendance patterns, we would expect that the patients characterized by lack of values - the anomics - to be the ones who would not be motivated to stay in treatment. The patients

with a moral view of alcoholism and those patients who see alcoholism as an illness to be cured will be those whose prior motivation would be assumed to be congenial to staying in treatment. However, prior motivation through values must be seen in the light of the structural setting of the clinic. Which of the values that the patient holds will equip him to survive and accept the role of patient in the clinic setting can be seen by reference to the structure of the clinic as a medical unit and by the ideology of the staff of the clinic - in so far as the structural setting reflects and allows the expression of the ideology of the clinic staff. In regard to the latter, an example to clarify could be that a member of the staff feels personally that alcoholics should be treated in an informal and personally friendly way, but in the capacity of a nurse or doctor the expectations of his position within the clinic preclude this mode of expression. Therefore, this study includes, in Chapter 4, a "behind the scenes" participant observation of the ideology held by the clinic staff, as well as discussion on the structural limits of its expression. In the final chapter we discuss in what ways the culture and structure of the clinic as a medical unit and as a social control agency can and do affect the patient or fail to affect the patient - in the latter case because of a lack of mechanisms which would keep the patient in treatment.

CHAPTER 2

METHODOLOGY

Research techniques have been likened to nets - we need certain types in order to catch certain fish - one being better to use in certain circumstances than another. Thus the nature of the information dictated which method of obtaining it was both possible and appropriate. A crude example of this would be that because the patient population was on an out-patient basis therefore interview and observation were practical and possible only at the time of the patient's visit; whereas the staff of the clinic were generally on duty on a daily 9 a.m. to 5 p.m. routine and this protracted time period of stability and routine made an analysis of the staff end of the organization by participant observation possible. On the other hand, recorded interviews and questionnaires were used to study, in depth, the patient's participation at the clinic.

A review and analysis of the official documents of the organization was undertaken in order to define the official ideology. Case records of the patients were also available to the researcher and were used for obtaining the appropriate information, such as age and religious affiliation.

Participant Observation

This study was guided by the aim of discovering ideology and attitudes existent within the clinic and thus the first

stage of field analysis which, according to Becker, is the selection and definition of problems and their context in sociological theory, was determined.[1]

The participant observation was basically descriptive, noting observations (which served as indicators) in the form of records of statements, interviews, symbolic acts and the physical setting.

For example, the "physical setting" of the clinic suggested an index of the illness conception of alcoholism. The designation "clinic" immediately implies this and the clinic, quite apart from its personnel, was physically arranged as a "medical centre" with waiting rooms, nurses' observation centre, examining rooms, medical records and a dispensary. Furthermore, the restriction of "visibility", by privacy and anonymity - to which we accorded the function of insulating the patient from outside view or detection and this can be seen further as an acknowledgment of the stigma of the alcoholic patient status with its possible social consequences - was seen in the physical setting. An example of this was that the clinic was located or "hidden" within a huge modern block of office buildings and the clinic was

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[1]Howard Becker."Problems of Inference and Proof in Participant Observation."American Sociological Review. Vol. 23. No. 6. December 1958, pp. 652-660

not recognizable as "alcoholic" but had an innocuous title - which the researcher will call "Castle Clinic". Its very location on the first floor was designed in order that patients could, if they wished, use the stairs rather than the elevator, thereby elevator passengers could not recognize and name the floor at which the patient alighted.

The role of the observer in a participant observation study has received much attention, particularly in the problematical area of whether or not the observer alters, by his presence, the situation which he is observing. In this case the observation was not conspicuous, but more truly that of the full participant, as the researcher was engaged for several weeks at the clinic in reviewing case records. The clinic had several part-time workers, and research projects in process, through which various individuals from disciplines and agencies had access to the clinic. Therefore there was nothing strange nor disruptive about another visitor or temporary staff member. The fact that the observation was conducted whilst the researcher was primarily engaged in viewing records meant that the staff was not in any way self-conscious about the researcher's presence and that routine was not disrupted. It appeared that the researcher was considered as another fellow colleague and worker, although on a temporary or outside basis. The acceptance and inclusion of the researcher into staff tea breaks and informal

"chat" sessions was an indication of this. The researcher's introduction into the organization had been made by the Director of the clinic, who had an interest in and positive approach to, research work.

Role of Researcher

Mention should be made of the role and purpose of the researcher as a sociologist. The ethics of his profession command him to report his findings objectively, fully and without bias. It is expected that prior to engaging in his research that he has ethically examined his purpose and considered the possible uses of his research findings.[2] In this study, the researcher was guided by a theoretical interest, but in full knowledge and hope that the findings of the research might be of practical use in the educational programme and in patient treatment at the clinic. The ethics behind this hardly need justifying, for if we have patients who are a high proportion of voluntary admissions and have sought help at the clinic, one can assume that at some stage they have conceived of themselves as having a "problem".

The concepts of license and mandate not only apply to medical and other allied professions, but to sociology itself. In this sense, the sociologist must necessarily deal with

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[2]Robert K. Merton. Social Theory and Social Structure. Free Press of Glencoe, Illinois, 1957. pp.214-9

matters which are "taken for granted". It may be that many organizations are doubtful or resentful on the "intrusion" of an "outsider" prying into their organization. Therefore, it is well to point out that the sociologist views as his professional training and equipment demands. As Becker writes:

> We who study organizations do bring to our work, if we are worth our salt, a certain objectivity and neutrality. We assume that organizations can be compared with one another no matter how different their avowed purposes may be...
> We do not expect the organization to be the perfect instrument for attaining its purposes, whatever they may be. This attitude necessary as it is to increase the knowledge of social organizations, contains what may appear a criticism to those deeply involved in an organization.
> But our purpose is not criticism, but observation and analysis. When we report what we have learned, it is important that we do so faithfully. We have a double duty - to our own profession of social observation and analysis and to those who have allowed us to observe their conduct.[3]

Questionnaire

A questionnaire was designed and given to explore the ideological dimensions of alcoholism as seen by the patient. The questions were designed to show the ways in which disapproval of an act was justified by a Respondent and can be classified by types of socio-cultural reference.[4] These are in terms of:

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[3]Howard Becker; Blanche Greer; Everett Hughes and Anselm Strauss. Boys in White. Chicago. Ill. University of Chicago Press. 1961. p.15.

[4]See - Ralph Turner. Moral Judgment: A Study in Roles. American Sociological Review: 17. 1952. pp.75/76.

1. Some harm done to an injured person (consequences).

2. Disruptive consequences to the social order.

3. Moral character of the person.

4. Act itself.

5. Wrong to personal standards and consequences to the individual. (a more detailed account of the theoretical import of the questions is included in Chapter 4.)

This frame of reference was incorporated into the questionnaire in regard to the use of alcohol. The same questions based upon this frame of reference were also used in the questionnaire to determine what the patient anticipated would be the clinic staff's view of alcoholism. For example, in Part 2 of the questionnaire, the same question as in Part 1 is repeated but with the preface:

> Now here are some questions on how you think the clinic staff view alcoholism - "I expect that the clinic staff will....."

The rationale behind this procedure was an attempt to determine whether the patient's own view coincided with what he viewed as the staff ideology.

Other questions in the questionnaire were more direct in their statement and were aimed at finding identification with the label of "alcoholic". Other questions were aimed at eliciting the respondents' views regarding alcoholism as an <u>illness</u> and whether illness was seen as temporarily legitimating - for example, that illness allows exemption from normal

role obligations, but that the patient is expected to actively strive to get better, and as a patient should be allowed a certain period of time in which to do so.

Part 3 of the questionnaire was arranged as "open-ended" questions. Question 4 - "Here is space to explain in your own words how you felt about coming to the clinic; for example, were you afraid or ashamed to come? Or has coming to the clinic made you think more or differently about yourself and about alcoholism? Please explain fully." - for example, was to allow the respondent a chance to state his pre-patient attitudes and to help the researcher know whether the patient felt moral shame in attending the clinic. Question 5 - "In your own words, what do you expect the clinic will be able to do for you?" and Question 6 - "How long do you think treatment will take?" - were to determine if the expectations of the respondents of the clinic were realistic, manipulative or unrealistic. Question 7 - "Who do you think would be most pleased if you stopped drinking - i.e. yourself, your wife, your mother...."; Question 8 - "Do you have any drinking friends who approve or encourage you in your drinking habits?" and Question 9 - "On the whole, would you say that your friends and/or family approve or disapprove of your drinking?", were designed to find if the respondent had an environment of friends or family (reference group) who encouraged or discouraged his

drinking. If, in fact, his environment was conducive to continued drinking or if motivation through close interpersonal relationships discouraged the continued excessive use of alcohol. Whilst part 3 is not directly relevant to the study, it was thought that such material could not be overlooked and might be made use of in the final stage of analysis of the questionnaire.

The case number of each patient was added to each completed questionnaire by the nurse in charge, through which information derived from the questionnaire could be supplemented if necessary with other relevant information about the individual patients - for example, the case record of a patient contains such information as his religion, age and employment status.

Questionnaire Format

Likert Form of the questionnaire was used for Part 1 and Part 2. In this way during the analysis, the questions which were found to be indiscriminating were discarded, also it proves a check that the items (questions) are empirically consistent, that is, "that every item is related to the same general attitude".[5] Furthermore, analysis was made more sophisticated by the use of scores and comparison between the groups in the upper

[5]See Likert-type scale in Research Methods in Social Relations: Revised Edition. Sellitz, Jahoda, Deutsch & Cook: Holt, Rhinehart and Winston, 1961. pp. 366-369.

and lower quartiles.

Coding of the Questionnaire

The questions were weighted, ensuring that each question was scored in the same direction as the underlying variable - the analysis of the questionnaire provided a further check, for if it had been found that there were a large number of negative D values then the process of analysis would have had to be repeated. In the questionnaire, there were two main underlying variables to be considered - the score on a socio-cultural attitude scale of alcoholism, and a score on illness - as legitimating dimension. These were calculated separately and then charted and compared against the patient's attendance record.

The scores on the patient's view of the ideology of the clinic were calculated and these were compared against other dimensions. For example, after a sufficient lapse of time it was checked - by patient's subsequent attendances, which are recorded on the case records - whether there had been any significant differences in clinic attendance between the two groups.

Study of Case Records of a past Population

However, if comparisons of the type outlined above were to be made, then it necessitated that an attempt be made to eliminate other hypotheses of differences between attenders and non-attenders at the clinic. We had to try and show that the sample population which we had taken to give our questionnaire was homogeneous. This was in fact one of the earliest considerations of the research - to proceed by elimination of gross

factors which might be determining in the attendance pattern of the clinic.

In order to attempt to assess if there were any other sociological factors than those contained in the questionnaire which were operating and affecting the patients' attendance at the clinic we used a past population and made a comparison of "drop-outs" - those patients whose attendance at the clinic was defined as three or less attendances - with regular attenders - those patients whose visits to the clinic numbered more than three attendances - by the variables of:

1. age
2. ethnicity
3. educational attainment
4. religion
5. marital status
6. "pressure" - exerted by agencies and employers upon the patient to attend the clinic. [6]

The method of comparing the "drop-out" population and the regular attender population was done by examination and recording of the appropriate data from admission and case files from a two-year period from May, 1963 - May 1965. The patients were initially admitted to the clinic within the same time period. Patients who had been transferred to institutions were excluded, as were patients who were known to have left the locality, and female patients were excluded by virtue of their numerical insignificance in the total patient population. The total number

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[6] See Appendix A for sub-categories of these variables, and for detail.

of drop-out patients in the two year period was found to be 168. As will be seen in Appendix A, chi square (.05) analysis supported the hypotheses that there were no differences on any of the variables in the two populations studied. We can safely assume from this that the six variables indicated were not significantly determining in regard to patients' attendance records at the clinic.

A note of caution of limitation must be introduced here. A necessary assumption had to be made by the researcher in that the past population was assumed to be comparable to that of the population to which the questionnaire was given. One must in fact assume that the patient population at the clinic had remained stable along these variables. The use of past records was necessitated by the fact that a large N is necessary to make statistical analysis by chi squares, which involved so many variables and that only with a past population could we compare drop-outs with regular attenders. On these grounds the use of a past population, along with the necessary caution of interpretation was justified, given the scope of the thesis.

Interviews

The researcher conducted formal and structural interviews with members of the staff. The aim behind the interviews was a further attempt to eliminate any alternative hypotheses or factors involved in patient's acceptance of treatment; for example, whether there were any personal as opposed to structural factors that must be accounted for in the patients' treatment on

initial arrival at the clinic. If procedure was standardized, then presumably we could eliminate gross differential treatment of the patient. The interviews were structured by a list of considerations likely to affect the patients' views of the clinic and his treatment. The outlines of the interview were:

1. Is there a standard procedure at initial interview? If so, what is this procedure?
2. Order of persons/status seen.
3. The kind of treatment given.
4. Order of persons seen.
5. Time factors - is there any waiting involved?
6. Other factors - treatment in terms of demeanour, etc.

Observations of Interviews Between Staff and Patients

A well-equipped "observation laboratory" was made available to the researcher. Through the use of a two-way mirror and recording equipment, the reseacher was able to observe, listen and record initial interviews of incoming patients conducted by the medical doctor in the observation room. The patient was informed of the procedure and his permission was obtained. Other similar interviews were recorded but without the researcher's presence. These interviews were regarded in the same light as the outline of the interviews with staff members, but with the addition in this case of the observation and recording of interaction patterns between patient and doctor.

The interviews revealed that there was a standard procedure at the initial interview in which the patient in this order:

1. Saw the receptionist (female).
2. Was taken to the waiting room, where the waiting period varied only by a few minutes. During this time the patient was given, by a professional nurse, a "face sheet" to complete.

3. The patient was given a medical examination by the doctor.
4. The doctor interviewed the patient following a "structured questionnaire.
5. The doctor prescribed medication for the patient and arranged the next appointment.

The observations of interviews between staff and patient similarly revealed that the patient was treated uniformly in terms of "demeanour" and other interpersonal factors. The researcher observed some doctor/patient interviews and found them to follow stereotyped lines outlined by the form which the doctor filled in, after asking the patient for the information. The interviews were strictly formal in the doctor/patient manner with the doctor's questions directed to statements about the patient's health and were conducted with a neutrality of tone and manner. The patients were observed using the title "doctor" at the end of each sentence, which may have been both a manner of deference to the title, and an indication of their recognition and acceptance of the patient/doctor relationship.[7]

On the whole the kind of treatment involved appeared sufficiently structured to eliminate any possibility of differential personal treatment at initial interview accounting for differential acceptance of treatment by the patient.

Review of Literature - Empirical Studies

Apart from general theoretical works, to be reviewed in the next chapter, there was a need to discover if empirical

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[7]A member of the staff informed the researcher that the patients were anxious to "see a doctor first. They don't always want to see a social welfare worker, but in case, prefer to see the doctor first".

studies had been made in the area of differential acceptance of treatment at outpatient clinic. Whilst it was found that there had been such studies, they proved to be predicated around different factors than those chosen for this study. Invariably the studies were longitudinal and as such, they were important leads in the study of practical factors involved in increasing the patient attendance record - for example, by the use of follow-up letters - or proving whether outpatient therapy worked in decreasing the use of alcohol, but were not connected with the main aim of this study - the investigation of the ideological factors involved in alcoholism. This dictated and justified the tentative and exploratory nature of this research as there were no real precedents.

Use of Documents

Official publications of the organization were studied for statistical information regarding the staff and the patient population, also for official statement of the aims of the organization which were analysed - using as a framework Hughes' concepts of mandate and license - and more generally in a search for factors involved in the official ideology. Similarly, other official sources of medical opinion - American Medical Association and World Health Organization publications - were scrutinized in order to see their position and stand on "alcoholism" as a disease and for value pronouncements.

Summary

A Participant Observation of the "staff side" of the

clinic was made to determine cultural and structural features, and how the clinic reflected the ideology of the "official" view of alcoholism.

A questionnaire designed to explore the ideological dimensions of alcoholism - including the conception of alcoholism as "illness" - was given to 35 incoming patients. The questionnaire included Likert-type questions to scale ideological dimensions and "open-ended" questions for validation of the structured questions.

Further, the questionnaire asked for patient's view of staff attitudes - the rationale behind this being to determine if the patient expressed areas of discrepancy between his own views and those views which he anticipated would be held by the staff.

Use of Documents

The establishment of the "official" ideology of the clinic as an agency was analysed through the study of the official documents of the agency and related medical agencies.

Elimination of Other Variables.

In an attempt to eliminate other factors involved in differential acceptance of treatment by the patients, the researcher examined a past population of the clinic by the six variables of age, ethnicity, educational attainment, religion and "pressure" - exerted upon the patients to attend the clinic. These categories were not found to be determining in patient

continuation in treatment.

The researcher found by questioning and observation that "personal" factors such as differential treatment at initial interview, were kept at a minimum through a standardized procedure, and therefore could not be regarded as an important factor in determining patient acceptance of treatment.

CHAPTER 3

GENERAL THEORETICAL ISSUES

The alcoholic patients in this study are coming to a clinic which can be classified both as a social control[1] agency and as a medical treatment unit. Therefore, in this chapter, theoretical discussion will focus on social control, and its corollary - deviance; and upon medicine as a branch of social control. In the succeeding chapter in particular, we shall examine the mandate of the medical profession in formulating an ideology within the profession and a philosophy of health and normality for the public at large. This will of course include an "official" view of illness and of alcoholism as illness - including moral pronouncements, These are pivotal to our study for we may expect that the clinic and the clinic staff will reflect these views.

A dominant cultural view of alcoholism will be expected to contain the "official" view and the acceptance of this may be seen in studies which have attempted to determine the acceptance of the illness conception of alcoholism as opposed to a strongly moralistic view. There has been some ambiguity in attitudes towards the illness conception of alcoholism both in the public view and occasionally in the "official" view. The divergence or incomplete acceptance of the illness view is evident in the report of the empirical studies which will be included in this chapter, and also see chapter 4 for pronounce-

[1]Social control - some form of intervention.

ments by the World Health Organization and American Medical Association. The fact that moral attitudes still persist is seen in the empirical studies quoted, and in the theoretical discussions of "stigma" pertaining to alcoholism, development of theoretical statements about deviance and illness, which can be seen to be pertinent to the establishment of the dominant values of the control culture, and the acceptance of these values by the general public. In the latter case we will examine studies which have attempted to assess the acceptance by the public of the "illness" view alcoholism. In the former regard, we are interested in establishing the ideology of the clinic in order that it can be compared to the ideology of the patients - as revealed through the questionnaire which was given to the patients - for we maintain that those patients who do not reflect either of the dominant cultural views of alcoholism - those patients who will be designated as "anomic" - will be those patients who will not display a readiness for acceptance of treatment. This will be examined in detail in subsequent chapters, whilst this chapter will deal on a higher level of abstraction with the same issues of deviance, illness and social control.

Alcoholism as Deviance

It is generally accepted that alcoholism lies within the field of deviant social behaviour problem - in the next chapter the definition of alcoholism as deviant from the point

of view of specific agencies such as the World Health Organization and the Ontario Drug and Alcohol Addiction Research Foundation are reviewed. However, sociologically considered, how and why does alcoholism lie within the classification of deviance? If, deviant behaviour is considered to be that which "violates institutionalized expectation, that is, expectations which are shared and recognized as legitimate within a social system"[2] then alcoholism can only be considered by reference to the values of that social system. To specify it as such, then the level must be that of the general over-all or "dominant" values of a society - in this case, American society. In other words, it does not take into account sub-cultural groupings within that over-all framework in which excessive drinking may be a positive value. Nor does the definition tell us much of why the values are of that order. One way of viewing this, is through a functionalist framework, in which society is seen as a functional system and deviance as a departure from the effectiveness of the system. The functional prerequisites of all on-going societies are seen to include measures to motivate and lead to conformity by the members of that society. For example, Parsons's theory of deviance can be seen as a theory which pre-supposes consensus; a theory which presumes that those who depart from the ideal standards presumed to exist within a given culture - standards

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[2]Albert K. Cohen;"The Study of Social Disorganization and Deviant Behaviour", in R.K. Merton et al. (eds.), Sociology Today, New York: Basic Books, 1959, p.462.

presumed to be functionally necessary - are to be defined as deviant.[3] Thus, individual members must be motivated to conform through acceptance of the major cultural values of the society. Within American society these values will include success through achievement in a 'legitimate' occupation, this will be integrated with the functional differentiation of tasks which need to be performed - these will be the roles of the individual members which they must perform with "responsibility". If this is not the case, then deviancy is assumed and there are mechanisms to bring the recalcitant members back into line. Amongst the latter, are "social control" agencies of an official kind. In fact, deviance is considered by Friedson to be "not conforming to institutional expectations which is generally thought to require the attention of social control agencies."[4] Two of the methods employed by social control agencies have been that of "punishment" seen as a deterrent and as an example, and rehabilitation seen as resocializing[5] the deviants by way of inculcating

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[3]See: Talcott Parsons. The Social System; Free Press of Glencoe, 1951, Chap. 7.

[4]Eliot Friedson, "Disability as Social Deviance", in Sociology and Rehabilitation. (ed. Marvin B. Sussman). American Sociological Association. 1965. p.73.

[5]"...the technical term socialization designates the processes by which people selectively acquire the values and attitudes, the interests, skills and knowledge - in short the culture - current in the groups..." Robert K. Merton, George G. Reader and Patricia L. Kendall (eds.). The Student-Physician: Introductory Studies in the Sociology of Medical Education. Cambridge, Mass: Harvard University Press, 1957, p.287.

values and modes of behaviour of conformity with the dominant values of society.

The levels of deviance then may be found to reside at several points - those of cultural values at a high or dominant level or of role expectations within a particular situation. In the first instance, the appeal will often be one that is thought of as "moral", containing it as it does high level or ultimate values. This has been an area traditionally associated with religion.[6] Within the assumed trend to secularization of our society and its concern with efficiency and active performance, it has been suggested by Parsons, that the appeal on the high level will bend to move from the religious and ethically moral "state of grace" and "sin" to that of an appeal to the "law" of secular society and to commitment to collectivities such as society to role obligations such as a job. It is in the latter areas which Parsons envisages as being the areas of social control around which the official agencies of our own society would cluster - rather than church memberships which would focus on

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[6]Parsons writes: "the problem of morality...concerns.... commitment to the values of society. This is the area of social control which has traditionally been most closely associated with religion...the context of the problem of social control of individuals refer to rather generalized states of individuals which may be conceived to "lie behind" their commitments to more differentiated and particularized role-obligations and norms." Talcott Parsons. "Definition of Health and Illness in the Light of American Values and Social Structure". Social Structure and Personality. Free Press of Glencoe. MacMillan Co. Collier Publishing Co.: New York, 1965, p.267.

morality bringing its own reward as a subjectively held state of grace.[7] But it appears that it is in the religious rather than in the secular sense that the concept of stigma has been thought to dwell. For example, when Goffman writes of the stigma applying to extreme cases, he is writing of subjective feelings arising out of the possession of an attribute which the incumbent feels to be on a moral level. Shame and defilement are terms which can be taken to represent high moral involvement, and are used by Goffman to describe the stigmatized individual in that:

> (for) the stigmatized individual...shame becomes a central possibility, arising from the individual's perception of one of his own attributes as being a defiling thing to possess.[8]

Perhaps an even more religious or magical description is that of the stigmatized individual as being "tainted", as witnessed in this quotation from Goffman:

> ...evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind...in the extreme, a person who is thoroughly bad or dangerous or weak. He is thus reduced in our minds from a whole and usual person to a tainted discounted one. Such an attribute is a stigma.[9]

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[7]Parsons, Op. Cit., p.268

[8]Erving Goffman. Stigma, Studies in the Management of Spoiled Identity. Prentice Hall, Inc., N.J. 1963., p. 7.

[9]Ibid., p.3.

On the other hand, Parsons's view of illness as stigmatized would tend to the secular - the undesirability of the illness state to be one of deprivation:

> In the light of the motivational problem the important feature of insulation is the deprivation, for the sick person, of any claim to a more general legitimacy for his pattern of deviance...the conditional legitimation which he enjoys is bought at a "price", namely, the recognition that illness itself is an undesirable state, to be recovered from as expeditiously as possible.[10]

For Parsons deprivation and stigma are seen in the lack of general legitimacy of illness and a withholding of the rewards of secular life. Illness is without the "rewards" of prestige and achievement, and could be described subjectively as lack of esteem and prestige rather than a state of sin - that is assuming that the incumbent was oriented to dominant values of American society. Even the "contagion" associated with stigma is seen by Parsons as no longer involving a ritual impurity but as being a rational device of insulation for the prevention of spread of motivation to illness. He writes:

> As Durkheim pointed out for the case of crime, the designation of illness as illegitimate is of the greatest importance to the healthy, in that it reinforces their own motivation <u>not</u> to fall ill, thus to avoid falling into a pattern of deviant behaviour. The stigmatizing of illness as undesirable, and the mobilization of considerable resources of the community to combat illness is a reaffirmation of the valuation of health and a countervailing influence against the temptation for illness, and hence the various components which go into its motivation, to

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[10] T. Parsons. Ibid., p.276

> grow and spread. Thus, the sick person is prevented from setting an example which other might be tempted to follow. [11]

It will be noted that included in the above quotation, stigma is held to be a sanction to the deviant but further it can be seen to be an example which acts as a deterrent to others, and points out the limits of normality.

Friedson in examining the contribution to medical sociology made by both Goffman by way of the conception of a subjectively held stigma - and Parsons by his analysis of illness and the sick role - has felt that the two views converge on the criterion of "stigma". The criterion of stigma is said by Friedson to rest upon that of "responsibility".[12] Friedson maintains that the ill person cannot be held responsible for his condition, therefore no stigma is attached. Writing of Parsons's concept of the sick role as one in which responsibility for illness is not assumed, and as one in which allows exemption from normal role responsibilities - albeit partial and conditional - Friedson maintains that "by his (Parsons) definition, the sick role is one in which the deviant is not blamed for his deviance".[13] To Friedson this means that Parsons does not apply stigma to the condition of illness. However, whilst Parsons claims that the sick role is partially and condition-

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[11] Ibid., p.276

[12] Friedson. Op. Cit., p.76

[13] Ibid. p.80

ally legitimate in that one may claim to have an illness and expect certain treatment and a time period of exemption from normal role responsibilities, still as we have already pointed out, Parsons is clear that illness is only partially and conditionally legitimated and there is no general legitimacy for his pattern of deviance. Parsons does view "responsibility" as being important in the type of social control and treatment which society allocates - whether treatment is to be punitive or correctional - in the latter role for instance, by therapy, in the case of illness.[14] It is in this sense that alcoholism can be said to be moving from crime to disease. As a disease the individual carrier is no longer held responsible for his condition, but the "undesirability" of his condition is nevertheless "stigmatized" by segregation and status deprivation. Illness is still "wrong" although its appeal to rightness may no longer be thought of as standing at a "moral" level of sin or state of grace - but rather at the secular level of societal values of achievement and capacity for role performance. It is perhaps significant in this regard that alcohol addiction is receiving much attention from labour and management. For instance, in the clinic in which this study was made, there is a well developed programme of liaison with some of the major industries in the area. And recently the civil service of Canada has announced that it officially regards alcoholism as illness

[14]See - Parsons. Ibid., p.271

and will deal with its employees accordingly.

Alcoholism as illness and as morally wrong - Empirical Studies

Empirical studies suggest that the current redefinitions of alcoholism as illness contains many dilemmas, and ambiguity of attitudes exist towards the conception. The illness conception has not always been conceptually fully developed. If one takes the medical view of alcoholism as presenting pathological symptoms then the definition is often without question and valid. However, if one takes the illness conception as being one in which no stigma is involved then can the view be supported? As this thesis has attempted to point out this may be a false alternative - in that within the sickness conception there is a stigma - albeit not the type of moral stigma which would include "shame" and "sin". However, empirical studies have usually been conducted on the basis of an either/or response to alcoholism as either illness or morally wrong or weak.

For instance, in 1958, Elmo Roper and Associates, conducted a nationwide survey in which the question - "If you knew someone who habitually drank so much that it affected his job and relations with people, would you say that he is morally weak or would you say that he is sick?" was asked.[15]

The percentage distribution of answers was:

morally weak	35
sick	58
no opinion	7

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[15]Quoted in - The Alcoholism Complex, Christopher D. Smithers Foundation, New York, N.Y., p.5.

The question, it will be noted, was asked on an either/or basis, that either one can define misusers of alcohol as morally wrong or as persons suffering from illness. This would seem to be verified by a study made in Finland[16] where:

> With the help of a check list consisting of five items, the subjects were asked to define what they mean by a misuse of alcohol. The list forms a cumulative scale in the sense the people endorsing a particular item usually endorse all the foregoing "items".
>
> The study found that there was one exception to the cumulative property of the scale. A few of the subjects did not endorse the first item "Alcoholism in whom the craving for alcohol has become a disease", although they endorsed the other items. This is due to the fact that they did not conceive of alcoholics as misusers of alcohol, but merely as "sick people."

However, a study by Mulford and Miller reports that:

> a relatively high proportion of certain professionals, (physicians, police chiefs and school principals) define the alcoholic as both sick and morally weak.[17]

Mulford and Miller go on to state that degree of public acceptance of the alcoholic as a sick person is probably a shallow one. In their own study which involved a check list questionnaire that provided for combination of views, they found only 24% of the sample who accepted the sickness concept without qualification.

It is an intriguing comment [illegible] societal definitions that they can assume at a manifest level what appears to be a reversal of a previously morally stigmatized conception of alcoholism, but

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[16] Allardt, Markanen, Takala. Drinking and Drinkers. The Foundation of Alcohol Studies, Finland, 1957, p.29.

[17] H.A. Mulford and D.E. Miller. "Public Definitions of the Alcoholic". Quarterly Journal of Studies of Alcoholism. 22:1961 pp. 312-320

when more refined and operationally defined concepts are introduced then the assumed changes turn out to be shallow.

Similarly in this study, the question, "I believe that alcoholism is an illness." was answered by incoming patients almost entirely at the "strongly agree" end of the scale. But when answers to the question, "the alcoholic is a sick man and therefore need not feel ashamed" were marked by a great deal of disparity of opinion by the same respondents.

Summary

A brief restatment of the above discussion follows in that we envisage there are two polar attitudes towards alcoholism - the illness conception which tends to the secular in that alcoholism as illness will be seen to be a disturbance in functioning and role capacity.[18] In this case, the subjective components of the sick role will include motivation to get better whilst deprivation exists through the lack of secular rewards and lack of achievement. Whereas, the values adhering to the "moral" view of alcoholism will

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[18]Parsons writes: "In a society as our own, illness is a very strategic expression of deviance; first, because our culture enforces an unusually high level of activity and independence and responsibility on the average individual; and second, because it connects so closely with the residual of childhood dependency... From the point of view of the stability of the social system, therefore, too frequent resort to this avenue of escape presents a serious danger. This is the primary content in which we think of illness as an institutionalized role and its relation to therapy as an important mechanism of social control".
See - Talcott Parsons and Renee Fox. "Illness, Therapy and the Modern Urban American Family", Journal of Social Issues. Vol. V111, 1951, p.32.

be of a "religious" type, and thereby alcoholism will be seen to be a "state of shame". We would hypothesize that within American society, the ideology is moving from the "moral" to the "secular" level, i.e. - illness, but that this change is still incomplete, and therefore both ideologies will still exist. The achievement ethos of our society inclines us to pay great attention to the problem of health, partly because of the unproductiveness of "sickness". It is also probable that illness is an area of social control which proves profitable by results in rehabilitation compared to strictly punitive methods. In either case, we would expect that more and more areas of social problems might fall into the area of "illness" - i.e. drug addiction, homosexuality. The very idea of a "normal human being" has been suggested by Goffman as having its source in the medical approach to humanity.[19] The notion of the normal is central to discussions of deviance in that the normal is the point of reference, as when Goffman writes:

> We and those who do not depart negatively from the particular expectations at issue, I shall call the normals.[20]

But if the normal is also equated with the medical view of normal and "healthy" then we see that the medical world is extremely determining in defining the nature of normality and "rightness".

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[19] Goffman. Ibid., p.14

[20] Ibid., p.18

As Parsons writes, medicine has historically been associated with the sacred sphere and even since the secularization of medicine it has assumed the role of definer of values and has been an agent of social control.[21] This view is seen in Hughes's conception of the medical mandate as being one which attempts to develop a "philosophy for society at large" concerning the nature of health - this is to be discussed in the following chapter.

Confusion seems to have arisen by use of the term "stigma" to cover social penalties and disevalued social states. Can we really claim a "tainting" of the order of the ritual pollution associated with Indian caste society or might it not be better to just talk in terms of "social penalties" and "consequences" of various degrees? One of these could be at the highest level of "moral" stigma but this term should, we maintain be kept in its narrow usage.[22] When we use the term "stigma" we shall use it in the broad sense we have criticized but making the distinction between this term and the term "moral stigma".

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[21]Parsons. Ibid.

[22]For example, Goffman's usage in Asylums, Doubleday Anchor. N.Y., 1961., seems correct - for he uses it in this restricted sense. However, in his essay Stigma; Op. Cit., he uses the concept in a wider, and we would maintain, less satisfactory way. He suggests, for example, that everybody is stigmatized - except the hetero-sexual, white, anglo-saxon male.

And again, Parsons's use of stigma, to mean with penalties or in some way deviant, is too broad in usage.

CHAPTER 4

THE IDEOLOGY OF THE CLINIC

This chapter analyzes the ideology of the clinic as a branch of an agency; as allied with the medical profession; and as a branch clinic which reflects "the official view" - and consequently as part of "control culture".[1] Analysis of official documents is made by applying Hughes's concepts of "licence and mandate".[2] In the last half of the chapter, the ideology of this particular clinic, as reflecting that of the stated "official" ideology of the organization in general, is examined in the light of data obtained from a participant observation. In both cases the discussion of the ideology operating will focus on the areas of the definition of alcoholism in terms of socio-cultural values and of alcoholism as "illness". A summary of findings is reported at the end of the chapter.

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[1] "Control culture" is defined as "a general term for the laws, procedures, programmes and organizations which in the name of a collectivity, help, rehabilitate, punish and/or otherwise manipulate deviants". See - Edwin Lemert, Social Pathology. McGraw Hill Co. Inc. 1951. p. 447.

[2] Hughes defines licence as consisting of legal permission and occupation to carry out certain activities which other may not, and to do so in exchange ...(it) also includes the right to do potentially dangerous things (i.e. prescribe treatment; give advice).
and mandate as the right to define the proper conduct of others toward the matters concerned with their work, this sometimes as in the professions extends to the entire moral issue.
E.C. Hughes. Men and Their Work. Free Press of Glencoe, Illinois. 1964. pp. 78-84.

Licence and Mandate

The uneven distribution of power within society is attributable to many factors, and as Hughes maintains, there is a "moral division of labour". Indeed, Hughes suggests that - "when an occupation reaches the status of a profession then it contains...that broad licence to control their work and that social mandate over affairs pertaining to it...".[3] Hughes also states that the professions, more than other kinds of occupations, claim a legal, moral and intellectual mandate, in that "they collectively presume to tell society at large what is good and right for the individual and for society at large." Hughes singles out the legal and the medical professions to illustrate his claim, and concerning the medical profession he writes:

> As regards the mandate of the medical profession it also tries to define for all of us the very nature of health and disease and in full form the mandate will include the function of developing a philosophy for society at large concerning the whole area of thought, value and action involved in their work.[4]

The concept of licence and mandate can be seen to define the nature of illness and concomitantly the definition of the nature of the model physician and of the model patient. In the latter case some considerations are, according to Hughes, the patient's co-operation, his acceptance of the physician's authority and prescriptions, his understanding or insight and

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[3]Op.cit., p.7

[4]Ibid. p.79

incidentally the effect of the patient on the physician's career, income, reputation, development of skills and fulfillment of self concept as a physician. In the latter instance, the emphasis is also on defining "the model physician". We see all of these factors operating in the following quotation which was on the occasion of the formal acceptance of the disease conception of alcoholism by the American Medical Association in 1956:

> For many years, the problem of coping with alcoholism was left for the most part to law enforcement, religion, and the social agencies of the country. Only comparatively recently has the public begun to accept it (alcoholism) as a disease entity that requires medical attention. This offers to the medical profession a challenge it cannot ignore... some physicans may be reluctant to accept alcoholism as a disease. They, along with many of the general public may feel there is a moral issue involved in excessive drinking. In some cases this could be true. However, when problem of compulsive drinking is involved, it is the obligation of the physician to make the differentiating diagnosis and treat it as the disease it is... With the passage of the new resolution, however, it is hoped this situation will be changed. The American Medical Association has accepted alcoholism as a disease that should be treated by a physician in a hospital setting when necessary. This will help remove the stigma heretofore so often attached to this diagnosis. It will give medical students and student nurses an opportunity to see and deal with these people... As with many other diseases that in the past were neglected, alcoholism will take its place, recognized by the physician as within his province - indeed, his duty - to treat with the same seriousness, devotion and interest he has given his other work. [5]

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[5] A Manual on Alcoholism. American Medical Association (researcher's emphasis).

The above quotation is limited to defining the illness conception of alcoholism, and placing it as a "disease" within the province of medical treatment - its exhortation of the physician's duty to treat the alcohol patient with seriousness and devotion may be seen as a reminder that the physician ought not to stigmatize the condition of alcoholism, but the very removal of "stigma" and the acceptance of the alcoholic into a hospital setting - though couched in terms of removing stigma from the patient - means that it also removes the effect of a"stigmatised" patient on the physician's reputation. Further, the document emphasizes the opportunity of the physician to increase his knowledge and his skills by "giving him an opportunity to deal with these people". The pronouncement does however "sit on the fence" as regards the overall moral issue involved, in that "in some cases this (moral issues involved) could be true".

The Second Alcoholism Subcommittee of the World Health Organization deals with both the acceptance of the illness conception of alcoholism and the moral issue involved and sees in this:

> A certain potential danger which attaches to the <u>disease conception</u> of alcoholism, or more precisely of addictive drinking.
> With the exception of specialists in alcoholism, the broader medical profession and the representatives of the biological and social sciences and the lay public use the term "alcoholism" as a designation for any form of excessive drinking instead of as a label for

> a limited and well-defined area of excessive drinking behaviours. Automatically, the disease conception of alcoholism becomes extended to all excessive drinking irrespective of whether or not there is any physical or psychological pathology involved in the drinking behaviour.
> Such an unwarranted extension of the disease conception can only be harmful, because sooner or later the misapplication will reflect on the legitimate use too and, more importantly, will tend to weaken the ethical basis of social sanctions against drunkenness. [6]

The interpretation of the above contains the suggestion that the "ethical basis of social sanctions against drunkenness" should not be weakened and therefore the sanctions are "good" or necessary. It also implies that the illness conception of alcoholism would, in fact, "legitimate" alcoholism from moral sanctions by placing it into the sphere of a disease. The specifications of the medical world is to apply the "disease" concept to the pathological symptoms alone, and not to the entire condition.

However the World Health Organization's definition of alcoholism is one that is based not on pathological symptoms but on basis of conformity as opposed to deviance and a standard of normality such as we have outlined in the last chapter. The definition reads:

> "A chronic disease, or disorder of behaviour, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the social drinking customs of

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[6] Expert Committee on Mental Health. Alcoholism Subcommittee. Second Report. World Health Organization Technical Report Series. No. 48. World Health Organization. Geneva. 1952. p.26.

> the community, and that interferes with the drinker's health, interpersonal relations or economic functioning.[7]

It can be seen that this definition includes the notion of "accepted cultural standards", and of alcoholism as "exceeding" and therefore not complying with these standards; it also includes the functional viewpoint of alcoholism as "interfering"... with..." economic functioning"; it includes a social view of alcoholism as "interferes with ....interpersonal relations". This can be interpreted in various ways, but would seem to suggest marital and associational groupings - regardless of subcultural differences - in which one might otherwise reasonably assume that lack of drinking could interfere with "interpersonal relationships" i.e. "the family that drinks together stays together" - and finally the definition of alcoholism includes the "interference with the drinker's own health". It can be seen that such an inclusive definition includes most points that have served as a frame of reference of "ideology", with the one exception that this definition does not morally condemn "the act itself". It is the consequences and implications of drinking, and not drinking per se that are seen as "wrong". It will be seen also that such an inclusive definition of "alcoholism" exemplifies Hughes's point that the mandate of the medical profession "defines for all of us the very nature of health and disease", and further that it "presumes to tell society at large what is good and right for the

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[7]See John R. Seeley. The WHO Definition of Alcoholism. Quarterly Journal of Studies on Alcohol.:20: 1959.

individual and society at large". In particular here, the presumption to include "the drinker's own health" may be mentioned. This is an area in which the individual might have envisaged more self-determination or autonomy.

The very same presumptions of telling "what is good and right to the individual and society at large" are seen again, in the following quotation from a publication of the agency, of which the clinic studied is a branch:

> In conclusion, we have seen that man may form a drug relationship that may lead to habituation or addiction with a variety of substances - many of which are not narcotic drugs. Society has demanded conformity and has sought various means to force individuals to behave in accordance with a prescribed plan believed best for the society at that time. This plan is best satisfied with a balance between work and play, and while this balance may have varied propositions which differ one from another, it is, nevertheless, healthy for the individual... it is hoped that in our era we will see a development in the treatment of these disturbances, move, under medical direction, from the correctional institution to the appropriate hospital and clinical setting....
> At the present time, society is greatly troubled by the prevalance of drug addiction... by contrast, society is not sufficiently concerned with the problems of alcoholism. [8]

This latter quotation can be seen as a stronger statement of laying down standards for both individuals and for society, than the positions stated by either the American Medical Association or by the alcoholic subcommittee of the World Health Organization. The quotation is taken from a document published

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[8] S.J. Holmes. Dependent Man and Some of His Crutches. The Alcoholism and Drug Addiction Research Foundation, an agency of the Province of Ontario. p.32. (researcher's emphasis).

by the Alcohol and Drug Research Foundation, which is a branch of the Provincial Government of Ontario and it may be that its definite stand is in part a consequence of its more direct concern with enforcement - rather than advisory capacity of the World Health Organization - and as such comes more directly under the heading of what we have called, following Lemert, "control culture". Certainly, it claims not only what should be defined as "problems" but in the name of society states the degree of emphasis that "society" should accord to "problems".

The Ideology of "Castle Clinic"

The clinic itself as a branch of a government agency, can be seen to reflect the "official" agency views on the "morality" of alcoholism and upon alcoholism as an "illness". A participant observation included these observations as indices:

Alcoholism as "illness"

The clinic was designed as a medical treatment centre and the physical lay-out of the building reflected this end, with waiting rooms, medical examination rooms, a nurses' station, a dispensary, a medical records department and consulting rooms. The staff included trained and professional nurses and doctors who were on duty in the customary uniforms of white. Upon entry, the patients filled out a face sheet with information as to their health and past hospitalization, etc. They were then given a regular medical examination, followed by a consultation interview with the doctor, and finally were given a pre-

scription or prescriptions which were filled in the dispensary by one of the nurses. An appointment was then made for their next visit. Unless emergency care was needed, they were only accepted as "intake" patients if they had made a prior appointment. The patient saw the social welfare worker only if the doctor suggested it, or if the patient himself requested it; and then the interview with the social welfare worker was made after the usual routine medical appointment.[9]

The weekly case conferences were another index of the medical aspect of the clinic, for although arranged as an intra-service conference, at which members of social services and the clergy were invited and did, from time to time, attend, the case conference centred upon the medical aspects of the patients' condition. It was the medical doctors who read the reports, and other members present merely commented from time to time on the more social aspects of the cases.

The medical case records of the patients were completed by relevant information obtained from previous hospitalizations or medical care, which the patient had received.

The annual report of the clinic included this statement as to the aims of the clinic:

> (To treat) the physical, mental and social aspects of this complex disease. [10]

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[9]The researcher was informed by a member of the staff that "patients want to see the doctor first". The social welfare worker was reported to be unhappy that her services were not used more often and earlier in the patient treatment.

[10]Researcher's emphasis.

Patient/Doctor Interviews

On observing some first interviews with patients, the researcher noted that the questionnaire which the doctor read to the patient was heavily loaded with medical information. The questions were directed to the patient's medical health as regards sleep, nutrition, state of kidneys, headaches, etc., and only a small percentage of the questions were aimed at gaining information about the patient's drinking behaviour. The doctor stated to the patient that he could "get better" and that the clinic could "help him" by getting him into better health. When asking questions about drinking, the doctor's tone was "neutral" but "assumed" drinking. An example was the form: "what was the longest you went without taking a drink?" The patient often nodded assent to the "assumption" questions, for example, "you know what blackouts are?" and the patient would nod assent. The patient's tacit affirmative could indicate a reluctance to answer or to affirm questions and knowledge of drinking behaviour, as this was not apparent in other areas of questioning.

The Clinic as a reflection of the Medical Profession

As noted in this chapter, Hughes sets up standards of the "ideal patient" and the nature of the "ideal physician". The ideal patient should enhance the physician's technique and learning and enhance the physician's conception of himself as physician. This is an area in which a prime example could be

a question as to the nature of mental illness, and to the reasons for shortage of medical personnel in this area. This may have a parallel in alcoholism in that the stigmatized patient can "infect" his physician, and the dirtier the work - morally - the less likely the physician is to be highly paid, and the high prestige physician is less likely to be attracted to such an area of work. In passing, it might be noted that the female status appears to be a restricting one in the area of medicine - the auxiliary status of "male" being the one that is expected to accompany the status "doctor". This may put the female physician at a disadvantage and thus we find her represented in "restricted" areas such as paediatrical work or "light" general practice or more particularly concentrated in the relatively underpaid sections of medicine such as public health. In this regard, although we cannot generalize from this study and from such a small sample, it is worth noting that at this clinic two of the complement of four resident doctors were female.

The attempt in this clinic to "upgrade" the services can be seen as an attempt to lift the stigma of alcoholism from the patient and to raise alcoholism to a status of other illnesses, from not only the patient's point of view but also from the physician's standpoint. The clinic, as it has been described, can only reflect well on the physician's conception of himself. The clinic is well-equipped, well-staffed - in the

sense that there is no overcrowding of waiting rooms, nor any sense of "no time" for all the doctors to see all the patients. There appears to be sufficient doctors for each to make full and unhurried examinations of the patients, and for the doctors to engage in their own research work, and to attend conferences relating to their work. The clinic is as an office, well furnished, set in a "good" part of town, and in a luxury building of modern offices. As such it is a far cry from the "skid row" makeshift offices that many doctors associate with this type of clinic work. Furthermore, the liaison with other branches of the medical world seems well-established, and the general practitioners or other interested medical specialists are invited to attend the weekly case conferences. These case conferences are held in a panelled board room, and a light luncheon is well presented in the manner of buffet type table complete with carafes of coffee and tea.

The Recognition of the Stigma of Alcoholism within the Clinic.

A recognition that the alcoholic patient can be stigmatized, with an effect upon his fate, operates on a manifest level within the clinic. At the first meeting with a member of the staff, the researcher was cautioned regarding the necessity for preserving the anonymity of the patients. Before any staff members, secretarial or otherwise, are hired at the clinic they are informed of the confidential nature of their work, particularly as regards patient identity. The emphasis on the

confidential nature of the work was phrased in this manner: "Staff are only hired if they are discreet - nothing of the clinic must be divulged - especially names of particular patients"- and again, in the following quotation an awareness can be seen of the possible sanctions against alcoholism: "Some of our patients are professional people and it would never do to have it leak out that they were patients - particularly at their places of work."

Also the location of the building was deliberately chosen to achieve "secrecy":

> This building was chosen because the large office building gives anonymity - it is on the first floor so that patients can walk up - no need to use the elevator.

On separate occasions the researcher noted comments of staff members which indicated recognition of the need for protection from "visibility" for the patients in order to avoid the social consequences of an alcoholic stigma. For example - and here was included a note of "pride" at the "nice" building and clinic:

> We have all kinds of patients here, but mostly they are nice people. We are in a nice building and people do not mind coming here...The skid row types don't take long to find us...We had only opened a day or so when they found out where we were...

Thus, it would seem as though the staff are aware of the nature of the stigmatized condition of their patients, and that much of the organization can be seen as a manifest effort to protect the patients from the consequences of their stigmatized condition.

Further indices of the awareness of the agency of the stigma, and consequences of stigma, can be seen in the name of the clinic which is something of a pseudonym, or at least has a name that could be used by any clinic and does not specify that it is an alcoholic clinic: it is a name similar to "Castle Clinic". Again the nature of the clinic is not divulged on office stationery; but either the title "Castle Clinic" is used, or merely the address, - suite and street number.

Recognition of the stigma attached to the label "alcoholic" is made within patient treatment at the clinic. The researcher was informed that:

> We do not tell the patient for the first few visits that he is an alcoholic. We are careful to avoid this.

Clinic Staff's View of the "Morality" of Alcoholism

Recognition of the consequences and the presence of the stigma upon alcoholic patients by the staff is one thing, but what values do the staff hold regarding alcoholism? We have seen that the clinic officially clearly regards it as "illness", but if we apply types of ideological reference to their conception

of alcoholism, then in what way is alcoholism seen as being "wrong"?

Is it regarded as wrong because of "consequences to the individual" in terms of "health"? The clinic is perhaps in a position to see this more than other consequences, and to apply other standards of "normality" of health of which laymen would not be aware. Therefore statements such as: "he looked older than his stated age" which was a frequent comment at case conferences, implies that there is an expectation of "aging" and appearance. Similarly, comments upon the pathological and physical degeneration symptoms of patients, which were attributable to the amount of alcohol consumed, and which were punctuated with comments of a sad prognosis as regards their future health, indicate a standard of comparison for "normality" of health and physical condition.

Similarly, the consequences of alcohol for the social life of the patients was considered by the staff at conferences, to be a sad one - of relationships lost or never formed. As regards consequences to injured persons such as family and children, the comments of the staff again reveal that the staff viewed these consequences as undesirable:

> The wives usually are the ones who suffer...they have often been trying for years to get the husbands off drink - and have put up with a lot.

These views were often supported by statements to the economic dimensions of alcoholism, both as regards the husband

not supporting his wife economically and by the loss of the male's productive time at work. In the latter instance, the link with some of the large industries within the town may be mentioned. The doctors of the industrial plants "refer" the worker to the clinic, and keep in touch with the clinic regarding the patient's attendance and improvement. Other references made to the economic aspects of drinking included judgments concerning the expected and appropriate usage of money. These judgments condemned money spent on alcohol as a major part of income spending. For example:

> That drinking must have cost him $35.00 a week - which is half his salary - could have been paying off a new car.

One of the greatest areas of concern expressed amongst the staff was for the moral worth of the patients in regard to the "moral character of the person" and "wrong to personal standards and consequences to the individual". The patient who was discovered to be living in a garage-cum-out-house was felt to be in a "bad way". As was the patient to whom it was attributed that alcohol had taken away "all that was decent", by which was meant the social relationships that are conventionally assumed to exist, with their appropriate sentiments and responsibilities. For example, one patient was described as having one last link with decency - his feelings for his son.

However, the greatest emphasis seemed to be upon the "moral worth" of the patient as it affected the staff whilst

the patient was at the clinic. This was viewed as affecting the patient's acceptance of treatment. For example, the "morally unworthy" in terms of sex offences were clearly not regarded as "really trying" to break with alcohol. Equally regarded were the patients who were designated as "manipulative" in any manner, as for example those receiving services but who were thought to be without the desire to quit drinking. These patients were frowned upon both as patients and as regards their "unworthy" orientation. These latter would come into the categories of those designated as "phony" - a category used several times - and one which seemed to be the reverse of the category of "really trying".

As can be seen by referring back to Hughes's discussion of the "ideal patient" it seems inevitable that the staff would be concerned with the values of the patient as it affected his motivation for treatment, for this is the area in which the patient reflects upon the doctor's conception of himself as a "healer". The well-motivated patient is the "ideal" both as regards expectations of the same "end" of treatment, and the one who is viewed as most likely to achieve this end, thus reflecting upon the doctor's view of his job as one that "sees results" by way of "cures". The "worth helping" patients may be conceived as both "morally worthy", but also as being those patients whom the doctor can identify as an "ideal patient".

Summary

The larger organizations of provincial agency and of medical profession, and the clinic as a branch of these have been analyzed through the concepts of "licence and mandate", and through the judgment by types of ideological reference in order to review the socio-cultural values surrounding alcoholism. Investigation revealed that in value terms, alcoholism is viewed as "wrong" when the judgment is based on:

1. Harm done to an injured person (s).
2. Disruptive consequences to the social order.
3. Moral character of persons.
4. Wrong to personal standards and consequences to individual.

Alcoholism was not seen to be wrong on a fifth dimension that of the "act itself". Therefore, we can conclude that it is the consequences and symptoms of alcoholism, rather than drinking per se, which are viewed by clinic staff and by agencies as "wrong". Although alcoholism is regarded as "illness" by these agencies and by the clinic, it is significant, we believe that the illness conception does not appear to extend to legitimation and exemption from the judgment of alcoholism as "wrong". In fact, the alcoholism subcommittee of the World Health Organization, saw in the illness conception, the danger that it might affect ethical sanctions against alcoholism, and viewed this as a "danger". But this appears as a debate, at a time of change, for the actual definition of alcoholism given by the World Health Organization is one in which alcoholism is seen as an illness

albeit with detrimental social consequences.

The American Medical Association side-steps the "moral" issue involved in alcoholism, but realizes that by placing alcoholism within the province of disease it will reduce the stigma attached to alcoholism.

As this chapter shows, the stigma of alcoholism is still very much with the patient.[11] The clinic takes cognizance of this fact, and of the consequences of being "found out" as an alcoholic patient. It does this by introducing methods of reducing patient "visibility" from public view. This is seen in the anonymity and confidential nature of the clinic.

It does so however in recognition that social penalties - for instance, as regards occupational hazards which may accrue to the patient if he is known as an alcoholic. It is, in fact, a recognition of public opinion and practice outside the sphere of the clinic.

Within the clinic the "official" view of alcoholism as illness is predominant, with a few exceptions where the patient was considered as morally unworthy for issues other than alcoholism - for example, criminal sexual practices. It is mainly however within the domain of the medical world that the patient

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[11]It is however interesting to speculate that the illness conception of alcoholism might have reduced (but not absolved) the "infection" to the physician of the patient's stigma. At least in the clinic studied, the staff were afforded "good" medical facilities, etc.

is evaluated by the staff. He is evaluated as a patient. There are categories of alcoholic patients that include the "really trying" and the "phony". These evaluations reflect on the self image of the physician as a healer. Other evaluations made by the staff on the social conditions and social relationships of the patients reflect the physician as an expert in social control concerned with the "normal" healthy individual as outlined by the ideology of the medical profession. These are to act as an exemplar of the values of the middle class and professions, and as such, reflect the dominant value system and therefore include "success", "responsibility" and "achievement" values in the social sphere.

However, in the clinic in their capacity as medical staff, the view of the patient necessarily centres around the patient as a disease entity requiring treatment. Case conferences are weighted on discussion of medical symptomology and the major part of patient admission is taken up with medical work - as taking x-rays, medical histories and dispensing medication.

Moral disapproval of patients by staff is seen "behind the scenes" but for acts peripheral, or other than, alcoholism. Disapproval of patients for lack of fullfilment of social obligations is expressed.

Whether or how this disapproval is communicated to patients was not apparent to the researcher, as the procedure appeared as formulated and structured in doctor/patient manner in

that any exchange of values - other than co-operation of patient - seemed unlikely. This could be seen to erase the likelihood of the patient being penalized by the staff for staff-perceived failings on the patient's part. However, this low rate of exchange of values might be restricting in resocializing the patient into new values.

Institutionalized patterns of doctor/patient relationships exist in which the transaction is one in which the doctor exhibits emotional neutrality and impartiality in personal terms. A doctor is expected to treat all patients in the same manner and not to be swayed by personal considerations and preference - in other words, part of the expectations of a doctor's role is that he will remain impartial and emotionally uninvolved in his relationships with his patients. On the reverse side of this, the patient is expected to co-operate with the doctor - in other words, to be a "good patient". It is in the latter regard, that we found that lack of motivation and acceptance of the patient role results in the categorization of patients into the "phony" and the "really trying". However, it may be that the structural components of an out-patient clinic are not of the order to be conducive to the socialization of the "phony" patient into the "really trying" patient. Compared to full time institutionalization, the mechanisms for socialization into the patient role in an out-patient clinic are slender. The patient in an out-patient clinic comes to the clinic only for an

hour or two every week or ten days. His visit consists of medical examination , which is conducted on a formal basis and in which the interchange of views is limited, and the dispensing of medication. From the point of view of socializing the patient into new values, the out-patient visit can only be a fragment in time.

CHAPTER 5

THE IDEOLOGY OF THE PATIENTS

This chapter examines the patients' ideology as revealed through a questionnaire; and then compares the patients - categorized by their scores obtained from the questionnaire - against their subsequent attendance pattern at the clinic.

Information regarding the views of the patients on alcoholism, both as regards "morality" and regards illness, was obtained through a questionnaire[1] which was given to the respondents at the time of their initial entry, as a patient, into the clinic.

Part 1 and Part 11 of the questionnaire were scaled according to a Likert-type scale, and thus the analysis required that items (questions) which were found to be lacking in "discriminative power" had to be discarded. The items which were discarded because of low D.P.'s, were questions 1,2,4,5,11,12,16, 17,21,23 and 24. In the main, the response on these items fell on the one end of the scale - the high/positive end - and could be discarded on inspection.

However, question 4 "alcoholism is an illness", although it had zero D.P., will be made mention of. It proved to have no scatter and showed great agreement between all patients, with all scores falling at the high end of the scale. Therefore as an example of the high agreement of the discarded questions, it will be used for comparison and discussion.

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[1]See Methodology Chapter; Appendix A; and Appendix C.

It will be remembered that in a previous chapter, the possibility of "shallow acceptance" of the illness conception of alcoholism was discussed with the suggestion that if the "illness" concept were to be made specific in its referents, then the acceptance of the illness concept might prove to be mere "lip service". This certainly seemed to be the case, as indicated by the patient response to item 4 - "alcoholism is an illness". This question had a universal acceptance by patient respondents at the "strongly agree" end of the scale. In effect then, all respondents agreed that "alcoholism is an illness". But if we regard the implication of this and we posit that illness implies an exemption of responsibility for one's condition; that in fact illness implies legitimate exemption from "moral"stigma, for one's condition, we find a very different result. The question - "the alcoholic is a sick man, and therefore need not feel ashamed" - was marked by a greatest disparity and showed the highest degree of difference of response - a D.P. of 3.20 - of all questions in the questionnaire. We can conclude from this, that there were patients who agreed that "alcoholism is an illness", but these same patients did not agree with the view that illness exempted alcoholism from moral shame - it must be remembered that there were also patients who did believe that alcoholism viewed as "illness" did exempt from shame.

A further exploration of the relationship between "morality"

and "illness" views of alcoholism was made by comparing the scores on the retained questions regarding "alcoholism as illness" with the score of the retained questions regarding "alcoholism is morally wrong". On inspection there appeared to be an inverse relationship between these scores - i.e. those respondents who had a high score on the "morality" scale tended to have a low score on the "illness" scale and those who had a high score on the "illness" scale tended to have a low score on the "morality" scale. An analysis by correlation coefficient proved that there was indeed an inverse relationship, but that it was not a statistically significant one.[2] An interpretation of this appears to be that those respondents who tended to see alcoholism as morally wrong continued to do so even with the introduction of the "illness" conception. One can doubt the value of the "illness" concept for the patient if held only shallowly for diminishing the "moral" stigma of alcoholism.

Did the illness concept appear to have any effect upon respondents' views of themselves as "patients"? The questions 11 and 12 - "The alcoholic should be allowed a certain time to get better"; "To overcome alcoholism it is necessary that the patient co-operate with the staff of the clinic", were in fact discarded because of high agreement responses. No definite

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[2] $R = .0986$
$Z = .325$

differences of attitudes could be found amongst the respondents with regard to patients' stated attitudes of "co-operating with the staff". Equally, the question - "The patient should be allowed a certain time to get better" - showed a high agreement response, indicating that the question had the full agreement that the "blanket" question - "alcoholism is an illness" - had.

In summary then, the "illness" conception of "alcoholism" was specifically and strongly shown in the patients' views as expressed in the questionnaire by the very sharp area of agreement upon the blanket and undefined question - "alcoholism is an illness", and the sharp disagreement on the view of illness - item 11 - seen as exempting or not exempting from moral shame.

Of the items on the questionnaire which were designed to form a value scale, it was seen that there was a descending scale of "difference" of opinion of the respondents, according to the type of ideological reference. The highest D.P. (1.89) was on item 9, which was the question - "to be an alcoholic is to be ashamed". The reference behind this question can be seen to be the subjective feelings of the individual as an index of "morality". In descending rank order of difference was item 8 - "drinking does not have any effect on moral character" - which had a D.P. of 1.62. It can be seen again that this question refers to subjective "moral" feelings. Item 7 - "there is nothingwrong in drinking" -(with a D.P. of 1.37) may have been interpreted by the respondents as drinking per se or

as the consequences to self and others of drinking. The question - "alcoholism does not harm the friends and relatives of those who drink" - showed a low D.P. of 1.1. And questions as to the consequences of drinking for society were even lower in discriminative power, and were skewed in nature, showing no strong areas of differences in attitudes along these lines. It would appear then, that the morality questions with an ideological referent of self and of subjectively-held shame were those that showed a strong area of disagreement amongst the respondents. It was in these areas that we could divide the population into categories according to difference of belief along these moral dimensions. It is important, we feel, that such an area of difference and discrimination by belief system can be found in such a population. The question of whether these differences of values and beliefs have relevance for the subsequent behaviour of patients was found by comparing categories of respondents. Categories were obtained by dividing respondents into those with a high score on the morality scale, those who had a low score on the morality scale, and those respondents who did not hold strong views; and these respondents' findings were compared with the respondents' subsequent attendance patterns at the clinic.

But before attempting to implement this comparison, mention should be made of Part 111 of the questionnaire, which consisted of "open-ended" questions through which the respondent could express

himself more freely and fully than in the forced response question. Item 4 - "Here is space to explain in your own words how you felt about coming to the clinic; for example, were you afraid or ashamed to come? Or has coming to the clinic made you think more or differently about yourself and about alcoholism? Please explain fully." - was a check on the validation of the "forced response", Likert-type questions. It proved to be highly rewarding in the latter regard, and if we compare the statements of those respondents in the upper quartile of the morality scale - high score - with those in the lower quartile - low score - then we find that shame and fear do appear to be connected with the morality scale, both positively and negatively, and that in fact the respondents have stressed this area of concern. The following are verbatim statements taken from the questionnaires:

Those Respondents who had High Scores on the Morality Scale

I felt a certain amount of shame having to come to the clinic for help, but since coming feel very good that I have done so and see myself in a different way and as a person that the clinic can be of great help to.

I reached a point where I became objectively aware of my illness and the subsequent necessity of treatment.

I never felt ashamed to come because I want to become a man with responsibility because I have a family to look after.

- how to think in other ways as becoming a human being and not as

a lost loose person.

When I first heard of the clinic I wanted nothing to do with it. I wasn't actually ashamed but scared what they would find.

I was ashamed to come but I though I had better do something about my drinking.

I was not ashamed really but I have been ashamed of things I have done while drinking and what I have done to people close to me. I have tried and failed to understand my problem.

I think I felt a little guilty about coming to the clinic at first because I didn't want people to know that I have a problem, but I though that the staff would understand and would like to help me...this gave me hope to come to the clinic.

I was sort of ashamed and did not know whether I could shake this feeling of depression and remorse... not knowing too much about the operations of the clinic...would they help me to get over what ever causes me to drink.

Was really ashamed of myself. I sincerely think the clinic and also the AA can really help me if I will only trust in God.

Those Respondents who had Low Scores on the Morality Scale

I was not afraid or ashamed to come but I realized that I had no will power and could not overcome drinking by myself.

I was ashamed of the fact that I could not control it but not afraid of asking for help.

- not ashamed or afraid to come, I do not feel any different because I do not drink every day, only when depressed.

Not ashamed because I don't think I am an alcoholic.

I was not ashamed because I came under doctor's order.

Not ashamed because I felt that the staff were interested in doing me a service.

No it did not afraid me or ashamed me to come here.

I was not ashamed to come.

I am not ashamed I am glad of the help as I believe it will straighten my mind and thinking for the future.

It can be seen that these statements constitute a validation of forced response - Likert-type - question, as those respondents in the high end of the scale on the morality score - obtained from the Likert-type questions - are those who on the whole, expressed shame and fear at attending the clinic; and the reverse is the case for those respondents with a low score on the morality scale.

It will be recalled that in Chapter 1, mention was made that a comparison of patients expressed views of the morality/illness aspects of alcoholism would be made to patients' preconceived views of the staff's ideological belief system along the morality/illness dimension. The responses on the questionnaire were studied to see if they revealed any disparity along these lines, if, in fact, the patients viewed the staff as having a different ideological perspective from their own.

The analysis of the questionnaire revealed that the patient responses indicated only two areas of discrepancy between the respondent's own beliefs and those the respondent anticipated that the staff would hold - mention must be made that this does not mean that there were in fact no such areas, but merely that the patient respondents did not see any areas other than those two. One of these areas was item 6 and its corresponding item 18. Item 6 was the patient's own belief regarding - "alcoholism is a vice" and the D.P. for this question was 1.37, whereas the

respondents thought that - "the clinic staff will believe that alcoholism is a vice", had a D.P. of 2.12. This shows a higher degree of variation in the view held regarding the "expected" belief of the staff on this question. It will be noted that this is again a question which is in the area of "morality", and that the patients believed that the staff would, in fact, hold stronger to the "morality" view than they (the patients) actually did.

Patients' Scores on "Morality" Questions Compared to Attendance Patterns

The comparisons made in the following table show that those patients who hold to a strong "moral" view of alcoholism are twice as likely to remain in treatment as those whose views are "neutral" on the moral issue involved in alcoholism. Moreover, those patients who are strongly opposed to a "moral" view of alcoholism are also twice as likely to remain in treatment as those patients whose views remain neutral on the moral issue. Therefore, with the necessary caution of interpretation allowing for the small sample number, we can say that those patients who are in the mid-categories - whose views are neutral - drop out of treatment at twice the rate of those who are categorized by either a strong moral view of alcoholism or by those who are opposed to the moral view of alcoholism.

Summary

The questions which were discarded from the scale because

they did not prove to be discriminating in attitude were:

(Item 1) "alcoholism has harmful consequences for the society in which we live"

(Item 2) "alcoholism is offensive to one's own personal standards."

(Item 4) "alcoholism is an illness."

(Item 5) "To overcome alcoholism it is necessary that the patient should actively strive to get better."

(Item 11) "the alcoholic should be allowed a certain time to get better."

(Item 12) "To overcome alcoholism it is necessary that the patient co-operate with the staff of the clinic."

They were noted in the discussion, because agreement with these questions between the patients, was at the positive -"strongly agree" - end of the scale. Particularly in the case of the question - "alcoholism is an illness" - where the area of disagreement amongst the patient respondents was nil. This could mean acceptance of a "blanket" phrase, which proved to have little true significance if the referents of the conception of illness had been introduced. For example, the question - "the alcoholic is a sick man and therefore need not feel ashamed" - was marked by a high degree of variation of response, and one can thereby infer that at least illness is not seen as legitimating alcoholism from shame, for some of the patients.

The retained questions, which showed a high degree of difference of opinion by the patient respondents, were:

(Item 6) "Alcoholism is a vice."

(Item 9) "To be an alcoholic is to be ashamed."

(Item 3) "Alcoholism does not harm the friends and relatives of those who drink."

(Item 8) "Drinking does not have any effect on the moral character."

(Item 7) "There is nothing wrong in drinking."

(Item 10) "The alcoholic is a sick man and therefore need not feel ashamed."

The corresponding questions,[3] but asking the patient how he thought the clinic staff would view the same issues, were also retained.

The scores for the respondents were obtained from the responses to the above questions.

Item 10 and its corresponding item 22 were calculated separately because of its reference to alcoholism as illness, although these two items were insufficient in themselves to form a scale, upon which to base any conclusions.

In summary, it can be said that patients could be classified according to attitudes towards the "moral" dimensions of alcoholism - those who had a high score on the scale obtained from the questionnaire were those who felt that alcoholism was to be considered as a vice and who themselves admitted of "shame". Those respondents who were in the lower quartile of the scale strongly repudiated the view that alcoholism was a vice and was something of which to be ashamed. Those respondents who fell into the mid-quartiles were those patients who were not characterized by strong views either positive or negative towards the moral aspects involved in alcoholism. The relationship of the categories of patients obtained

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[3]See - Appendix C - for Likert scale analysis.
See - Appendix B - for Questionnaire.

through this score - to attendance patterns - was found to vary significantly, as revealed in Appendix C.

CHAPTER 6

SUMMARY AND CONCLUSIONS

This chapter will proceed by a brief review of the study; followed by a discussion of the linkage between the varying levels of discussion seen throughout the thesis in order that it can be seen in its totality. For example, what is the relationship of the literature of the clinic to patients' attendance patterns.

The final part of this chapter will be a discussion of the significance of the findings of the study and conclusions.

A Brief Review of the Study

In Chapter I we described a patient arriving at the clinic and noted his chances - that of one in three - of remaining in treatment beyond the first three visits. We proceeded by analysis of past data, and by comparing findings from other studies, in order to eliminate factors involved in this high rate of non-acceptance of treatment. Factors such as age, religious affiliation or the amount of "pressure" the patient had received from official agencies to attend the clinic, etc., were discarded as not being significant factors in determination of attendance patterns. We had to look for other factors of difference between those patients who remained in treatment and those who did not.

The dirction we chose was that of difference by attitudes which could be thought to reflect different sociocultural values

towards alcoholism. Two main directions of values, as seen in studies which had attempted to assess public views towards alcoholism and as seen in the official literature of medical and associated agencies, were particularly thought to be of interest in this study. The one view centred around the values of alcoholism as "morally" wrong. This view was stated to be linked with an ideology which was of a religious nature, whilst other views of alcoholism would centre around a secular view of alcoholism as "wrong" because of commitment to "secular" values - such as effective achievement in an occupation. In the main we felt that the secular view would centre around an illness conception of alcoholism. Whereas we restricted the use of "moral" to describing the religious type of commitment, whose subjective components would be those of shame and vice, and alcoholism would be felt to be wrong at the highest level of moral appeal; whereas the secular view would tend to see the social consequences of alcoholism as wrong but would tend to accept the illness view of alcoholism as an undesirable state to be overcome. Its undesirability would be seen to lie in secular ways of interference with values of achievement, but not as a state of <u>shame</u> or <u>sin</u>.

The patient's commitment to <u>either</u> set of values would seem to be in conformity with the dominant values of society, as both views can be seen as a part of the ideology of our society. However it may be hypothesized that within our society there is a gradual change from the religious "moral" view to the secular

- i.e. alcoholism as illness. The patient's acceptance of either of the dominant values -- the illness view or the morality view -- towards alcoholism was compared against his attendance pattern at the clinic. It was found that those patients who were not characterized by either of the dominant value patterns towards alcoholism -- those patients who were to be considered as anomic because they did not reveal any strong values towards alcoholism - were those patients who were twice as likely to fall out of treatment as those who were characterized by strong value orientation.[1]

It will be seen that by moving from considerations of the patient we have, by the introduction of patient's values, moved into a wider sphere than that of merely considering the patient as an isolated unit. One way of regarding this is that of actors seen as participating in several social systems simultaneously but in which each system can be regarded and analyzed separately from the others. Sociologically, it means that we do not regard the patient in isolation from his social environment, but think in terms of interdependent and interlocking of the component parts which make up the social environment. Concretely, in terms of the patients' attitudes we implicitly infer that patients values will vary, and that these different attitudes exist partly to the patients' participation in different social systems. One of these can be regarded as the patient's

[1]Limits of the evaluation must again be stressed, as the sample number was comparatively small.

particular subculture.[2]

But the subcultures which exist can also be compared against a broader sphere of reference, that of the cultural values of society itself - in this case the dominant values of American society.[3] These were seen to include the secular values of "achievement" and "responsibility", and the reward which accrued to individual members for conformity with these values was stated to be that of prestige. It was stated that dominant values would include as an ideology the type of religious backing which involved notions of pollution and contagion, to justify social distance, which are imposed as a penalty upon those who do not conform -- in this regard, a "moral" stigma. This was seen to be a form of social control -- in that it acted as a punishment and example. However, it was suggested that with the secularization of society; its increased emphasis upon rationality, efficiency and performance, that social control would tend to the rehabilitative rather than the deterrent and punitive. In this latter regard, the medical approach to humanity with its emphasis on health and efficient capacity for role performance, and its control lying partly in prestigeful and powerful position of the medical profession thus allowing the promulgating of these

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[2]Reference group theory, is an underlying assumption. See - R.K. Merton, Social Theory and Social Structure. Revised and Enlarged Edition. Free Press of Glencoe, 1957, pp. 225-384.

[3]See - Figure I and Figure IV for a schematic representation of this discussion.

FIGURE I

THE PATIENT

Cultural System

Patient: Values of subculture (Reference group)

Dominant values of culture (instrumental - activism, achievement orientation).

In relation to alcoholism - "secularization" of alcoholism concept - from sin into illness.

Structural System

Patient - clinic staff - patient's significant others.

FIGURE II

CLINIC STAFF

Cultural System

Clinic Staff: Ideology of Agency, Ideology of Medical institutions.

Dominant Values: (instrumental - activism, achievement orientation) Conceptions of "Health" and Normality"

Social Control

Structural System

Medical profession and medical agencies

exercise social control

attempt to aid rehabilitation

define patient's role.

FIGURE III

PATIENT/CLINIC STAFF

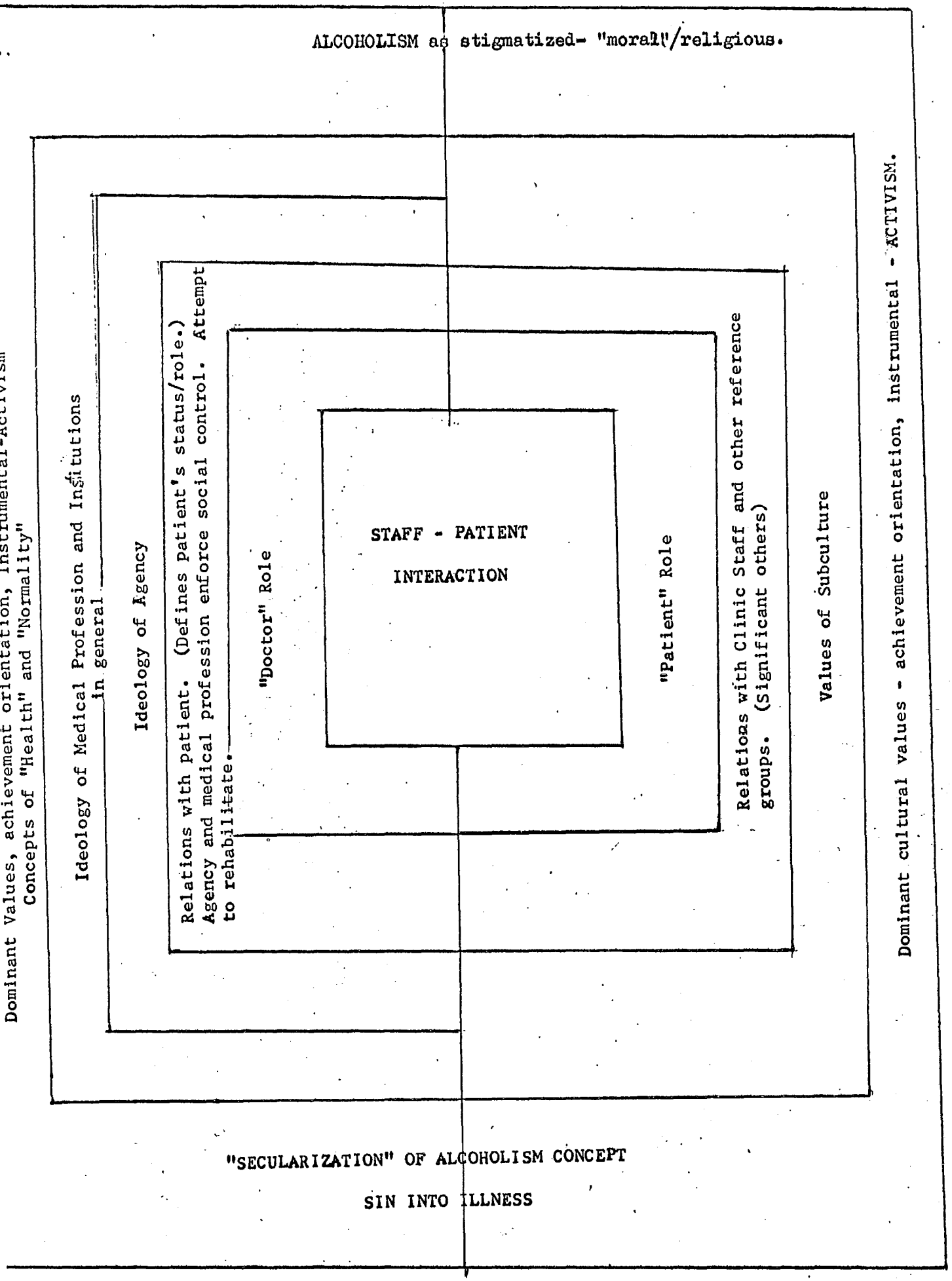
Interactive Situation

Clinic Staff/Patient

Structural "Doctor" role/ "Patient" role

Cultural Doctor's values/ Patient's values.

FIGURE IV


ALCOHOLISM as stigmatized- "moral"/religious.
Dominant Values, achievement orientation, instrumental-activism
Concepts of "Health" and "Normality"
Ideology of Medical Profession and Institutions in general
Ideology of Agency
Relations with patient. (Defines patient's status/role.) Agency and medical profession enforce social control. Attempt to rehabilitate.
"Doctor" Role
STAFF - PATIENT
INTERACTION
"Patient" Role
Relations with Clinic Staff and other reference groups. (Significant others)
Values of Subculture
Dominant cultural values - achievement orientation, instrumental - ACTIVISM.
"SECULARIZATION" OF ALCOHOLISM CONCEPT
SIN INTO ILLNESS

values, would tend to be an emerging and increasing power in the area of social control. Its intervention by way of proclaiming illness and defining the sick can be seen as power, but also as a process in which the accent is upon rehabilitation rather than punishment. Therefore, this form of social control can be said to be of the secular kind in which moral stigma should decrease -- although illness itself would still be seen as undesirable state. It was tentatively suggested that the illness view of alcoholism would tend to usurp the religious and moral view of alcoholism -- partly because of the general trend of defining of social problems into the area of "illness" and partly because of the increasingly secular views of our society.[4]

The fact that both kinds of ideology continue to exist regarding alcoholism was seen in the review -- in Chapter 4 -- of the literature of the control agencies, such as the Alcohol and Drug Addiction Research Foundation and the statements of the American Medical Association. The increasing emphasis upon alcoholism as an illness was predominant, and we noted that the institutionalization of this involved the medical world in an increase in potential patients and a gain in knowledge and skills to the medical practitioner.

The patient's attitudes towards alcoholism -- see Figure I and Figure IV for schematic representation -- "filtered" through

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[4]This would assume that religious and magical values are being superseded by the secular. See Herberg. Protestant, Catholic, Jew. Chapter 5. Doubleday Anchor, Inc. New York. 1960.

reference groups and 'significant others', was also seen to reflect either of the two dominant views towards alcoholism. Where they did not, we concluded that the patients were 'anomic' in that they did not hold the dominant values. The patient is therefore seen as being involved in social contexts which include both immediate reference groups and the larger group -- society. His attitudes are compared and evaluated against the other groupings -- i.e. the dominant value system.

However, the patient, his values and the relevance of his values to the dominant values is still an incomplete picture. Just as the patient is involved in sets of relationships on his side, so the clinic staff are involved in diverse social worlds. And in the final case, the patient is only a patient by virtue of his relationship with the clinic. Here the two worlds of the patient and the clinic staff meet -- see Figure III. But first the clinic staff must be seen as representative of the agency and of medical institutions - the values that this entails - the cultural system - and the kinds of relationships which exist - the structural system - See Figure II.

The ideology of the clinic and of the agency has been shown, in Chapter 4, to include the evaluation of "health" and of capacity for 'normal' role performance of the individual, and the right to define and intervene, in these areas. The participant observation

of the clinic revealed that the staff exemplify the ideals of the medical profession in dealing with patients as primarily "disease" entities to be cured. "Moral" judgments that are made about patients are often peripheral to the question of alcoholism,' although alcoholism is seen as restricting the patients' capacity for efficient occupational performance and as limiting his relationships with family etc., these effects are viewed as undesirable. By and large though, the concern is with treating the physical symptoms which have arisen as a by-product of the consumption of alcohol, and attempting to control the patients' drinking through the introduction of protective medication. The clinic staff can be thought of as representing the dominant values of both health and normality in the case of alcoholism; and of achievement and activism generally; -- see Figure IV.

The clinic, as a social control agency, intervenes in the alcoholic's fate and operates in the name of society and conformity. It does so by an act of judgment and placement - in that it defines the alcoholic as "patient". Structurally considered this invoves patients, doctors and nurses, and defines the relationships that are expected to exist between these sets of people. For example, the sick role is one in which the patient is submissive to the doctors' authority whilst the patient is expected to actively strive to get better, etc. Referring back

to Chapter 3, we see that the sick role also entitles the patient "ideally" to exemption from normal role obligations and from responsibility for his condition.

The doctor defines the "ideal" patient as one who lives up to his expectations of a patient, in that he is motivated to "get better", co-operates with the doctor in attendance and acceptance of medication, and shows signs of "improving". It is indeed circular that the patient who is motivated and who does improve, is the one who is designated as "worth helping".

The doctor role, following Parson's discussion,[5] is one that is characterized in the interactive situation with the patient, by functional specificity, universalism and affective neutrality. Rephrased this means that his job is defined as treating a specific condition with the technical knowledge and skills learned within his professional training; treating all patients in like manner regardless of personal preference; remaining objective and emotionally uninvolved in his relationships with his patients. Though these characteristics can be seen to have arisen in response to various strains inherent in the doctor/patient relationship, and therefore as being functional necessities, they result in a formal relationship which may not be most appropriate to all illness. The type of relationship which develops between doctor and patient on a therapeutic milieu, say of the psychiatric kind -- although it does include some of the characteristics mentioned previously -- yet varies in that the patient is allowed

[5]Talcott Parsons. The Social System. The Free Press of Glencoe. 1951. pp. 428-473.

more freedom of emotional expression and involvement, with the doctor varying between a response of support and a denial of reciprocity. However, in the non-psychiatric medical practice the transaction is more specific in nature and more limited to delineation of physical symptoms. This will be seen by referring back to Chapter 4, in which the interviews of doctor/patient were described, and these seemed "ideal" of the doctor role in terms of functional specificity; technical expertise and affective neutrality.

Discussion and Conclusions

Following on from the previous discussion, we implied that the filling of the "normal" role expectations of a doctor was restricting in the particular setting of alcoholism. If alcoholism is an illness yet it is a very different illness than measles. It is a social illness, and the aim of the clinic states that it treats "the physical and social aspects of this complex disease". We are suggesting that the two aspects - the physical and the social - cannot be segregated successfully. The pattern of organization of an alcoholic clinic cannot be that of a strictly out-patient clinic - even an emergency out-patient clinic must consider itself as an emergency as well as a medical unit.

The involvement of the medical world in a sphere of the socially disvalued condition of alcoholism is seen to raise special

problems. First if the patient is to be protected from the still existing sanctions against his condition - from work situations in which he might be defined as unreliable and untrustworthy were his condition to become known - then the clinic must provide for protection for his identity. This the clinic does provide - however it must be seen that the patient must be conscious of such possibilities of being "found out" and of the clinic's protection. This perhaps lends weight to the moral considerations of alcoholism as "something to hide" and presumably therefore of something of which to be ashamed. It can be seen then that the clinic is in something of a double bind in this situation for whilst alcoholism continues to be disvalued by employers and other members of the patient's social world - the clinic must continue to provide secrecy and protection for its patients. But in doing so it may be giving weight to the moral concerns of alcoholism as being something to hide rather than as just another undesirable illness which may be treated openly, in a general hospital.

The clinic also takes cognizance of its special role in varying manner. The employment of a social welfare worker and the consultant work of two psychiatrists are to be seen as efforts to integrate the services of social, therapeutic and medical. However we can speculate on the success of this but feel that it might present the patient with fragmented relationships,[6] at a

[6] See - Morris E. Chafetz, M.D. "A Procedure for Establishing Therapeutic Contact with the Alcoholic". Quarterly Journal of Studies on Alcohol. 22. No.2. June 1961. pp. 325-328 who writes that "confronted with tenuous fragmented relationships, the alcoholic cannot form effective therapeutic alliance".

time when he has difficulty in forming any relationships. The indications seem to be that the patient wants to see the doctor but that he expects more from the doctor "than just pills".[7]

What "the more" that he expects is perhaps "to find myself and not be a lost lose person".[8] In other words he expects some guidance, or resocialization into the values of conformity culture. If he already holds these values then he appears to be in a better position for maintaining treatment. But if he is not equipped with the prior motivation then the clinic does not seem structurally equipped to socialize him into motivation. The nature of an out-patient clinic with a brief allotment of time given every week or so, is obviously not in a strong position to re-educate, nor is the present role of the medical doctor, untrained to coping with the therapeutic and social aspects of alcoholism, and restricted by an image of a doctor role which governs the expected behaviour of doctors from mumps to measles through alcoholism.

The resocialization of the alcoholic, through the auspices of Alcoholics Anonymous, seems to be one answer to the problem. It is one that is suggested by the World Health Organization[9] for incorporation with clinic treatment, and one that is augmented by the clinic under study. The clinic accepts and

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[7]Verbatim statement from patient.

[8]Verbatim statement from patient.

[9]Expert Committee on Mental Health. Alcoholism Subcommittee. Second Report No. 48. World Health Organization. p.5.

suggests that its patients contact Alcoholics Anonymous. To this researcher, this seems an unsatisfactory arrangement - if we are correct in the assumption of the illness conception as an alternative to the "moral" and religious conception. For Alcoholics Anonymous inculcate, within their members, an ideology that is religious in flavour and tone.[10] Entrance into Alcoholics Anonymous is tantamount to a conversion experience, and the creeds and way of life of the organization become a total commitment at the expense of other more "normal" and secular activities. And, it is the latter area that ideally the patient should be rehabilitated.

The findings relating to patient's values - reported in Chapter 5 - were not only do those patients who are highly committed to "moral" values stay in treatment twice as often as those who remain neutral on this issue; but also those patients who strongly reject the "moral" view. We believe that those patients who reject the "moral" view will be those who take the secular view of alcoholism as an illness to be treated. A limit of this study was that this area - the secular - was not sufficiently

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[10] See - Irving Peter Gellman. The Sober Alcoholic. An Organizational Analysis of Alcoholics Anonymous. College and University Press. New Haven. Conn., 1964. who writes of the most frequently quoted slogan being "A A is a way of life", and of the time and energy devoted to A.A. Also of rituals and "sacred" artifacts intrinsic to A A - see p.65. Further the A A involves a philosophy contained in its "Twelve Steps", and prayers as for example the "Serenity Prayer".

defined and located. We suggest that further study should be made in this area. To do so, and to implement the positive commitment of patients to a secular view of alcoholism, not only as an illness to be treated but with health as a positive value, seems to be the inevitable area, as one towards which our society is moving, and as the area within which social control agencies should concern themselves.

In this case, it would seem as though fragmentation of contacts for the patients through differently trained specialists should be kept at a minimum, and that increasingly the medical doctor should be the one focus of full attention for the patient. This would indicate a return to social medicine in a true sense, and would be a speciality within the medical profession. The nature of the 'ideal' patient, if instead of referring to those patients who are <u>already</u> motivated to be rehabilitated, could be redefined in terms of those who are <u>still to be</u> motivated, then this process would be seen as reflecting the physicians'role as, not only healer of the sick, but as promoter of the healthy.

Appendix A

Comparison of Attendance with Patient's "Background" Variables with accompanying Chi-Square Analysis

KEY TO ABBREVIATIONS

Religion:	P	Protestant
	$\overline{P}$	Non Protestant
Ethnicity:	E	English or Canadian (unspecified)
	$\overline{E}$	Other
Marital Status:	M	Married - including separated
	$\overline{M}$	Non married - single and divorced
Pressure:	+	From legal agencies and/or employer
	-	Appointments without legal or employer referral

D.O. :* "Drop-out" - 3 or less visits to the clinic

R.A.: Regular Attender -- more than 3 visits to the clinic

* The "drop-out" population excluded those patients who had been transferred to institutions; those patients who were known to have left the locality; and female patients (by virtue of their numerical insignificance in the total patient population). The total N of "drop-out" patients in the two year period was found to be 168.

Comparison of "Drop Out" Population and Regular Attender Population by Background Variables

		Drop Out	Regular Attender	%
Pressure:	+	55	56	33.0
	-	113	112	66.0
Religion:	P	110	108	64.3
	$\overline{P}$	58	60	35.7
Age:	35 and over	119	111	66.1
	under 35	49	57	33.9
Ethnicity:	E	94	84	50.0
	$\overline{E}$	74	84	50.0
Education:	Grade 8 and over	97	96	57.1
	under Grade 8	71	72	42.9
Marital Status:	M	127	138	82.1
	$\overline{M}$	41	30	17.9

Pressure x Attendance

Pressure	D.O.	R.A.		Total	
+	55	56	(33.3%)	111	
-	113	112	(66.6%)	225	$X^2 = 0.0134$ *
Total	168	168		336	

Religion x Attendance

Religion	D.O.	R.A.		Total	
P	110	108	(64.3%)	218	
$\overline{P}$	58	60	(37.3%)	118	$X^2 = .0522$ *
Total	168	168		336	

Age x Attendance

Age	D.O.	R.A.		Total	
35 and over	119	111	(66.1%)	230	
under 35	49	57	(33.9%)	106	$X^2 = .8820$ *
Total	168	168		336	

* Not significant at the .05 level

Ethnicity x Attendance

Ethnicity	D.O.	R.A.	Total	
E	94	84 (50.0%)	178	
$\bar{E}$	74	84 (50.0%)	158	$X^2 = 1.1947$ *
Total	168	168	336	

Education x Attendance

Education	D.O.	R.A.	Total	
Grade 8 & over	97	96 (57.1%)	193	
Under Grade 8	71	72 (42.9%)	143	$X^2 = 0.0121$ *
Total	168	168	336	

Marital Status x Attendance

Marital Status	D.O.	R.A.	Total	
M	127	138 (82.1%)	265	
$\bar{M}$	41	30 (17.9%)	71	$X^2 = 2.1608$ *
Total	168	168	336	

* Not significant at the .05 level

Appendix B

Sample Questionnaire

Here are some statements about your views on the use of alcohol. Would you please check one (only) of the five choices in each case. Thank You.

1. Alcoholism has harmful consequences for the society in which we live.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

2. Alcoholism is offensive to one's own personal standards.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

3. Alcoholism does not harm the friends and relatives of those who drink.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

4. Alcoholism is an illness.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

5. To overcome alcoholism it is necessary that the patient should actively strive to get better.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

6. Alcoholism is a vice.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

7. There is nothing wrong in drinking.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

8. Drinking does not have any effect on the moral character.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

9. To be an alcoholic is to be ashamed.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

10. The alcoholic is a sick man and therefore need not feel ashamed.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

11. The alcoholic should be allowed a certain time to get better.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

12. To overcome alcoholism it is necessary that the patient co-operate with the staff of the clinic.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

Part 2

Now here are some questions on how you think the clinic staff view alcoholism.

I expect that the clinic staff -

13. --- will view alcoholism as having harmful consequences for the society in which we live.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

14. --- believes alcoholism to be offensive to personal standards.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

15. --- believes that alcoholism does not harm the friends and relatives of those who drink.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

16. --- believes that alcoholism is an illness.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

17. --- will believe that the patient should actively strive to get better.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

18. --- will believe that alcoholism is a vice.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

19a --- will take the view that there is nothing wrong in drinking.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

19b --- will think that there is nothing wrong in drinking.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

20. --- will believe that drinking does not affect the moral character.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

21. --- believes that to be an alcoholic is to be ashamed.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

22. --- views the alcoholic as a sick man and therefore one who need not feel ashamed.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

23. --- will think that the alcoholic should be allowed a certain time to get better.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

24. --- will expect the patient in order to overcome alcoholism, to co-operate with the staff.

Strongly agree ___
Agree ___
Undecided ___
Disagree ___
Strongly disagree ___

Part 3

Here are some more personal questions about how you feel. Give yourself time to think before you answer.

1. I believe myself to be an alcoholic. Yes ___
No ___

2. I believe that the clinic thinks of alcoholism as an illness. Yes ___
No ___

3. I believe that the clinic will regard me as an alcoholic. Yes ___
No ___

4. Here is space to explain in your own words how you felt about coming to the clinic; for example, were you afraid or ashamed to come? Or has coming to the clinic made you think more or differently about yourself and about alcoholism? Please explain fully.

5. In your own words, what do you expect the clinic will be able to do for you?

6. How long do you think treatment will take?

7. Who do you think would be most pleased if you stopped drinking - i.e. yourself, your wife, your mother .....

8. Do you have any drinking friends who approve or encourage you in your drinking habits?

Yes____
No ____

9. On the whole, would you say that your friends and/or family approve or disapprove of your drinking?

Thank you.

Appendix C

The Relationship Between Attendance and Patients' Moral Attitudes with accompanying Chi-Square Analysis

RETAINED QUESTIONS ON LIKERT TYPE SCALE

"MORALITY " QUESTIONS

Group	Number	Score 1	2	3	4	5	Weighted Total	high-low differential	D.P. (mean of differential)
* Item No. 13									
High	8				1	7	39	11	1.37
Low	8	1	1	1	3	2	27		
Item No. 14									
High	8			1	1	6	37	11	1.37
Low	8	2		1	4	1	26		
Item No. 15									
High	8				3	5	37	9	1.12
Low	8	1		2	4	1	28		
Item No. 18									
High	8			1	1	6	37	17	2.12
Low	8	1	3	3	1		20		
Item No. 19									
High	8	1	1		3	3	30	11	1.37
Low	8		6	1	4		19		
Item No. 20									
High	8		1		5	2	32	12	1.5
Low	8	1	4		3		20		

* See corresponding questions in questionnaire - (Appendix B.)

Group	Number	Score 1	2	3	4	5	Weighted Total	high-low differential	D.P. (mean of differential)
Item No.19b									
High	8		2	1	2	3	30	12	1.5
Low	8		6	2			18		
Item No. 6									
High	8			1	2	5	36	11	1.37
Low	8		2	4	1	1	25		
Item No. 7									
High	8		2		3	3	31	11	1.37
Low	8		5	2	1		20		
Item No. 9									
High	8				3	5	37	15	1.87
Low	8	1	4		2	1			
Item No. 3									
High	8				4	4	36	9	1.1
Low	8			1	6		27		
Item No. 8									
High	8				5	3	35	13	1.62
Low	8		2	2	3		22		

Group	Number	ILLNESS QUESTIONS Score 1	2	3	4	5	Weighted Total	high-low differential	D.P. (mean of differential
Item No. 4									
Low	8			2	2	4	34	3	.0
High	8			1	1	6	37		(discarded)
Item No. 10									
Low	8	2	6				14	26	3.2
High	8				5	3	40		
Item No. 22									
Low	8		4	2	2		20	17	2.127
High	8			1	1	6	37		
Item No. 11									
Low	8	2	1	3	2		29	1	.12
High	8	2		2	4		30		(discarded)

As many items as possible should reach a D.P. of 1.00, and few if any should drop below 0.50.

Attendance x Moral Attitudes

Moral Attitudes	Drop-Out	Regular Attender	Total	
*High & Low Score	8	8	16	
				$x^2 = 2.86$**
Medium Score	14	4	18	
	22	12	34	

* By "High" scorers we mean those patients who attached considerable moral stigma to alcoholism; those in the "Medium" group were quite neutral regarding any feelings as to moral implications; the "Low" scorers were those who held a secular view of alcoholism in that they strongly repudiated the idea that alcoholism carried a connotation of moral shame.

High scores and low scores were identical in attendance patterns, i.e.;

Moral Attendance	Drop-Out	Regular Attender
High Score	4	4
Low Score	4	4

** In a Chi Square test, as with other statistical tests used to investigate the relationship between two variables, the hypothesis is stated in negative terms; this is called the null hypothesis. In the test above the implicit null hypothesis is that "there is no relationship between 'Attendance' and 'Moral Attitudes'." Our findings permit us to say that at the .1 level of significance this null hypothesis can be rejected since <u>there is</u> a relationship between the two variables being investigated.

Generally speaking statisticians do not use a .1 level of significance. Normally a .05 level of significance is the accepted level. This means that if the assumption of the null hypothesis is correct the chance of obtaining a Chi Square this large or larger is one in twenty. We have used a more liberal level because we are dealing with a small N

(or total sample). Blalock states "that when a sample is small it requires...a striking relationship in order to obtain significance." In other words significant relationships are more difficult to obtain when the N is small as compared to large samples. For example he states that with large samples "a difference may be stastically significant without being significant in any other sense" or that it has little meaning. In the present situation it therefore seems reasonable to assume that if the study was replicated with a larger sample our results would be far more striking than they currently appear. (For an elaboration of this point see Herbert M. Blalock, Social Statistics, New York: McGraw-Hill Book Company, Inc., 1960, pp. 225-227.)

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