

MORAL ACCOUNTS: THE NARRATIVE RECONSTRUCTION OF THE  
ALCOHOLIC EXPERIENCE IN A CLINICAL SETTING

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Thesis presented for the degree of PhD in the  
University of London

February 1996

Goldsmiths' College



## ABSTRACT

This thesis is a sociological study of the narrative reconstruction of alcoholic patients' accounts of their life experiences including drinking, in a clinical setting. The research data consist, *first*, of forty tape-recorded, unstructured interviews with alcoholic patients admitted to a 4-week intensive treatment programme in an Alcohol Treatment Unit, based in a psychiatric hospital. *Second*, professionals' letters referring to alcoholic patients constitute additional data for the analysis.

The focus of the study is to describe what is accomplished by patients' and professionals' discourses, and how it is done. Following arguments developed by Voysey (1975), Cuff (1980) and Baruch (1981), patients' accounts of their life experiences are treated as situated accounts constructed to display respondents as morally adequate individuals. Professionals' discourses are treated as discourses which also constitute patients as morally responsible persons.

The qualitative analysis of the narrative structure of alcoholic patients' accounts, through the Membership Categorisation Device (Sacks, 1972), indicates patients' skills and competence in producing a new version of reality, using the appropriate vocabulary (Mills, 1940) for a clinical setting.

Some tabulations of categories used in descriptions have helped to show consistency throughout the data. Some explanations for the findings are explored in terms of the context, gender differences and the ambiguity found in formulations of alcoholism.

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**For my parents and my family**

## ACKNOWLEDGEMENTS

I would like to thank the alcoholic patients who consented to participate in tape-recorded interviews, and the Director of the Alcohol Treatment Unit, Dr G.K. Shaw, who kindly gave permission to conduct this study. My thanks are also due to Professor Gerry Stimson for his useful suggestions in the initial stages of the thesis.

Finally, I want to thank my supervisor, Professor David Silverman, whose guidance, helpful comments and encouragement, throughout this study, provided me with the motivation necessary to complete the thesis.

## PART I. INTRODUCTION

### Chapter One: Aims of study, literature review, and description of the Alcohol Treatment Unit

#### a) Aims of study

The aims of this study may be summarised by the following points:

1. To show how alcoholic patients account for their experiences in a clinical setting, at an unstructured interview. Using Sacks (1972) to explain the ways in which they display and formulate their moral adequacy through the construction of their talk. Using Saussure (1960) to analyse the narrative structure of alcoholic patients' accounts by means of syntagmatic and paradigmatic approaches.
2. To show how professionals formulate patients' drink problem and their moral adequacy.
3. To explain how patients' accounts and professionals' letters accomplish intelligible accounts, and how they compare.

This study is about alcoholic patients' presentations of their life experiences, and the ways in which they account for their drink problem. I will show how patients and professionals accomplish intelligible moral accounts through devices based on Sacks's (1972) membership categorisation. In Part II, I will describe similarities and differences in their methods.

The general narrative structure of patients' accounts will

also be presented in Part II. Following Saussure (1960), a syntagmatic and paradigmatic approach will highlight the plot structure, the logical and chronological sequence and meanings of different parts of the account.



## **b) Review of medical and psychological theories of alcoholism**

Most theories of alcoholism have been based on quantitative approaches (e.g. variable based, quantitative with ex post facto 'interpretations'). The quantitative literature contains no single agreed definition of alcoholism, nor of the alcoholic personality which has been the focus in the 1930s to the 1970s.

However, the quantitative literature remains focused on what *type* of individual becomes an alcoholic i.e. the personality of the alcoholic, *when* and *why* i.e. under what circumstances is the individual considered an alcoholic and what are the reasons for his alcoholism. The approach requires searching for objective factors, and little attempt is made to explain how and why alcohol problems are presented by individuals labelled as alcoholics.

Following the research findings of the Yale School of Alcohol Studies and the founding of Alcoholics Anonymous, the World Health Organisation recognised alcoholism as a disease, in 1951. In an American survey (Mulford and Miller, 1964), a random sample of the general public gave their views of the alcoholic. The alcoholic was perceived as being sick, as suffering from an illness or a disease, and yet lacking willpower and self-will.

The predominant medical or disease concept of alcoholism in the West reflects this ambiguity between medical and moral

versions of the condition. Alcoholism, as a disease or an illness, is not the responsibility of the drinker. However, the concepts of self-responsibility and self-control lay the responsibility on the drinker who abuses alcohol.

In the 1970s, it has been suggested that individuals who develop alcohol problems should be referred as 'problem drinkers' rather than 'alcoholics' (Cahalan, 1970). This implied that alcoholics are far from being uniform (Pattison et al, 1977). 'Problem drinking' is often used in the current literature.

In this section, I shall present and discuss the predominant medical and psychological perspectives on alcoholism including the disease concept, the Alcoholics Anonymous perspective, genetic theories, behavioural/learning theories and psychoanalytic theories. I will later deal with conventional sociological views of alcoholism, in I.1.c.

#### Disease concept of alcoholism, craving and loss of control

Discussions of the disease concept of alcoholism date from the 18th century (Levine, 1978). However the medical model, as a scientific approach, has been advanced by the Yale Centre of Alcohol Studies in the 1940s. Craving and loss of control have become part of modern medical formulations of alcoholism (Jellinek, 1941 & 1960; Keller, 1972).

Jellinek (1960) differentiated five species of alcoholism,

i.e. *Alpha*, *Beta*, *Gamma*, *Delta* and *Epsilon*, which incorporate concepts of addiction, craving and loss of control.

i) The *Alpha* alcoholic is described as a psychologically dependent alcoholic with no physical addiction.

ii) *Beta* alcoholism is one where there is a physical illness such as cirrhosis of the liver or gastritis, without physical or psychological dependence.

iii) *Gamma* alcoholism is characterised by increased tissue tolerance, withdrawal symptoms, craving and loss of control.

iv) The *Delta* alcoholic is the continuous drinker with the three characteristics of the gamma type, but instead of the loss of control, Delta alcoholism includes 'inability to abstain'.

v) The *Epsilon* alcoholic is the periodic alcoholic.

Jellinek stated that only Gamma and Delta species of alcoholism can be considered as diseases.

However, he had difficulty in defining disease in this context, and suggested that '*a disease is what the medical profession recognises as such*' (1960, 12). This position is similar to my approach, in this study, as I present medical professionals' formulations of alcoholism, and also 'lay' (patient) accounts of the condition.

Mark Keller (1972) is often seen as carrying on Jellinek's tradition and defending the Yale Centre's position. He too, following Jellinek, explains alcoholism as a disease based on the concept of 'loss of control' and 'compulsion to drink'

which emphasise the involuntary aspect of the disease, therefore removing moral responsibility from the individual.

It has been pointed out that the recognition of the larger political utility of the conception of alcoholism as an identifiable entity became a common theme in American sociological and public-health writing on alcohol issues by the end of the 1970s (Room, 1983). Attention has been drawn, since the 1970s, to prevention issues. Cahalan (1970) suggested that 'problem drinking' ought to be considered as a preferable term to 'alcoholism', as it highlights the multidimensional nature of the problem and that it is not a single entity.

Pioneered by Griffith Edwards (1973), a British psychiatrist, this 'alcohol-related problems' approach gave way to a non-disease conceptualisation which at the same time referred to a disease-like entity, i.e. 'alcohol dependence syndrome' (Edwards et al, 1976). This formulation, which included a variety of physical and psychological characteristics was discussed at a World Health Organisation meeting, followed by a publication (1980). This publication highlighted the new notion that although a wide variety of problems are related to the development of the 'alcohol dependence syndrome', alcohol dependence constitutes only a small part of the total of alcohol-related problems.

Concepts such as 'loss of control' and 'craving' have thus

become the jargon of alcohol researchers in the quantitative alcoholism literature. Craving is defined by Edwards and Gross (1976), as a sign of subjective awareness of a 'compulsion to drink', which is in turn one of the central elements of the 'alcohol dependence syndrome'. 'Compulsion to drink' is included in a recent definition of alcohol and drug dependence by World Health Organisation (1993). Therefore, alcoholism has been medicalised and the alcoholic has been defined as suffering from a disease or illness called 'alcoholism'.

Sociologists such as Ivan Illich (1976) and Peter Conrad (1980) have pointed out that, in recent years, the jurisdiction of the medical profession has expanded and included many problems that formerly were not defined as medical entities. Illich refers to this as 'medicalisation of life', and Conrad calls it 'medicalisation of deviance'.

Illich focuses on all aspects of life such as pregnancy and childbirth, diet, exercise, drug addiction, alcoholism, etc. Conrad's interest lies in medicalisation of deviant behaviour such as crime, violence, drug addiction, alcoholism, mental illness which have been labelled as medical problems, as illness. The medical profession has been mandated to provide some type of treatment for these problems. This highlights the social construction of disease and illness.

Nevertheless, the disease model of alcoholism has been

accepted by self-help groups such as Alcoholics Anonymous (AA), which has led to its widespread dominance in Western cultures.

#### The Alcoholics Anonymous (AA) perspective

Alcoholics Anonymous is based upon a theory of understanding that presumes that understanding of alcoholism derives from the shared, common experiences of alcoholics. AA was founded in the USA in 1935, and began to establish itself in the UK in the late 1940s. The AA meeting is of great importance to AA's functioning. The number of people will vary from group to group, but is usually around 10 to 20. A chairman is elected for the evening, and he/she will probably be sitting at a table with one or two members who have been asked to give their 'stories'. The meeting will start with the chairman saying 'My name is Tom. I am an alcoholic'. Only first names are used. Informality is emphasised. The starting point of the evening is thus one individual's reaffirmation, which, in AA terms, is the starting point of recovery for every individual, i.e. the admission that he or she is suffering from alcoholism. Reference is often made during the meeting to 'The Twelve Steps' which represent the basic ideology of AA, and members are strongly urged to follow them. These steps indicate clearly that AA is a quasi-religious movement. The individual confesses his or her alcoholism, understood as sins, and repents. For instance, one step states that the individual admits to God the exact nature of his/her 'wrongs', and another refers to him or her being ready to have God

remove all 'defects of character'. Old drinking friends are dropped, and new friends found who think and talk AA.

This religious aspect of AA is contradictory to its claim, as has been pointed out by Alasuutari (1990), that an alcoholic is a sick person, not responsible for his or her behaviour or condition. This reflects the ambiguity between 'moral' and 'medical' versions of alcoholism which will be discussed in Chapter Nine. Alasuutari's approach to the study of alcoholism will be described in Chapter Three, when discussing the literature used in the analysis of the data.

AA therefore defines alcoholism as a disease in its own right, as an allergy to alcohol. The illness is conceptualised as being physical, mental, spiritual, emotional and self-destructive. The illness is in remission only through death or abstinence from alcohol. The individual is thus an alcoholic for life, hence the AA belief 'once an alcoholic, always an alcoholic'. This contradiction is weakened, however, by AA's belief that an alcoholic cannot help himself or herself alone, without group support and a power greater than himself/herself. This ethical and philosophical position of AA places itself at odds with the claims of most modern science. AA refuses to accept that a return to a normal drinking style is possible for the alcoholic. AA's presentation as a treatment model based on medical knowledge about alcoholism as a disease, is suggested by Alasuutari to be a 'legitimation strategy'. As alcoholism has become a

medical condition, and the disease model, part of medical knowledge, AA's claim for offering a way to treat one's alcoholism becomes a legitimate claim. Despite the widespread acceptance of the disease model of alcoholism, further explanations of what type of individual develops this disease have been offered by genetic theories.

#### Genetic theories of alcoholism

Goodwin and Guze (1974), Madsen (1974), Goodwin (1976,1979) and Schukitt and Duby (1983) have all contributed to the debate on genetic factors in alcoholism. Goodwin (1979) has suggested that there are genetic variations in the response to alcohol that could predispose an individual to abuse or avoid the use of alcohol. These variations include (i) adverse reactions to alcohol such as the 'flushing' response in Japanese subjects which may result in an intolerance to alcohol, (ii) factors that enable a high intake of alcohol, and (iii) differences in the way that alcohol affects the brain, leading to more euphoria in some individuals than others.

More recently, Schukit and Duby (1983) have also shown a possible genetic factor in the metabolism of alcohol. However, these findings have not led to a genetic theory of alcoholism as such. Environmental factors have been taken into account.

Ullman (1958) has argued that the 'integration hypothesis' would suggest that family, religious, work and ethnic groups



will have lower rates of alcohol problems, when they have clear rules on the use of alcohol. It has been reported that the Italians and the American Jewish community have integrated alcohol use successfully into their group structure, thus have very low incidence of alcohol problems (Bales, 1946; Beauchamp, 1980). On the other hand, the Irish (Stivers, 1976), American Black and Hispanic communities (Kane, 1981) have not integrated alcohol use successfully.

This 'integration hypothesis' mediates to some extent the genetic predisposition argument, but does not explain how 'alcohol-integrated' cultures identify some of their members as alcoholics. In opposition to the disease model of alcoholism as well as genetic theories, psychologists have developed their own theories of alcoholism.

#### Behavioural, learning theories of alcoholism

Behavioural psychologists disagreed with the Alcoholism Movement's absolute commitment to lifetime abstinence. They have been more identified than sociologists with a position antagonistic to the disease concept of alcoholism. The main behavioural science theories seek causal explanations. They search for inner psychological states that precede drinking and for social, psychological and cultural factors that lead to a psychological predisposition to drink (Madsen, 1974).

'Tension' or 'anxiety reduction' theory defines drinking as a learned means of reducing anxiety present in the psychological

and social environments of the drinker (Conger, 1951; Ludwig, 1983). Dependency on alcohol is assumed to be established in predisposed individuals who learn to use alcohol to achieve states of euphoria and to reduce feelings of anxiety or tension. The use of alcohol continues as a reinforcer, producing reduction in unpleasant cognitive and emotional states. Individuals drink gradually more to feel normal, as an increased consumption is required in the process of withdrawal (Ludwig, 1983).

Two studies (Mello, 1972 & 1983; Sobell and Sobell, 1978) offer behavioural analyses based on methods of conditioning. Mello studied the alcoholic's preferred pattern of drinking and the reinforcing effects of alcohol, whilst Sobell and Sobell claimed to have succeeded in 'shaping' the behaviours of the alcoholics in their study so that they could practice controlled social drinking. Behavioural theorists have incorporated the possibility for alcoholics to return to normal drinking. Since the report by a British clinician, Davies (1962), it has been argued that at least certain types of alcoholics could return to normal drinking (Pattison, 1966; Pattison et al, 1968; Armor et al, 1978; Pendery et al, 1982). Davies had reported that 7 alcohol addicts from his sample of 93 had returned to normal drinking after a period of abstinence. The sociologists, Armor, Polich and Stambul (1978), produced the Rand Report and played a role in the support for the idea that alcoholics were capable of 'controlled drinking'.

Denzin (1987) defines behaviourist, learning theories of alcoholism as an experimental branch of natural science. He criticises them for excluding any cognitive or emotional interpretations of alcoholic learning (factors such as meaning, intentionality and self). On the other hand, he offers a theory of an emotionally ill 'self', a divided self based on Laing's (1965) theories and dependent on Alcoholics Anonymous members' stories which convey emotional and spiritual experiences. The search for emotional interpretations is also taken up by psychoanalysts.

#### Psychoanalytic theories

Psychoanalytic theories centre around themes of sexuality and childhood experiences which relate to alcoholism in adulthood. McClelland et al's (1972) power theory of drinking refutes the theory that argues that men drink primarily to reduce their anxiety, as well as dependency theory. They suggest that men who have accentuated needs for personal, not social, power drink excessively. They argue that such men have a desire for personal dominance over others, a desire to gain power and glory. This formulation is not well developed for female heavy drinkers. Williams (1976), on the other hand, emphasises the alcoholic's need for dependency. He argues that the prealcoholic has a permanently unfulfilled desire or need for maternal care and attention, and yet he is ashamed of this need and wants to be free of this care. A dependency conflict, thus created, originates in childhood. Both theories are concerned with heavy drinking and inadequate

masculine identity; The power theory emphasises the 'need for power-conflict' whilst the dependency theory emphasises early childhood experiences. These theories, however, have not been as widely accepted as the disease model which has been adopted by the '*Alcoholism Movement*', a term used to describe initially the work of the Yale Centre of Alcohol Studies.

**c) The '*Alcoholism Movement*' and sociological views of alcoholism**

The '*Alcoholism Movement*' included writings by early sociologists such as Bacon (1949). The movement's acceptance of the disease model of alcoholism meant that a new scientific approach had replaced the old moralistic approach, and that there was a singular entity called alcoholism which was different from 'normal drinking'. This entity was thought as a disease which the alcoholic suffered involuntarily. It was therefore rational and humane to treat alcoholics as sick, rather than as immoral or criminal.

In the 1940s and early 1950s, Bacon (1949) played a leading role in the alcoholism movement and adhered to the movement's disease concept of alcoholism. However, in the same period, some sociologists ignored the alcoholism movement's emphasis on the disease concept, and studied drinking patterns and problems in a broader sense (Riley and Marden, 1947; Lemert, 1951).

Sociological criticism emphasised the acceptance of the disease concept as a matter of social policy rather than a

scientific discovery. This produced an angry response by Keller who condemned those social scientists who would criticise the disease concept, and suggested that they ought to leave it to formulators of social policy at the Yale Centre of Alcohol Studies. Sociological work in the late 1950s and 1960s was already centring around criticism of the disease concept (Pittman and Snyder, 1962; Seeley, 1962; ; Mulford and Miller, 1964; Roman and Trice, 1968; Christie and Bruun, 1969). Sociologists were differentiating themselves from the alcoholism movement.

More recently, sociological studies have centred around life stories told by Alcoholics Anonymous members. Thune (1977) and Denzin (1987) have analysed stories told by members of Alcoholics Anonymous, with a 'life history approach', concentrating on the relation between active and recovering alcoholics. Denzin's theory, which was briefly mentioned above in 1.b., will be described further following a description of Thune's approach.

Thune has used a phenomenological perspective to examine the treatment programme of AA members. He suggests that insight into an individual's life comes from an analysis of the world as he constructs it. Central to this personalised world is the individual's vision of what constitutes his own self. He argues that the nature, the meaning and experience of these constructions of the self and the world by an alcoholic are subject to an ongoing process of reconstitution and

redefinition, both in the process of his becoming an alcoholic and in the course of any successful treatment and recovery programme.

Thune states that he believes that the success of AA lies in its claim that a treatment directed at reconstitution and redefinition of self and world provides a better way to deal with alcoholism than a model holding it analogous to physical diseases. He suggests that AA's 'treatment' involves the systematic manipulation of symbolic elements within an individual's life to provide a new vision of that life, and his world.

This approach is developed further by Denzin (1987) who presents a symbolic interactionist theory of the recovering alcoholic self, based on his study of AA members' confessional self stories. He describes alcoholism as a 'disease of time and emotion'. He argues that the alcoholic is an emotionally ill individual, and experiences, as noted earlier, a divided self (Laing 1965). The alcoholic is trapped within an inner structure of negative emotional experiences that turn on extreme self-centredness and self-narcissism. He further suggests that a resentment toward self and others is produced which is focused on gaps and failures in achievement. The alcoholic, Denzin suggests, uses alcohol as a mirror, seeking in the self-reflections that alcohol offers a truer picture of himself. Deriving from psychoanalytical theories of the self, Denzin further suggests that the alcoholic has

internalised a conflicting set of inner self-ideals which derive from a 'mothering' or 'fathering' figure, and from his own version of those ideals.

Thus, Denzin explains that alcohol becomes a means of joining these two self-structures, and consequently, the recovering alcoholic undergoes a radical transformation of self. The alcoholic becomes an 'outsider' as society continues to sanction the cultural and interactional use of alcohol on a regular basis. Denzin is imposing an interpretation that comes from outside the research context, and he may have overlooked the possibility that AA members could be influenced by cultural emphasis on accounts which appeal to 'feelings' and 'emotions' (Silverman and Bloor, 1989).

A sociological view of the changing concepts from habitual drunkenness to alcohol addiction is discussed by Harry Levine (1978). He argues that the development of the modern conception of alcoholism as an addictive disease dates from the late 18th century. He points out that, in the last 200 years, definitions of habitual drunkenness have been shaped by developments in thought about deviance, and particularly about mental illness. Until the end of the 18th century, 'drunkards' were regarded as individuals who loved to drink and sometimes drank to excess. Drunkenness was a choice, a sinful one, which some people made. The characterisation of alcoholism as an addiction occurred in the late 18th century by Dr Benjamin Rush, regarded as the founder of the Temperance

movement, who also reconstructed madness as a disease. Alcoholism as an addiction and a disease was 'rediscovered' in the 1930s and 1940s by Alcoholics Anonymous and the Yale Centre of Alcohol Studies.

Levine suggests that the medical model of madness in general, in Europe and the United States at the end of the 18th and beginning of the 19th centuries, was a model of deviance in general and part of the new world view of the middle class. The therapy called 'moral treatment' replaced the traditional mechanisms of social control with fear and guilt. The 'mad' were now expected to control themselves, and madness had become a curable disease, with its main symptom as loss of self-control. Thus social control depended upon self-control. Levine states that self-control had become very important to the middle class, and refers to Weber (1958) who argued that the conditions of life in capitalist society required that individuals methodically regulate their activities in order to survive and succeed. Levine further suggests that the reformulation of drug and alcohol problems does not look primarily at the interaction between individual and drug, but at the relationship between individual and social environment. The rise of the new popular and scientific 'gaze' is rooted as the old one was, in changes in the organisation of daily life.

Levine argues that the disease or illness conception of alcoholism has not succeeded in removing the stigma of 'self'



from the conduct of the alcoholic. He suggests that if a new model of alcohol problems were to emerge, it would have to be part of a reformulation of social problems in general. Thus any new paradigm or model would have to compete and coexist with the addiction perspective for a long time, just as, for the last 200 years, the addiction model has had to compete and coexist with the preaddiction view.

Levine's historical and cultural analysis is further discussed by Fitzpatrick (1986), a sociologist from Middlesex Hospital, London. He argues that the majority of people, if asked whether alcoholism is a disease, would reply that it is, whilst in the Victorian era, people would regard it as a moral weakness. He points out that social criteria are being brought into the definition of disease, which considerably extend the term beyond its orthodox medical usage. He offers an explanation for the modern 'multifactorial' approach to disease, which, he states, is socially determined. He explains that this approach refers to a combination of environmental and behavioural factors, interacting with genetic predispositions, which place the individual at greater risk, whether through long-term consumption of an inappropriate diet, or stress.

He further suggests, following Robinson's (1976) and Strong's (1980) arguments, that what troubles doctors most is whether they can help the alcoholic. Strong has argued that although few doctors seem to blame the alcoholic in a moral sense, they

nevertheless feel irritated about their involvement in a problem where patients often deny their 'illness' and are poorly motivated to cooperate in treatment. Doctors feel that there are few effective medical remedies available for what they see as a complex social problem.

Explanation for the widespread acceptance of the disease model of alcoholism, despite its problematic aspects, has been provided by Robin Room (1972 & 1983), a sociologist from the Alcohol Research Group, Medical Research Institute of San Francisco. He has argued that the promulgation of disease concepts of alcoholism have been brought about essentially as a means of getting a better deal for the alcoholic rather than as a logical consequence of scholarly work and scientific discoveries. He suggests that the public presentation of the disease concept of alcoholism has been consistently vague concerning the content of the concept. He suggests that the recognition of the larger political utility of the conception of alcoholism as an identifiable entity became a common theme in American sociological and public-health writing on alcohol issues by the end of 1970s. Alcohol sociologists tended to maintain their isolation from the labelling literature with the exception of Roman and Trice (1968). Roman and Trice pointed out that the disease concept of alcoholism has led to the assignment of the labelling function to medical authorities which in turn has led to the placement of alcoholics and deviant drinkers in 'sick roles'. They suggest that the expectations surrounding these sick roles serve to

further develop, legitimise, and in some cases even perpetuate the abnormal use of alcohol.

### **Conclusion**

Discussions concerning the medical model of alcoholism as a disease predominate in the quantitative alcoholism literature, and concepts such as 'loss of control', 'craving' or 'compulsion to drink' have become part of the accepted jargon. In their critique of the disease concept of alcoholism, behavioural psychologists and psychiatrists have offered counter-conceptions, whilst sociologists have rather concentrated on a critique of the concept.

The diversity of explanations of alcoholism, found in the quantitative literature, thus highlights the ambiguity and vagueness of the concepts. This is reflected in this study in patients' ambiguous notions of the disease concept of alcoholism and personal responsibility and pathology (see Chapter Nine). Ambiguity, however, in everyday life is not viewed as a problem; it is used skilfully by patients and alcohol professionals as we will see in Chapter Five, in MCD analysis. For instance, one female patient's account of her husband's violence helps to avoid her from appearing as a disloyal wife, thus indicating her skills in her competence as a respondent (Chapter Five, patient no.12). In the next section (Part I.1.d) I shall describe the Alcohol Treatment Unit which provides the setting for the patients included in this study.

#### d) The Alcohol Treatment Unit

The Alcohol Treatment Unit (ATU) situated in the grounds of a psychiatric hospital in the South East England, in which I have worked for eleven years as research sociologist, was set up in 1962 following the publication of a DHSS White Paper. This White Paper recommended that the number of treatment units for alcoholism should be significantly increased to provide at least one per Regional Health Authority.

However, after thirty years of existence, this unit had to close down in 1992, following the National Health Service and Community Care Act of 1990 and its associated White Papers. The legislation emphasised 'community care' of the mentally ill, and planning started for the closure of the psychiatric hospital. The official reason given for the closure of the ATU was its financial non-viability. Treatment evaluation research continued in a small research team, which was part of the Alcohol Research Unit of the ATU, for a further two years until 1994. The ATU consisted of eight beds for detoxification purposes and 17 beds used for patients undergoing a treatment programme run for a four-weekly period (8-10 beds) and for patients with significant disabilities categorised as the 'middle group'.

The description of the ATU and its different treatments that follows is extracted from an unpublished report written by the staff of the ATU in a collaborative effort in 1990. The ATU offered different levels of treatment, and its aims were not

necessarily abstinence-based. Attempts were made to understand individual problems of any patient and match treatment type to individual needs. Primary treatment services for alcoholics were provided through the Unit's weekly out-patient clinics at two London NHS hospitals. Secondary care services in the form of three types of treatment were supplied at the Unit, mentioned above. Research concentrated on alcoholic brain damage, treatment evaluation and various drug effectiveness trials. The 'core' treatment staff consisted of a consultant psychiatrist as the Unit's director, an associate specialist, one senior registrar, one registrar, a clinical assistant, a psychologist, two social workers, an occupational therapist, 12 members of the nursing staff, two secretaries and two domestics. Employed as a research sociologist, I was not part of the treatment staff.

Patients were admitted to one of the treatments offered in the ATU via the out-patient clinics where the initial assessment was made. Referrals came from mainly primary agencies such as GPs, Hospital Registrars and probation officers.

Detoxification lasted 5-7 days on average and patients were encouraged to take part in group discussions. Their social and financial problems were dealt with by a social worker. The 'middle group' patients were offered 'anxiety management' when appropriate, and were tested for brain damage through computerised psychometric test battery by the psychologist. They usually stayed 3-6 months in the Unit.

## THE TREATMENT PROGRAMME

The patient sample, in this study, is drawn from the 'treatment programme' which was a four-week residential intensive programme admitting six to ten patients en-bloc. It was not uncommon for a small number of patients to drop out of a programme and leave the hospital.

The Programme was designed to meet the needs of people with a drink problem who required more help than could be offered in an out-patient setting and who either did not require detoxification or had recently received it. This programme did not focus exclusively on alcohol. But drinking patterns and the problems caused by alcohol were still an important factor. It was expected to offer patients an opportunity to consider and assess their lives, their relationships and the strategies employed to cope with difficulties. Patients were assessed for suitability for the programme by the multi-disciplinary staff. The programme consisted, in part, of group meetings as follows:

### Unstructured groups:

These group sessions were designed to encourage patients to explore their feelings. Group leaders adopted a non-directive role, observed and commented on happenings within the groups in terms of group processes.

### Structured groups:

#### i. Educational groups:

Talks were given by staff members covering physical,

psychological and social aspects of alcoholism, harm and dependency. Patients were also shown a variety of video films and were given a talk and instruction in relaxation techniques.

**ii. Problem solving groups:**

**Good and bad points:**

Patients made a list of their good and bad points and shared with the group. They were encouraged to see that they have good and bad points regardless of their sober and drinking periods.

**Turning points:**

Patients were asked to reflect on their past and recognise significant events which had influenced their lives. Coping patterns were assessed for their adequacy and new ones were considered where necessary.

**Goals:**

Patients were asked to set realistic targets and to consider and develop means of achieving these targets and goals.

**Drinking patterns and consequences:**

Patients were asked to consider their individual patterns of drinking and to consider related beliefs and expectations and to review the consequences of their drinking. Each person's drinking pattern was considered to be unique. Sobriety management was considered by concentrating on strategies to deal with such issues as points of vulnerability, anger and frustration at being unable to drink, relationships in the family, work and leisure settings.

**Social skills:**

Each group member completed a detailed questionnaire identifying social situations which presented particular difficulties. Techniques such as 'role play' were used accompanied by feedback and encouragement from the group and were used to increase the patient's competence and confidence.

**iii. Awareness groups:**

The aim of these exercises was to enable patients to learn more about themselves and to appreciate how others saw them. Therefore, a variety of group activities such as group painting sessions, video role play sessions and job interview situations were organised.

**iv. Theme-centred discussion groups:**

These were mainly seminars where a staff member would introduce a topic which then was open for general discussion with group members. Topics included aims of treatment, coping with sobriety, families, leisure, Alcoholics Anonymous etc.

**v. Art/pottery:**

These sessions encourage creativity and self-expression. Individual assessments of patients are made during the four weeks and final assessments made in the final week of the programme. On completion of the programme, patients are discharged unless they have various problems to be dealt with, such as financial or accommodation problems to be sorted out by the social worker.



Most patients were referred to this alcohol treatment unit by their general practitioners, others by probation officers, social workers or hospital registrars. In some cases self-referrals were accepted, particularly when these were former patients of the unit. At the time of patients' discharge, the unit's Senior Registrar would write a 'discharge letter' to patients' General Practitioner. The GP would be asked to continue seeing the patient after discharge from hospital and help him/her to maintain sobriety. The unit's social workers would be involved in writing to social services departments, solicitors or directors of 'dry houses', in their attempts to help patients with their problems.

These various referral letters are of interest in this study and a number of these will be included in the analysis. They offer a different source of data and enable comparisons to be made between patients' and professionals' discourses on alcohol and alcohol-related problems.

## Chapter Two: Methodology

### a) The natural history of the research project

My interest in developing a PhD study in the field of alcoholism came about naturally as I had been working in this field for many years. My research experience and training however had been exclusively in quantitative socio-medical studies on alcoholism prior to my PhD study. I was involved at first, in the late sixties to mid-seventies, in an epidemiological study of student drinking habits and attitudes, and a census study of the residents of a reception centre. Later, I got involved in an evaluation study of an organisation providing accommodation to homeless persons and the assessment of outcome in groups of alcoholic patients.

The first study I worked on, was at the Institute of Psychiatry, Addiction Research Unit, having recently completed a postgraduate diploma in Social Policy and Administration at the London School of Economics and Political Science. I took part in a one-night census of the residents of a large reception centre which provided night shelter for many homeless persons. I was part of a team of researchers conducting the census. The aim of that study was to establish the proportion of people with a history of criminal and psychiatric behaviour, and drug and alcohol misuse. The findings have been published in the British Journal of Psychiatry (1968). The reception centre was closed down in the eighties. As a member of staff of the Addiction Research

Unit (ARU), I presented regular papers in seminars regarding my research work or other published work. This helped me to develop skills in presentation of research material.

The second and main study I was involved in at the ARU, was an epidemiological study of drinking behaviour and attitudes among first year university students in two colleges of an English university. A psychologist and myself were responsible for the design, data collection and the writing-up of the results of this study. Over a thousand students completed lengthy questionnaires and most of those repeated it on their third year, thus enabling us to look into changes in attitudes and behaviour regarding drinking and other kinds of behaviour such as smoking, fast driving, criminality. The results are published in the American Journal 'Quarterly Journal of Studies on Alcohol' (Orford et al, 1974).

I later worked briefly on an evaluation study of St Mungo Community's work, interviewing residents of the houses who were homeless persons, offered short-term accommodation. Contact with these persons was made through the Community's workers who organised a soup-run every night in Central London. Evaluation meant an assessment of the role of the Community in the rehabilitation of homeless persons.

Since I joined the Alcohol Treatment Unit of a Psychiatric hospital, I have been involved in further quantitative studies designed to measure treatment outcome in alcoholic patients.

Two studies were concerned with the effectiveness of Tiapride, a non-sedative anxiety-reducing drug in the prevention of relapse and the long-term management of alcoholics. The results of these two studies have been reported in the British Journal of Psychiatry (1987 and 1994).

Two further studies in which I have been the main researcher consisted of evaluation of the Treatment Programme, a 4-week intensive in-patient course for alcoholic patients and the short Alcohol Detoxification treatment, both described in the previous section. A third evaluation study in the Alcohol Treatment Unit, is an eight-year follow-up of the 112 alcoholic patients who took part in the evaluation study of the Treatment Programme. I worked on this study after I started designing my PhD study. When I decided to develop a PhD study, my initial interest was to find out what patients thought of their drink problem, how they conceptualised it. This would have been a quantitative study but quite different from the usual measurement of outcome studies. I therefore began designing a quantitative study enquiring into alcoholic patients' concepts of alcoholism. The sample was to be drawn from groups of alcoholics, admitted to a 4-week in-patient Treatment Programme in the alcohol treatment unit where I was employed. Having developed some rating scales on concepts of alcoholism, following interviews with patients, I carried out a pilot study on a small sample. Patients were asked to complete 5-point rating scales consisting of statements, by indicating whether they agreed or not with each statement,

responses ranging from 'agree strongly' to 'disagree strongly'.

This whole process took about eight months. However, I was feeling uncomfortable with the results of my pilot study as I tried to make sense of the data. I felt very uncertain about the attitudes and beliefs expressed in the scales; I began to question how could one consider that all patients who stated 'agree strongly' for instance on the rating scales, meant the same thing. I then thought of starting another study using semi-structured questionnaires to find out the social meanings of alcoholism among in-patient alcoholics. Rather than develop this idea further, at this stage, with the encouragement of my supervisor, I decided not to use the traditional ways of looking at reliability and validity of data. I started thinking of a new study with a qualitative methodology which I was introduced to on my MA course in Sociology in 1985-86. On this course, I became aware of the relevance of the status of interview data, how naturally occurring data or unstructured interview data can be treated as analysable texts which do not need to be considered as being true or false.

Consequently, as my main interest in my work had been alcoholism for many years, I decided to look at alcoholic patients' accounts of their experiences by means of open-ended interviews rather than the traditional structured methods. I therefore asked the patients to tell me about their drinking,

allowing them to talk with a non-directive approach. I tape-recorded some interviews in the beginning, and, when I looked at my transcripts, I knew this was what I ought to do.

The qualitative data resulting from this kind of approach was so rich and rewarding that I decided to proceed in this way and carried out 40 interviews. At first my approach to the analysis of the data was to look at 'social meanings', concerned mainly with 'why' certain causes of alcoholism were given as explanations, partly inspired by Mary Douglas's work (1975). I then tried a 'frame analysis' following Goffman's methodology (Goffman, 1974). After having applied the frame analysis to some patients' interview data, I still was not satisfied with the results as I had no means of knowing if the staff used similar frames. Patients' hospital notes did not reveal sufficient data to study this. I realised that my interest lay in the 'how' question first. I wanted to see how patients were formulating and presenting their drinking problem and then to attempt to look at 'why' they were presenting in these particular ways. I was introduced to ethnomethodology and to studies in conversation analysis. Having read Schegloff's (1991) and Sacks's writings (1967, 1972 and 1992), I became interested in the structure of 'talk' and the way members make use of categories to describe themselves.

Adopting the qualitative structural approach, I was able to look at the narrative structure of patients' accounts to see

how were the texts accomplished, how were they organised. The structure of the accounts seemed to have a common chronologically organised pattern. Examination of the narratives made me realise that patients were showing their skills in presenting themselves as morally adequate individuals, as Baruch (1981) had found in his sample of parents of children with congenital illness. I also found that patients were displaying considerable insights into their problems and were emerging as well informed individuals. I then thought of comparing patients' accounts to naturally-occurring professionals' texts. This has proved to be a very interesting analytical experience for me. I found similarities and differences in these texts which will be described in detail in later chapters. Professionals' texts were drawn from hospital notes containing the Senior Registrar's 'discharge letters' to patients' General Practitioners, Social Workers' letters to various agencies and referral letters written by GPs and Hospital Registrars.

These narratives also present displays of the modern medical 'whole person' approach to illness which is the focus in the 'Treatment Programme'. All patients in this study had nearly completed this programme at the time of their interview.

My current approach is therefore not simply an analytical shift, but another way of looking at interview data to see how it can help our understanding of alcoholic patients' versions and presentations of their problems. The details of the

methodology adopted in this study will be explained in the next chapter.

**The interviewer's role in the study and the interpretation of the research data:**

Patients' perceptions of my role is an important issue which needs to be considered. Despite my initial introduction to patients before starting the interview, describing myself as the unit's research sociologist, I was addressed by most patients as 'doctor'. I was identified with the medical staff. This invariably must have had some influence in patients' versions of their drinking problems. My role may further be understood as a researcher presenting a version of social encounters which makes sense to me, from a social scientist's perspective.

**STATUS OF INTERVIEW DATA**

Patients' presentations of their life experiences are treated in this study as a new version of reality, a new way of understanding and formulating one's life experiences. They can also be considered as situated accounts (Mills, 1940) which are neither true nor false. In this sense, any autobiographical account can only be conceived as a model of reconstructing one's life experiences rather than as falsified truths or inauthentic accounts. The reconstructive structure of autobiographies has been emphasised by Kohli (1981) who points out that narratives always contain a reconstructive element.



Regarding the account giver's personal belief in the realness of the account, Goffman (1959) has pointed out that the story teller may believe in the realness of his/her version. He describes the 'sincere performer' as one of the ways of performing, in the following way: '...the sincere performer can be fully taken by his own act. He can be sincerely convinced that the impression of reality which he stages is the real reality. When his audience is also convinced in this way, then only the sociologist or the socially disgruntled will have any doubts about the 'realness' of what is presented' (1959, 28). Blumer (1939) reports on Thomas and Znaniecki's definition of 'subjective truth' as the goal of a biography, and their emphasis on the sincerity of the autobiography. This version of 'subjective truth', in this study, can be understood as patients' sincere belief in their reconstructed life history within a clinical context.

Interview data are treated as a topic, not as a resource. As in interactionist approaches, interviewees are seen as experiencing subjects constructing their social worlds in the course of the interview. Interview responses need not be taken as being true or false, instead, they can be treated as displays of perspectives and moral forms. As Silverman (1993) suggests, interviews share with any account an involvement in moral realities. As such, they offer a rich source of data which provide access to how people account for both their troubles and good fortune. Similarly, Whyte (1980) suggested that the interviewer, when dealing with subjective material,

is not trying to discover the true attitude or sentiment of the informant. He further pointed out that ambivalence is a fairly common condition of people, that people can and do hold conflicting sentiments at any given time, and also hold varying sentiments according to the situations in which they find themselves. Ambivalence in patients' accounts of their drink problem will be discussed in Chapter Nine.

Patients' accounts are treated, in this study, as reconstructions of the alcoholic patients' experiences in a clinical setting, and as displays of moral adequacy. This follows Durkheim's (1974) conclusion that the social world is permeated with moral forms. This view of the status of accounts is shared by several writers such as Baruch (1981), Cuff (1980) and Voysey (1975). These views will be explained in Chapter Three, when the literature used in the analysis of the data will be discussed.

## **b) Sampling procedures and data collection**

The patient sample comprised a total of forty alcoholic patients (29 males and 11 females) admitted to a 4-week intensive in-patient Treatment Programme, in 1988-89, in an Alcohol Treatment Unit situated in a psychiatric hospital in South East England. They were drawn from seven groups of six to eight patients each. To obtain qualitative data, unstructured, tape-recorded interviews with these forty patients were conducted, lasting from 20 minutes to 1 hour and 10 minutes.

I initiated the interview with the following phrase: '*tell me about your drinking*'. It was followed by a narrative produced by the patient giving a reconstructed account of his/her life experiences. When a patient stopped and seemed uneasy about continuing, I then asked: 'is there any more about your drinking?'. This often helped the patient to resume his/her 'talk'. During the interview, I sometimes moved a little, or uttered sounds like 'mm', to show that I was paying attention to what was being said.

All patients were interviewed in the 4th week of the Treatment Programme. Some patients had been detoxified for a period of 5-7 days in the same Alcohol Treatment Unit, prior to entry to the 4-week Treatment Programme. Others who did not need detoxification and were 'dry', were admitted directly to the Programme, following outpatient appointments at the Unit's clinics based in two hospitals.

Of a total of 48 patients admitted to the seven Treatment groups, 6 patients discharged themselves in the first week of a Programme, and 2 patients refused to take part in this study. On completion of forty interviews, I decided to discontinue as interviews were adding no new insights.

As patients knew that I was the researcher in the Unit, I explained that this was different from other studies as I was not going to ask questions. There was no objection to using a tape-recorder. I introduced myself as a 'research sociologist', nevertheless I was identified with the Unit's therapists and addressed as 'doctor', as mentioned earlier in Chapter 2.a.

Transcripts were prepared from these audio-recordings for data analysis which is basically qualitative. However, some simple tabulations were done to show consistency of the findings. The analysis will be discussed in detail in part II.

A number of letters written by the Unit's professionals are also included in the analysis for the purpose of comparing patients' and professionals' versions of alcohol problems. Eighty 'discharge' letters written by the Unit's Senior Registrar (psychiatrist) to patients' General Practitioner, 23 letters written by the Unit's Social Worker to Government departments, solicitors or to directors of 'dry houses' have been included. In addition, 30 'referral' letters written by General Practitioners and 22 by Hospital Registrars, referring

patients to this Treatment Unit, have also been included in the analysis. The unequal number of different professionals' letters is due to their availability in patients' notes.

### **Chapter Three: The literature used in the analysis of the data: studies of the moral order**

Data analysis of the findings in this study, reported in Part II, will focus on theories and approaches concerned with the moral order present in accounts. In particular, I will look at Alasuutari (1987; 1990), Voysey (1975), Cuff (1980), Baruch (1981; 1982) and Sacks (1972; 1992). However, an analysis of the general structure of the narrative will be based on Saussure's (1974) theories of syntagmatic and paradigmatic relationships. This will be explained in Chapter Four.

The common features between the approaches of Alasuutari, Voysey, Cuff, Baruch and Sacks, and my own consist mainly of **a)** treating accounts of life experiences or life-histories as narrative reconstructions conveying respondent's current thinking (Alasuutari); **b)** treating accounts as displays of moral adequacy (Baruch); and **c)** interpreting respondents' self-descriptions in terms of 'membership categorisation devices' (Sacks). This kind of approach differs from the medical and psychological theories concerned with the nature of alcoholism, the epidemiology of alcoholism, the personality of the alcoholic and reasons for drinking. Their methodology consists of quantitative data collection searching for 'objective' variables such as physical symptoms resulting from heavy drinking or for psychological reasons located in the individual .

Similarly, much sociological work in the 1960s and 1970s (Mulford and Miller, 1964; Roman and Trice, 1968; Room, 1972)), also involved quantitative data such as public attitudes towards the disease concept of alcoholism, consequences of labelling the alcoholic as being 'sick', and reasons for the widespread acceptance of the disease model. On the other hand, qualitative sociological work like Denzin's relies on normative theories, psychoanalytical explanations of the 'self', and depends on Laing's theories, as we have seen in Part I.1.c.

By contrast, my approach does not search for variables, it is mainly qualitative. Equally, unlike Denzin, it does not rely on normative theories and psychoanalytical explanations. Instead, it focuses on the way that alcoholic patients and professionals account for alcohol problems, and how patients reconstruct their life experiences including their drinking to accomplish an intelligible account.

An approach, different from the quantitative approaches discussed in Part I.1.b, is offered by the Finnish sociologist, Pertti Alasuutari (1987 & 1990). He reports (1990) on his analysis of life-histories told by alcoholics who were clients of a clinic in Finland (A-clinic) where the AA ideology does not prevail. He compares these with the life-histories of non-alcoholic blue-collar men. His approach is a qualitative, interpretive method that treats life-histories as narratives which involve subjective and

intersubjective reconstructions of the past. He pays attention to the chronological order of the sequences in an account, following Propp's (1968) method of analysis of the plot structure of Russian folk tales. He explains how 'desire', a yearning for something undefined often opposed to the concept of 'need', is transformed into 'craving' for alcohol, and the tension between desire and self-control in the modern conception of the individual. Craving implies a need, and has special significance in medical definitions of alcoholism i.e. a subjective awareness of a compulsion to drink, as mentioned in Part I.1.b. The notion of 'desire', Alasuutari suggests, is an historical and cultural construct, and is central to the modern conception of alcoholism, as the notion of 'craving' or 'loss of control' is simply a special case of the notion of desire. Following Foucault (1985), Alasuutari argues, the history of the notion of desire is linked with 'techniques of the self', and therefore with the notion of *self-discipline*. He further suggests that the emergence of the notion of a general 'self-discipline' gave rise also to its twin concept, 'desire'.

Elias (1978; 1982) has argued that the notion of 'self-discipline' hardly existed in the Middle Ages, but it gradually became self-evident, and that the civilizing process meant that the regulation of drives became stricter. Outer constraints were gradually internalised into self-restraint. Unlike Elias however, Alasuutari suggests that the rise of a general self-discipline is also the birth of the notion of



'drives' or an equally general 'desire'. He explains that it is only when it makes sense to say that one is self-disciplined without specifying in relation to what, that the notion of *desire* starts to make sense.

Alasuutari describes alcoholism as a reinterpretation, and as a product of an accounting strategy, of socially unacceptable drinking habits. In his data, the life-histories told by men without alcohol problems differed from those told by alcoholics. The latter would emphasise hardships and crises and the inevitability of divorce, whilst the non-alcoholic men tended to emphasise settling down, getting married, buying property and living conditions.

Alasuutari addresses the tension in the modern individual between desire and self-control, the division between the realms of knowledge and normality, on the one hand, and madness and pathology on the other. He explains this duality as itself historical and a product of modernization. He compares it to Foucault's (1965) analysis of the historical genesis of the *Same* and the *Other*, Reason and Madness or Discourse and the Other, how modern types of subjectivity are constituted by this division. In the *History of Sexuality*, Foucault (1979) studied how history and society could be defined in terms of desires and interdictions.

Alasuutari describes the alcoholic's story as a reflection of his present way of thinking and behaving. In terms of a



common narrative structure, stories differed from each other in their overall contents. He suggests two frames within which drinking may be perceived: the *alcoholism frame* and the *everyday life frame*. These frames provide an explanation for the tension between desire and self-control on the one hand, and transformation of desire into craving on the other. The use of 'frame' here is closer to Giddens' (1984) emphasis on the cognitive nature of frames rather than Goffman's (1974) use of frames. Giddens describes frames as clusters of rules which help to constitute and regulate activities defining them as activities of a certain sort and as a subject to a given range of sanctions.

There is mutual communication when drinking is perceived in the 'everyday life frame'. A drink may be used as a sign that conveys a particular meaning, such as a glass of champagne to celebrate a birthday or anniversary. An individual's drinking is taken for granted. This is not the case in the 'alcoholism' frame. In this frame, an individual's drinking habits are thought to deviate from what is conceived as normal or acceptable. Alasuutari suggests that the alcoholism frame, which is characteristic of many Western societies, including Finland, makes a distinction between the *normal* and *pathological*. According to the alcoholism frame, the alcoholic cannot help but drink since his/her desire has been transformed into an overwhelming *craving*. The attention is shifted away from the role of drinking as just another medium of communication, or as a symbol and realisation of the social

organisation of everyday life. Instead, the interest is in the particular style with which an individual drinks, reinterpreted as a personality trait or as proof of a personal pathology. Alasuutari suggests that the distinction between normal and abnormal is a characteristic of Western views of unacceptable drinking.

Alasuutari's approach, in the study of life-histories as narrative reconstructions, highlights the usefulness of an interpretive method for an understanding of cultural presentations and descriptions of alcoholism.

My own study consists of 40 accounts of life experiences given by alcoholic patients in a Treatment Programme, in an Alcohol Treatment Unit where the AA ideology does not predominate. The programme is run by a multidisciplinary team, comprising mainly medical staff. My approach, as mentioned earlier, is similar to Alasuutari's approach which treats life-histories or accounts of life experiences as narrative reconstructions which convey individuals' current thinking. However, my analysis also includes treatment of patients' accounts as displays of moral adequacy (Baruch, 1981 & 1982).

When analysing the narrative structure of alcoholic patients' accounts, I have found a common element in patients' discourses, i.e. displays of moral adequacy with an emphasis on normality. Professionals' letters too present patients as morally adequate and responsible individuals.

My treatment of patients' accounts as displays of moral adequacy has been influenced by the theoretical contributions of several researchers such as Voysey (1975), Cuff (1980) and particularly Baruch (1981; 1982).

Voysey treats statements made by parents of sick children as public accounts which are produced and formulated to satisfy the official morality of normal parenthood. She studied parental responses to a variety of serious childhood illnesses. She claims that parents maintain a normal respectable appearance.

Concerning the status of accounts generally, Cuff states that the predominant feature of all accounts is their display of moral adequacy. Any account can be scrutinised in terms of whether it comes over as a 'proper' description of what is happening in the social world, and how it displays the character of the teller. Cuff analyses the problem of versions in everyday situations, regarding family problems in a radio programme where experts and family members give their versions of the family's problems. Cuff suggests that when a teller recounts events to do with himself and other members of his social unit, he is talking about unit events in which he is implicated and morally involved. Moral involvement here refers to the way members can standardly and routinely deploy their social knowledge about the nature of the unit for what has happened. The teller is likely to be heard as one-sided and thus morally condemned, unless he assembles accounts in

such a way that they consider his own involvement. This means that versions of the event under discussion are developed which consider the possibility of the respondents being responsible for the unit trouble. Cuff calls these versions 'determinate alternative possible accounts'.

Baruch's approach agrees with Voysey's and Cuff's theoretical orientation in treating accounts as displays of moral adequacy. Unlike Voysey, however, who interviewed only mothers, Baruch decided to interview fathers as well. Fathers were mostly interviewed with their wives. Like Voysey, Baruch treats parents' accounts not as true or false accounts but as displays of moral adequacy upholding official morality related to a conception of normal parenthood. The responses are treated as situated accounts, constructed for the research interview, which display the respondent as a morally adequate parent. Thus, moral realities, Baruch argued, represented in the interview, are located in the cultural world.

Parents of children with congenital illness were interviewed, in Baruch's study. They told the researcher about their encounters with the medical profession. The analysis was mainly qualitative with a quantitative application of Sacks's analysis of descriptions (1972), to identify the normative character of parents' accounts. My own analysis also includes application of Sacks's method of recognising descriptions, qualitatively as well as with some quantification to show consistency of descriptions across the sample.

Baruch was able to extend his analysis to deviant cases. Based on Sacks's (1972) 'membership categorisation device', Baruch explained, in one of the deviant cases, that parents were describing professional-child activities rather than parent-child activities which were more commonly used by parents in his sample. The parents, in this deviant case, were medical professionals who presented events objectively from a medical perspective, whilst other parents took the opportunity to display themselves as adequate normal parents. Nonetheless, parents in this deviant case were also displaying themselves as morally adequate persons who can produce observably 'objective' accounts.

My analytical orientation thus agrees with the approach of the researchers discussed above, particularly with Alasuutari regarding the narrative structure of accounts in relation to alcoholism, and Baruch who, besides treating accounts as displays of moral adequacy, also adopted Sacks's method of identifying descriptions in terms of 'membership categories'.

However, following an analysis of the narrative structure of patients' accounts, a major part of my analysis consists of recognising descriptions based on Sacks's 'membership categorisation device'. The examination of 'talk' has been an ethnomethodological concern and the study of, naturally occurring, talk has become widely known as conversation analysis. This area of study was developed by Harvey Sacks (1972) who had studied at the University of California, Los

Angeles, with Harold Garfinkel. Based on Garfinkel's ideas (1967), ethnomethodological work has thus generated studies which enquire into the organised structure of talk. Conversation analysis is described by Benson and Hughes (1983) as a discipline in its own right and as a sociology of everyday life.

When Sacks refers to norms, he describes how people use them to provide some orderliness in the activities observed or reported. This differs from standard ethnography consisting of observation, fieldnotes, as it is concerned with the descriptive process. For instance, Moerman (1974) found standard ethnographic methods problematic when he studied a Thai tribe called the 'Lue'. His self-criticism of this approach, led to his question 'when are the Lue?' replacing his initial question 'who are the Lue?'. It was through their common activities that the Lue became a tribe.

Sacks notes that for any person, there are numerous categories for 'correctly' describing him/her, and that whenever there is 'talk', there are descriptions of such things as events, actions, feelings and states of mind. All talk has a topical character. He describes the cultural 'machinery' by which members produce and recognise descriptions, and proposes that there are general methods members use and general structures of common sense knowledge they rely on, to accomplish a sense of what is referred to in the 'talk'.

He suggests '*membership category*' and '*membership categorisation device*' as basic concepts. Members methodically select a category from a 'collection' of categories which go together, to describe themselves. These collections are called '*membership categorisation devices*' (MCD). Selection of a category from an MCD can be heard to exclude it from being identified with some other category from the same device. As Silverman (1993) points out, Sacks's MCDs can be seen to be organised around Saussure's (1974) concept of '*paradigmatic oppositions*' which generally refer to polar oppositions. When, for example, the category 'mother' is selected from the collection 'family', it excludes her from being identified as a 'father'.

When a collection hearably represents a social unit or a team such as a 'family', it is then duplicatively organised. A collection may also be heard to contain '*relational pairs*' referring to pairs of categories linked together in standard ways such as 'brother-sister' (SRP). Sacks also introduced the concept of '*category-bound activities*' (CBA) which by common sense are tied to certain membership categories and vice versa.

The *consistency rule* states that, when one category from a given collection is used to describe one member of that population, then other categories from the same collection may be used on other members of that population. Certain collections of categories such as the 'family', have the



structure of a 'team' or a 'social unit' whereby categories are '*duplicatively organised*'. In this case, the 'hearing rule' applies, i.e. when categories are used to identify a number of persons from a 'team-like' unit, then the hearer should hear it that way. Certain collections of categories do not have this 'team-like' character, for example the 'stage of life' device with categories such as baby, child, adolescent, adult. Some membership categories occur in several distinct devices and may seem to be ambiguous, for example 'baby' occurs in the device 'family' and also in the device 'stage of life'. However, Sacks suggests that a hearer may use the '*consistency rule corollary*' and not notice any ambiguity, thus the corollary is a *hearer's maxim*.

Furthermore, when a category is described in such a way that it does not relate commonsensically to that collection, it is then called a '*category modifier*'. I shall argue that category modification may give a lively character to the description and highlight the individual's moral adequacy; for example, when 'father' from the collection 'family' is described as a 'drunk' or an 'alcoholic', it is not heard as a common sense attribute for a father.

A '*relevance*' rule will apply when statements such as 'Jews are rich' or 'women are fickle' not only provide possible explanations, but on the occurrence of some activity, they tell you where to look first to see whether you have an explanation, i.e. look to see whether the person who did it is

a member of the class or classes to which the activity is category-bound. The use of 'we' or 'they' or a class of people such as 'women' or 'Jews' denotes a class of categories to which the person is a member of, and the activity in question is category-bound. In this study, a common expression used by patients was 'most young people do' when describing their early drinking experiences, thus identifying themselves with a class of people engaged in this category-bound activity, emphasising their normality and subsequently moral adequacy.

This whole apparatus of referring to a class of category sets which may involve age, sex, race, religion is called by Sacks (1992), the '*MIR membership categorisation device*'. 'M' stands for membership, 'I' for inference-rich, and 'R' for representative. These are members' categories which are inference-rich, i.e. a great deal of knowledge that members of a society have is stored in terms of these categories. A member of any category is thus a representative of that category for the purpose of using whatever knowledge is stored by referring to that category. This also implies that an account being produced is not challengeable and needs no defending.

The following examples illustrate Sacks's investigations into the organisation and use of membership categories. These examples will include children's descriptions when telling stories in the statement '*The baby cried. The mommy picked it*

up' (1972), 'Hotrodders' as a revolutionary category (1992, Fall 1965, Lecture 7), and a caller's statement '*I am nothing*' (1992, Fall 1964 & Winter 1965, Lecture 9).

The first example consists of the first two sentences from a story offered by a two year and nine months old girl to the author of the book 'Children tell stories'. These sentences are: '*The baby cried. The mommy picked it up*'. Sacks makes certain observations about the common sense way of hearing these sentences. The mommy is heard as the 'mommy' of this baby and not another baby and vice versa. We do not need to know who the baby is, or who the mommy is, to hear it this way. It is also natural to hear that the mommy picked the baby up after it cried, not before. We also hear that the mommy picked the baby up because it cried, thus the second event, i.e. 'the mommy picked it up' follows the first event, i.e. 'the baby cried'. The activity of crying is bound to 'baby' and picking it up is an activity bound to the mother. The common sense hearing is contained in the sentences which do not speak for themselves. Other possible hearings can be given with more thought. This initial, natural hearing, Sacks notes, is a cultural accomplishment.

'Mommy' and 'baby' are also heard as members of the same family, a 'social unit', duplicatively organised. They are also 'mutually constitutive', that is, we derive our understanding of each from the use of the other. In these two sentences, Sacks shows how children accomplish telling a story

in terms of descriptions that gives the hearer a sense of understanding, of what is referred to.

The second example concerns the use of 'hotrodders' and 'teenager' as two separate categories. He shows how a young person may prefer to be categorised as 'hotrodder' to 'teenager'. When using the term 'teenager', adults refer to certain category-bound activities, whilst a young person would refer to activities known to the in-group when using the term 'hotrodder'. The category 'teenager' is a category owned by adults, and 'hotrodder' is a type set by young persons. On the other hand, Sacks argues, if adults also come to use the term 'hotrodder' then this would mean a very large gain for a collection of young persons. Adults would have to use it under an important constraint that what it takes to be a member and what is known about members, is something that the members enforce. Thus, Sacks suggests, it would make a considerable shift in the independence problem, as it would not be an issue where each kid faces the adult world on his own.

Therefore, the young person has to do what it is that the group provides as the way to become a member, hence a machinery for social control is set up over candidate members. Sacks argues that a classical attempt at doing rebellion, in the Western tradition, is to set up a category one administers oneself which others come to use in the unique fashion that they used another category before. This example shows how members of subcultures may prefer their own categorisation to

being categorised by other groups.

The third example also shows the importance of categorisation and refers to callers' statement, i.e. 'I am nothing', to a suicide prevention centre. Sacks notes that suicidal persons recurrently say 'I am nothing' or 'I have nothing'. He shows that people review a variety of categories of persons and find no one to turn to, before arriving at the conclusion 'I am nothing'. This is a correct or logical conclusion whereby society's recognised values are reassessed as they are relevant at a certain stage of life. Sacks (1967) has shown how telephone counsellors would try to suggest who a caller might turn to through a 'search procedure' based on knowledge of relational pairs such as mother-daughter, brother-sister.

These three examples show how members make use of categories to describe themselves and how certain types of activities are commonsensically bound to certain membership categories<sup>1</sup>. When applying Sacks's approach to recognising and identifying descriptions, to patients' and professionals' discourses, in this study, I shall be examining 'how' patients are describing themselves and their life experiences including their drink

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<sup>1</sup> Sacks's work also includes the social organisation of turn-taking in conversation. Sacks, Schegloff and Jefferson (1974) have drawn attention to turn-taking and close order sequencing in conversation. These involve ways in which a current utterance is tied to a preceding one, the opening and closing of conversation, and the whole range of procedures people use in interacting with one another. Turn-taking in conversation does not apply to patients' and professionals' discourses in this study, therefore this area of Sacks's work will not be used in data analysis.

problem and accomplishing an intelligible account. I shall be focusing on how the 'talk' is accomplished, not with what respondents and alcohol professionals 'believe' or 'think'.

In conclusion, my approach in the analysis of alcoholic patients' accounts and alcohol professionals' letters has been influenced by approaches developed by Alasuutari, Voysey, Cuff, Baruch and Sacks. The analysis in Part II will present the narrative structure of patients' accounts (Chapter Four), and will show how displays of moral adequacy are predominant in patients' and professionals' discourses. It will also show how moral adequacy and the accomplishment of accounts are skilfully achieved, based on Sacks's Membership Categorisation Device (Chapter Five). Finally, some simple counting techniques, applied to MCDs, will show the consistency of descriptions throughout patients' and professionals' discourses (Chapter Six).

## PART II. DATA ANALYSIS

### Chapter Four: The narrative

The structural view of language, presented by Saussure (1974), emphasises the relations of elements to one another within a linguistic system which consists of different levels of structure. Saussure claimed that the entire linguistic system can be explained in terms of a theory of syntagmatic and paradigmatic relations.

Syntagmatic relations are defined as the relations of a term with terms which precede and follow it in sequence. Paradigmatic relations are the oppositions between elements which can replace one another. He called the system of a language *la langue* and the actual speech as *la parole*. *La langue* is what the individual assimilates when he/she learns a language. *Parole*, on the other hand, involves the combinations by which the speaker uses the code of the linguistic system in order to express his/her own thoughts. In the act of *parole* the speaker selects and combines elements of the linguistic system, and gives these forms a concrete phonic and psychological manifestation, as sounds and meanings. This distinction thus provides a principle of relevance for linguistics. This presents a very brief summary of the structuralist view of language. A language is conceived as a system of elements which are wholly defined by their relations to one another, and the linguistic system is explained as consisting of different levels of structure.

At each level one can identify elements which contrast with one another and combine to form higher-level units, and the principles of structure remain the same. Saussure states that a language is a system of pure values which are determined by nothing except the momentary arrangement of its terms.

Saussure emphasised that nothing can be taken for granted as a unit of language, and stressed the importance of adopting the right methodological perspective and seeing language as a system of signs and of socially determined values. He further stressed the need to avoid a historical analysis of language. It therefore follows that if the meanings assigned to objects or actions by members of a culture are not purely random phenomena, then there must be a semiological system of distinctions, categories and rules of combination which one hopes to describe.

For the study of narratives, the two main branches of structuralist approaches are the syntagmatic and paradigmatic approaches, mentioned above. Using concepts adopted from linguistics, the syntagmatic approach refers to the form in which the events of a story or account are logically and chronologically linked together to make up the plot (i.e. what follows what). The paradigmatic approach, on the other hand, concentrates on polarities (i.e. either/or structures).

Propp (1968) interested in the former approach, studied the plot structure of Russian fairy tales, and found a sort of



master tale, a type of tale when the plot structure consists of the same functions in the same chronological order. Yet individual stories did not need to contain all functions, and could be conceived as variants of the master tale.

Claude Lévi-Strauss (1968), on the other hand, using the paradigmatic approach, presented a structural study of myth. He argued that the meaning of myth can be traced back to a limited number of binary oppositions. He considered the plot of a story as merely a surface, and examined the content of a myth by breaking down the story into separate sentences and by rearranging them in an appropriate manner. Unlike Lévi-Strauss, Propp's syntagmatic method provides no interpretation as to the kind of society that has created a particular type of story.

In the qualitative data analysis of alcoholic patients' accounts of reconstructed life experiences, I shall adopt a structuralist approach, analysing *first*, in this chapter, the *syntagmatic* relations between different levels of structure, their relatedness and their orderly sequence as they feature in the unfolding of the account. *Second*, a detailed *paradigmatic* analysis will be applied to patients' accounts and professionals' letters by means of Membership Categorisation Device developed by Sacks (1972), in Chapter Five. Simple counting techniques will also be applied to the data as a way of supporting and increasing its reliability.

Patients' response to the interviewer's initiating phrase 'tell me about your drinking' consisted of a reformulation of the phrase into a major question about reasons for developing a drinking problem and psycho-pathology of drinking, and was interpreted as a request for self-analysis. Past life experiences feature first, leading on to the present stay in hospital and finally to plans for the future in a logical sequence and constituting a life-course<sup>1</sup>.

The plot structure of patients' accounts is threefold: *Past*, *Present* and *Future* linked logically and chronologically resembling a life-course. This threefold master plot is common to most study patients' accounts (N=37). However, accounts differ from each other in their overall contents and emphasis. Variations are found within the different levels of structure, such as different life events and different reasons for drinking. Thus individual accounts can be conceived as variants of a master form of an account.

The analysis in this section on the narrative structure of patients' accounts will not be as long as the MCD analysis in Part II which is a more specific analysis of how patients describe themselves and their life experiences. This section examines the general narrative structure of these accounts as different levels show a logical and chronological sequence. In addition to this syntagmatic analysis, some paradigmatic

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<sup>1</sup> Williams (1984) had found that his question 'Why do you think you got arthritis' was translated into substantive questions on the genesis of illness-experience.

analysis will highlight the meaning of elements within different structural levels and their relatedness.

The narrative plot in patients' accounts unfolds with a reconstruction of the Past where opposite terms are used such as normality ruptured by life events which are given as explanations for the rise of the drink problem. This relates to displays of moral adequacy, and indeed in the following structural levels themes will be shown to be related in terms of achievement of the moral order.

### **The PAST**

Patients' relationship with the world is reinterpreted and reconstructed to give a new meaning to life experiences in relation to the drinking problem. The structure of the Past is characterised mainly by three features: normality, dramatised life story and reasons for the escalation to problem drinking, all related to patient's displays of moral adequacy (Baruch, 1981). It has the form of a life history which includes drinking as one of many problems featuring in the context of a life-course. Often an unhappy childhood, lack of parental love or affection, death of parents or siblings help build up a dramatic past, thus providing an explanation for the subsequent development of a drink problem. The narrative begins when the patient was a 'normal' teenager. Childhood experiences feature only with reference to the patient's relationship with his/her parents.

The following extract which constitutes the beginning of patient no.1's account, illustrates the emphasis on Normality. Extracts will be numbered consecutively throughout the thesis including extracts from both patients' interview transcripts and professionals' letters. Each extract will identify patient or letter number as well.

**Extract 1 - patient no.1 (male)**

'I'm 45 years old, I've been drinking virtually since I was allowed to, that is from the age of 17. In the early days, I used to drink at weekends as most young people do. I got drunk a few times, it was just a question of growing up as most young lads do.'

This patient responds to the interviewer's question 'tell me about your drinking' by an account of his drinking experiences as a teenager. He makes a point about his normal drinking habits and emphasises that his drinking pattern was initially part of a teenager's normal lifestyle. He also states that getting drunk a few times was simply part of the growing up process of most young people.

The function of presenting early experiences of drinking showing that at some point in his life he was a normal drinker, is to emphasise his moral adequacy. It also helps formulate his alcoholism as an illness or a problem which has developed and ruptured his normal life-course, and needs to be resolved. This formulation is predominant in the multi-disciplinary discourses of the Treatment Programme, hence the setting has some relevance here although not directly invoked.

Based on Schegloff's arguments (1991), one need not consider the relevance of the setting unless it is invoked in the talk. We shall see later when discussing the 'Present', how the setting, i.e. the Treatment Programme is invoked in patients' talk. In the next extract, patient no.13 is also starting his account with his normal drinking pattern.

**Extract 2 - patient no.13 (male)**

'I first started drinking in the Forces. I spent about 10 years in the Army. But it was social drinking to start with, you know, usually 4 pints in the evening. That was from 1965-1975. I got married after that. Then I just carried on, sort of social drinking, 5 or 6 pints you know.'

This patient starts with a normal drinking period, thus emphasising his moral adequacy, and indeed he states that he was drinking normally for a long period of time. He starts his drinking experiences in the Army. However he is pointing out that after his marriage his drinking continued but was still more or less social drinking. Another example of 'Normality' can be seen in the beginning of patient no.18's account.

**Extract 3 - patient no.18 (male)**

'...I went on to the drink but not heavy, just with the lads, you know, bits and pieces, going out Friday evenings and weekends to the local pub'.

This patient too is talking first about his normal drinking experiences shared with other youth and only drinking on Fridays and weekends. The following female patient starts her account describing how she started drinking.

**Extract 4 - patient no.2 (female)**

'...Well, I started drinking socially when I first met my husband. I'd never drunk before that. I didn't know what drink was to be quite honest.'

This patient is formulating her normal drinking experiences with regard to her relationship with her husband. Again she refers to it as social drinking.

The expressions found in these extracts referring to drinking with the lads, or in social occasions, as normal activities which most young people do can be seen as constituting a set of typifications (Schutz, 1964) which patients bring to the interview situation. Schutz argued that social life becomes routine and stable, and that social reality consists of commonsense typifications. Patients also sometimes assume that their commonsense beliefs and everyday standards are shared with the interviewer, as we can see in extracts 2 and 3, in the use of the expression 'you know'. Baruch (1981) too had encountered this kind of assumption when interviewing parents of children with congenital defect.

Life experiences linked with drinking experiences presented in the beginning of the narrative therefore constitute 'normality' and set the stage for a normal life-course to follow. This 'normal' process, however, is broken up by a number of ruptures which lead on to the development of the drink problem. This constitutes the next feature in the narrative structure of the Past.

Ruptures in terms of life events such as unemployment, redundancy, separation, divorce, domestic violence, arrests, illness and death offset the normal life-course. These ruptures lead on to the progression from social to heavy drinking and provide a rational explanation for the rise of problem drinking. Reasons are often offered for drinking and they mostly are psychologically oriented. They constitute acceptable vocabularies of motive (Mills, 1940) in the Treatment Programme such as 'lacking in confidence', 'relief of anxiety', 'insecurity' and 'inability to cope with situations' or 'inability to cope with stress' more commonly expressed by patients. Motives as mediated behaviours were described in Part 1, when discussing Mill's ideas. Displays of moral adequacy continue in this level of the narrative in self-descriptions by patients as good parents, daughters or sons, or just responsible members of society. Statements often include expressions such as 'I love my kids', 'I'd never hurt my children', 'I've always cared for my parents' and 'my kids have always had cooked meals' and 'I've been a good mother'.

As was discussed in Part I, Baruch (1981) had found that parents' stories of encounters with the health professions were displays of moral adequacy. This view is also shared with Voysey (1975) and Cuff (1980) whose study of a radio programme showed that an account may be defined as simply a version of events or everyday situations. Silverman (1987) too in his study of diabetic clinics, suggests that doctors

can skilfully redefine an ambiguous situation by appealing to their clinical knowledge, to constitute parental accounts as mere 'versions' of events.

In this part of the narrative structure there is in some cases, a temporary return to normality from a fragmented lifestyle, when the patient is able to get a job or get back with the spouse and maintains sobriety for a limited period of time. He/she attempts to make some sense of a chaotic life.

The next extracts 5-11 illustrate displays of moral adequacy, psychological reasons given for drinking including 'inability to cope' and a chaotic Past with dramatic life events. These life events provide an explanation for the inevitability of the rise of the drink problem.

**Extract 5 - patient no.10 (female)**

'I've been a good mother to my children. I was lacking in confidence and I do realise now that I need a job. I need to be independent, be responsible for myself.'

This patient clearly displays herself as morally adequate by pointing out that she has been a good mother, and by indicating that she does want to take the responsibility for herself. She also offers a psychological reason for her drinking such as lacking in confidence.

**Extract 6 - patient no.4 (male)**

'Well, I started drinking just before my final exams, and I was about 17½. I was very shy and fatter, you know. I



met a girl, it was a relationship to start with, she was a good-looking girl. I was just in a very difficult situation, so I started drinking at that stage. Before, all I had was a glass of whisky, I mean I was very conscientious. Before, I never liked drink, because I've seen the abuse of drink all through my life...At school I was happy, a perfect student, very good at sports and I was into all sorts of activities as well.'

This patient is displaying himself as morally adequate by his self-description as a conscientious person. He also describes himself as being a perfect student and good at sports. He describes his need to drink when confronted with a relationship with a good-looking girl, thus offering a psychological reason. Reasons are often psychologically oriented but in some cases patients locate them outside themselves in the social world, by referring to a dominant parent, a violent spouse or to cultural patterns.

Patient no.19 ascribes his drinking to his anxiety attacks.

**Extract 7 - Patient no.19 (male)**

'...I first really started drinking when I split up with the fiancée. I started getting anxiety attacks. One night I went out for a drink when I had one of these attacks; I started drinking and the attack just went away, calmed me down and went away...I was always anxious about flying. I was in the airport in Spain and the plane was delayed for 12 hours. The flight was very bad, you know, snow-storm, and we did land obviously safely in England. After we landed, the anxiety seemed to hit me and I went for a drink to calm me down.'

This patient is offering a psychological reason for his drinking, i.e. anxiety attacks. He attributes his drinking following his flight from Spain and his break-up with his fiancée to his anxiety attacks. This explanation is again an

acceptable vocabulary of motive (Mills, 1940) and an intelligible reason for drinking.

**Extract 8 - patient no.4 (male)**

'I don't blame other people or really situations for why I drink. It's my inability to cope with them, that's the reason, and for me alcohol has always represented short periods of oblivion if you like, when I really can just put everything to one side, when I don't have to deal with it to-day...I was very immature, naive and was very very nervous before I came here. Straightaway, the first relationship I had, I drank to cope with it.'

This patient emphasises his inability to cope with situations. He specially refers to his inability to build a relationship as he states that he is a very nervous person. He uses words which are part of an acceptable vocabulary (Mills, 1940) in the psychologically oriented Treatment Programme, such as 'immature', 'nervous' and 'drank to cope with it'.

**Extract 9 - patient no.15 (male)**

'...But what I was doing was overstepping the mark. I was cramming too much, just pure stress and strain, but you don't realise it. You do get pulled down mentally and not realise it...You come home and you had a very stressful day; so you think you need a drink.'

This patient is attributing the need to drink to stress. Inability to cope with stress was a common reason given by 35 patients in this study. Gareth Williams (1984) also found this to be the most common factor in his study group of individuals diagnosed as suffering from rheumatoid arthritis. Allan Young (1980) defines 'stress' discourse as social discourse which claims to situate pathogenesis within everyday

experience. He points out that discourse on stress is firmly entrenched in modern thinking on illness and disease. Internal psycho-pathological stressors in my study group referred to over-anxiety, depression, tension, lack of confidence, feelings of insecurity and inadequacy. The contextual nature of expressed reasons for heavy drinking will be discussed in Chapter Seven.

**Extract 10 - patient no.20 (male)**

'...I kept coming for tests after I left 'detox', and stayed off the drink for 3 months. I found it very difficult to socialise with people, to mix with people without the alcohol.'

Alcohol is described here as a necessary means for socialising with people. Again this is a psychological reason acceptable in the setting of the Treatment Programme.

**Extract 11 - patient no. 18 (male)**

'...My wife left me once before through my drinking, by this time we had a baby of two and we went back together. Well, I didn't really seek help and my drinking habits got worse, worse and worse. Then my mother died, that sort of made things double worse. Well, I hit the bottle, heavier. Then I sort of came off the bottle and just drank socially and kept this up for a few years. But then, you know, I was getting in trouble with the Police, fighting, arguments, which wasn't very respectable. It was affecting my work, you know, turning up late on a set, not being there for films and pictures. So of course the money started going up and down like a yoyo. The wife said: "I'm not having this no more", and she left, and took the baby with her. So I continued drinking.'

Extract 11 illustrates the chaotic and eventful characterisation of the Past. This patient describes the consequences of his drinking on his marriage and his career,

and tells us about his mother's death. He also gets into fights and in trouble with the Police. He reports a temporary return to normality when he gets together with his wife and baby. At the end of this extract, his continued drinking seems the inevitable outcome of a chaotic life.

The beginning of patients' accounts is therefore characterised by the Past starting with a normal life-course which is then ruptured and we hear about events, a chaotic and dramatic life which justify the drink problem emerging as an inevitable outcome. Displays of moral adequacy also characterise this part of the account. Ruptures are presented as dramatised versions of everyday life experiences with a lively character, as illustrated in extract 11. Webb and Stimson (1976) have reported that patients' accounts of medical encounters had a dramatic quality and a highly personal content.

Towards the end of the dramatised account, the drink problem is no longer contained and is recognised and accepted by the patient who then seeks treatment. This leads to the present stay in hospital and current admission to the treatment programme.

### **The PRESENT**

The 'present' is characterised by beneficial aspects of the treatment programme which at the time of the interview, is nearly completed. There are several themes that feature in

this part of the narrative, such as knowledgeability about the medical concept of alcoholism as a disease or illness and the physical consequences of drinking alcohol, improved social skills, self assertiveness, self-analysis and increased self-confidence and insight. Some patients express their view of alcoholism as an illness, and later in the account state that it is entirely their fault, thus assuming total responsibility for their drink problem. This appears to be an ambivalent attitude. Whyte (1980) has suggested that ambivalence is a fairly common condition of people. He further suggests that men can and do hold conflicting sentiments at any given time. In this level of the structure, there is also acceptance of a drink problem by patients except three deviant cases who will be discussed later in this section. Thus, patients continue to emerge as morally responsible adults who are able to learn from experts' teachings and have insight into their problems.

The following patient presents herself as a knowledgeable person who has learned from the Programme about the harmful effects of alcohol on the body and brain.

**Extract 12 - patient no.12 (female)**

'Well, I mean I think most of the group will agree with me on this; it was this shock that we got when we saw like the ones here what they call 'wet brains'. I think that with alcohol, you know, I mean I might get cirrhosis of the liver. But I think you don't really imagine that you could just be walking around like a zombie you know. They actually said that during one of my blackouts I could have come through like a 'wet brain', because that's what actually happens apparently.'

By talking about the consequences of drinking, this patient is

displaying herself as a knowledgeable person who has benefited from the teachings of the Treatment Programme. She mentions cirrhosis of the liver which is an alcohol-related disease, and refers to brain damage, resulting from heavy use of alcohol, as 'wet brain' which is part of the vocabulary used among patients and sometimes by staff. The setting here is directly invoked, showing her increased knowledge, and the use of relevant and acceptable vocabulary (Mills, 1940).

**Extract 13 - patient no.15 (male)**

'...For me it was nothing new. I knew what my problem was before I came here. But for the rest of the group, there were things which they didn't know before. I think that this is an illness that will never leave me. There's no cure for alcoholism, not for me there isn't, I know that. I've just got to accept the fact that I've got it and I'm stuck with it.'

This patient is also displaying knowledgeability. He is defining alcoholism as a disease, hence showing that he is aware of the medical definition of alcoholism. In addition he is also indicating that he knows the medical position that there is no cure for this condition.

It is interesting the way he expresses his knowledgeability, by emphasising the fact that he knew before this current admission. This kind of reporting by patients was named 'atrocious stories' by Webb and Stimson (1976) who suggest that this in some way redresses the imbalance that exists in the patient-doctor relationship.

**Extract 14 - patient no.11 (male)**

'...I mean alcohol is just as bad as drugs, it is a drug but it's a socially accepted one. I find now that I have a lot more understanding of what alcohol does, how it affects relationships, how it affects your work, and how it affects your mind. It does different things with different people.'

This patient is also showing that he knows about the effects of alcohol. Besides the physical effects on the mind, he is showing that he is aware how alcohol affects relationships and work. He is at the same time pointing out that he has learned from the Treatment Programme as he says 'I find now'. This illustrates the 'whole person' approach predominant in the Treatment Programme and indeed more generally, in the modern medical discourse. This will be discussed in Part III when explaining the findings of this study.

Towards the end of the narrative, patients express their decisions for future action to restore normality in their lives, and return to the normal life-course. The Future is the last level in this threefold structure of patients' narrative.

**The FUTURE**

Plans for the future include change of lifestyle, staying abstinent and reducing opportunities for drinking such as avoiding pubs. Abstinence is the immediate goal and for many patients it is the only alternative. However, some patients, usually relatively young patients, envisage the possibility of a return to social drinking at some point in the future.

Thus, they predict a return to their normal life process in teenage years before the onset of a chaotic life. Common plans refer to getting a job, getting back with the spouse and children, finding a place to live and, in patients' own words, to 'settle down' and 'sort out' one's life, and in some cases to living independently without the spouse.

In this last level of the threefold plot structure patients again emphasise their moral adequacy by expressing their determination to change their lifestyle and return to normality disrupted by dramatic events and heavy drinking. Displays of moral adequacy feature in all patients' accounts including deviant cases, and outlined in terms of consistency across patients' accounts, discussed later in Chapter Six.

The next two extracts illustrate how patients express their future plans to try to live a normal life.

**Extract 15 - patient no.1 (male)**

'The only answer now is to leave this Treatment Programme and get the sort of job that I enjoy doing. But above all to stay dry. That is the only possible way that I could ever achieve the sort of stable life that I desperately need.'

This extract shows how this patient is planning to get a job, stay sober. He also mentions that he needs a stable life.

**Extract 16 - patient no.18 (male)**

'...and now it's coming to the end of my course, I'm going out to spend some time with friends hopefully they don't drink at all, they have been good friends. I'll find out if I can get a nice little flat and start a new life without the drink, and build up from there.'



Patient no.16 is also emphasising abstinence, and planning to get a flat and start a new life. He too is planning to restore some normality in his life. Having good friends is part of a display of moral adequacy.

The threefold plot in the narrative structure of patients' accounts thus unfolds in a logical and chronological sequence of events constituting a life-course. The chart, on the next page, illustrates this plot structure.

**FIGURE 1:**  
**THE NARRATIVE: THREEFOLD PLOT STRUCTURE OF PATIENTS' ACCOUNTS**

----- PAST -----	
NORMALITY	
	Normal teenager Social drinker
-----	-----
DRAMATISED PART OF THE ACCOUNT	TEMPORARY RETURN TO NORMALITY
<u>Ruptures (life events)</u> Separation, divorce, illness, death, suicide attempt, loss of job, arrests	- getting a job - buying a house - buying a car - getting back with spouse
<u>Drinking - out of control</u> Reasons for heavy drinking:	- playing sports again
Alcoholism as an illness/disease	- back to a normal diet
External reasons - drinking subculture - cultural patterns - stress agents: dominant parent, violent spouse	
Internal reasons - inability to cope with stress, anger, frustration, hatred, over-anxiety, depression, insecurity, lack of self-confidence (psycho-pathology of drinking)	
<u>Displays of moral adequacy</u> - caring for children, parents - successful at work - normal drinking ('as most young people do') - good at sports, hard working student	
----- PRESENT -----	
	- improved communication skills - become more self-assertive - increased self-confidence, self-awareness - gained insight - increased knowledge about: a) the 'self' (feelings, emotions) b) harmful effects of alcohol on the body and the brain
----- FUTURE -----	
	<b>Return to Normality (Plans for the future)</b> - avoid pubs, refuse a drink (say 'no'), get a job, take up a 'hobby' - find a place to live - 'sort out' relationships: go back to spouse/children or leave spouse and leave independently

The chart (figure 1) starts with the beginning of the account where normal, social drinking as a teenage activity is emphasised. This is part of patients' displays of moral adequacy.

It then lists the kind of ruptures of a normal life-course that are expressed by patients. These are life events such as divorce, illness, death, arrests, loss of a job, suicide attempts, which present a dramatic life disrupting normality. They also provide legitimate explanations for patients' drinking pattern getting out of control, and escalating to heavier/problem drinking.

In this part of the reconstructed life experiences, the Past, a number of reasons constitute the main features. These consist of external reasons such as heavy drinking styles as part of the norms of subcultures, i.e. the Army or the Navy, and reasons located inside the person such as feelings of anger, frustration, or mental states of depression or anxiety. The inability to cope with stress in general or associated with feelings listed above, i.e. psycho-pathological reasons for drinking are provided by patients. All these reasons help towards the display of patients as morally adequate individuals.

The main features of the Present, listed in the chart, include improved communication skills, gaining insight and knowledge about the harmful effects of alcohol and increased self-

confidence and self-awareness, becoming more self-assertive, through the 'Treatment Programme'. This also emphasises patients' moral adequacy.

The last level of this threefold structure, i.e. the Future, is presented with its main features consisting of patients' expressed plans to avoid pubs, refuse a drink, get a job, a place to live, take up a 'hobby', and 'sort out' their relationships. This kind of determination for a change of lifestyle to maintain abstinence again displays patients as morally adequate, responsible individuals.

#### **Study patients' accounts and the AA member's 'life story'**

Patients' accounts of their life experiences, in this study, are reinterpretations of reality viewed in a new way. Similarly, as mentioned in the literature review (Part I), Thune (1977) has suggested that an AA (Alcoholics Anonymous) member comes to understand his life in a new way, that he views it with a different structure and logic than he had previously. According to Thune, the 'life story' has provided to an AA member the most effective means for transmissions of its values and assumptions, while reflecting the members' new, shared way of perceiving the world.

It is also argued by Alasuutari (1990) that, although the telling of life histories does not have a similar position in a Finnish A-clinic, an alcoholism treatment institution, nonetheless members discuss and redefine reality and the world

view of the teller is reflected in all life histories. He suggests that the picture of life history an individual translates into speaking terms, into a story, reflects his present way of thinking and behaving.

Denzin (1987) has pointed out the confessional aspect of the AA alcoholic's story. An AA member believes that he/she has an allergy to alcohol and therefore will always define himself/herself as an alcoholic. Recovery is assumed to be a spiritual awakening of the individual.

The confessional element is also reflected in this study, whereby patients are encouraged to talk about themselves. As discussed in the literature review (Part I), the acceptance of alcoholism as a personal pathology, and the distinction between normal and abnormal is a characteristic of Western views of unacceptable drinking (Alasuutari, 1990), and it therefore applies to AA theory as well as psychological and learning theories.

Unlike AA members, however, patients in this study do not view their recovery as a spiritual awakening; they emphasise learning how to deal with their emotions such as anger, how to cope with stress and be self-assertive, as part of their recovery process. The study patients, thus, use a self-analytical approach in their reinterpretations of their drinking experience, rather than a spiritual one.

I have examined all patients' accounts to see if the narrative structure and all the different levels were applicable throughout the interviews. I was asking whether all patients were talking in the same way, presenting a similar account, thus showing consistency of the findings. I found two accounts (patient nos. 29 and 32) which deviate slightly and a third (patient no.16) which is more clearly a deviant case.

These three accounts are among the shortest interviews lasting about 20 minutes. They are characteristically different mainly by their denial of any drink problem or of the label 'alcoholic', whilst the rest of the patients admit to having a drink problem.

The following extract is taken from one of the two patients whose account deviates mainly by his denial of the label 'alcoholic'.

**Extract 17 - patient no.29 (male)**

1 'It started when I was in the Air Force. I got drunk once  
2 but I was drinking Saturday nights only. When I came out,  
3 I went on drinking Saturday nights, but I started drinking  
4 more. It never occurred to me that I was drinking more  
5 than a anyone else. I was drinking several pints a day in  
6 pubs. Steadily I suppose I was drinking more but I wasn't  
7 aware at the time.  
8 Then I went to Hong Kong and I married in Hong Kong. The  
9 drinking went down naturally because my wife hardly drank  
10 at all...Money of course was never a problem. The cost  
11 didn't come into it you know. My marriage broke up because  
12 all I was bringing into the marriage was material things  
13 and nothing else basically. When you're drinking you just  
14 don't. I came back to the U.K. and I did nothing but drink  
15 every day...I suppose I was getting through the money and  
16 I cut down until I was drinking 3 or 4 pints beer a  
17 day...Then when I was in Saudi Arabia, I didn't drink for  
18 4½ years. I never thought of myself as an alcoholic  
19 because I stopped you see. Why should it ever occur to me  
20 that I was alcoholic, I didn't drink for 4½ years. I know

21 I must change my lifestyle and I know I can do it. I don't  
22 think I'm an alcoholic.'

This patient starts with an account of a normal sensible drinking pattern (lines 1-5). Then he shows (lines 6-7) that he now has insight into his heavy drinking habit which refers to the present Treatment Programme. He later (lines 11-13) talks about his marriage breaking down, a traumatic event, and his continued daily drinking pattern also contributes to the dramatic nature of his account which characterises the Past in patients' accounts. Although he denies the label 'alcoholic', he shows that he has learned from the Programme by stating that he knows he must change his lifestyle emphasised in the Treatment. He thus emerges as a morally adequate individual. However there seems to be an absence of psychological motives for his drinking which is characteristic of other patients' accounts.

Therefore this patient's account contains 'normality', dramatisation of the Past, and display of moral adequacy, but deviates in the denial of the label 'alcoholic' and in the absence of psychological reasons for drinking. The next extract is from the second patient's account which deviates mainly by the denial of any drink problem. He also differs from other accounts as he does not present a dramatic Past.

**Extract 18 - patient no.32 (male)**

1 'I was drinking normally I suppose from the age of 19 when  
2 I was in the Royal Air Force. I got married and stayed in  
3 the Force for 12 years and looking back now, I can see

4 everybody drank a lot in the Force. It was stressful being  
5 in the Force. Drink was part of the social system as it  
6 were that was going at the time. I continued until the age  
7 of 40, when I realised that I was drinking to relax, for  
8 social reasons as well as when I got bored, but...Hopefully  
9 I'll get a job which is not stressful. There's no need to  
10 earn vast sums of money, I have no mortgage to pay. I'm  
11 conscious that it is up to me to control my drinking, and  
12 no one else can do it for me, but I don't see that as a  
13 problem. I do not have a problem, I know I can control my  
14 drinking.'

This patient too talks about normal, sensible drinking to start with, but he shows insight by talking about stress in the Force and drinking a lot (1-5). He is offering a psychological reason for drinking. He continues displaying himself as an insightful person giving social and psychological reasons for drinking such as to relax and when bored (7-8).

Again he emerges as an insightful person, in lines 10-12, when he talks about not needing vast sums of money and that it is up to him to control his drinking. He also emerges as morally adequate person. He then denies having any drink problem. This patient therefore deviates by his denial of any drink problem, and by the absence of any dramatic events characterising the Past.

The following extract is the third patient's account, which a deviant case as it differs in all aspects of the narrative structure. Nonetheless, it is also a display of moral adequacy, appealing to a moral world known in common with other patients.



**Extract 19 - patient no.16 (male)**

1 'I drank socially from about when I came to England so that  
2 would be 1958, '59, went to Queen Elizabeth College, then  
3 went overseas and came back in 1966. I started drinking  
4 then more heavily. I don't think my drinking was anything  
5 out of the ordinary things people do. My life was fairly  
6 steady. I met a lady and we've been together since 1972.  
7 Then in 1988, I decided that I was going to do a B.Sc  
8 course, anyway I managed. I felt so happy, I thought I  
9 needed to celebrate. I went straight to drinking whisky  
10 and ended up in 'detox'. I am careful, I don't drink a lot  
11 with people at parties, and I know that when I'm happy I  
12 must control my drinking. I can do it, so you see I don't  
13 think of myself as an alcoholic. I drink when I'm happy.'

This patient starts with social drinking, emphasising some normality in his Past as all patients do, which establishes his moral adequacy. But he states that his heavy drinking was not different from ordinary people (3-5). Unlike other patients, he is displaying a stable lifestyle. He gets married and gets a B.Sc degree too, with no dramatic events rupturing this steady life-course( lines 6-8).

Following his degree, he gives social reasons for drinking, i.e. drinking when happy and to celebrate (lines 8-9), which is an event but not a traumatic one, rather a happy event. He not only denies the label 'alcoholic', but states that he is in control of his drinking. In the rest of his account, he continues talking about happy occasions when he drank to excess.

This account stands out as a deviant case as it has a very different narrative structure. The characteristic features of the Past, Present and the Future are not found in this account

except for the display of moral adequacy. He presents heavy drinking and the need for 'detox' as something that can happen to anyone. No dramatic events, nor any psychological motives are given.

These three accounts, particularly the third case, indicate that we all appeal to moral forms in our descriptions of ourselves and of the world. However, they also highlight our differences in the way that we talk about ourselves, our intersubjective world, and show that we do not all talk alike. They reveal that it is possible to give a different account.

These deviant cases suggest that the three levels of structure, i.e. the Past, the Present and the Future are not distinct in all accounts. The characteristic features of the three levels are also not necessarily present, but the appeal to the moral order is common to all the accounts. However, the way that this moral order is accounted for will vary from one account to another.

Therefore, this confirms Alasuutari's (1990) suggestion that alcoholism is understood in moral terms in most Western cultures. It is also consistent with the findings of other researchers such as Baruch (1981), Cuff (1980) and Voysey (1975).

The way that 'normality' features in these three accounts, shows that we are all moral actors (Schutz, 1964) but we are

capable of giving different accounts and do not talk alike. The deviant cases illustrate, thus, that we are not '*cultural dopes*' (Garfinkel, 1967), and that we do describe ourselves and the world in different ways. In the next section, I shall describe how alcoholic patients and alcohol professionals accomplish their talk through the MCD analysis (Sacks, 1972).

## **Chapter Five: Patients' and professionals' discourses:**

### **similarities and differences - selected texts**

My literature review (Chapter Three) showed that patients' accounts of their encounters with the medical profession were displays of moral adequacy (Baruch, 1981) and that, more specifically, alcoholism was viewed as a moral matter in Western cultures (Alasuutari, 1990). In addition, the psychological terminology relating to reasons for drinking, used in patients' accounts, fits with the psychological orientation of the Treatment Programme and thus represents a situated vocabulary of motives.

The previous chapter on the 'narrative' discussed how patients' narratives predominantly display their moral adequacy. This chapter will show how morality, displays of moral adequacy and situated vocabularies of motive are accomplished through the use of membership categories (Sacks, 1972). 'Membership Categorisation Device' analysis, discussed earlier in Chapter Three, will be applied to selected texts from patients' and professionals' discourses. By analysing professionals' letters as well, similarities and differences in patients' and professionals' discourses will thus be highlighted.

The part of Sacks's work which relates to the analysis undertaken in this study was discussed in Chapter Three. The objective here is to address 'how' the talk is achieved, and

thus how social structures are talked into being. The talk produced by patients and professionals is treated as a topic in this analysis of MCDs. As we shall see, patients and professionals sometimes use category-modifiers associated with membership categories. These tend to draw the listener's attention and curiosity, and create lively stories. They may also help in enhancing patients' moral adequacy. The use of MCDs indicate possibilities for producing a strong and powerful impact in the organisation of 'talk'.

The selected texts for analysis in this chapter will present an extract from a patient's interview talk with comments, followed by an extract from a professional's letter referring to the same patient, followed by comments. Some simple counting is used to provide additional support to the analysis. As Hammersley (1993) has argued, qualitative and quantitative research procedures are but different forms of the analytic practice of re-representation in science, in that both seek to arrange and rearrange the complexities of 'raw' data.

The extracts that follow highlight similarities and differences found in patients' and professionals' discourses through the MCD analysis. They illustrate displays of moral adequacy, accounts of intelligible reasons given for drinking by both patients and professionals, as well as the different emphases and functions of the patients' and professionals' descriptions.

The extracts are organised by subheadings which represent the main theme applicable to selected texts. An extract from a patient's account will be followed by the MCD analysis, and then an extract from a professional's letter relating to the same patient will be presented followed again by the MCD analysis. Conclusions will be drawn from both analyses.

The first subheading refers to displays of moral adequacy. As pointed out in the chapter on the 'Narrative' (Chapter Four), all study patients engage in displays of moral adequacy, in doing 'moral talk'.

a) MORAL ADEQUACY

The first two extracts are from the interview with patient no.10 and the senior registrar's 'discharge letter' to this patient's General Practitioner. The patient is defined, in both accounts, as a morally responsible adult, however differences do emerge and these will be explained in this section.

**Extract 20 - patient no.10 (female)**

1 P: 'I've been a good mother to my children. I was lacking in  
2 confidence and I do realise now that I need a job, I need  
3 to be independent, be responsible for myself. I think I  
4 have the confidence now to get a job. I'm still carrying  
5 anger, not toward my children but toward myself because I  
6 feel rejected so until I do something about it, I  
7 think if you do not prove it to yourself that you can do  
8 it, then you're trapped in yourself and you're attracting  
9 trouble all the time, trouble with relationships, trouble  
10 with people and I think once you get your own confidence  
11 back then you attract confident people. You go into  
12 marriages and when something goes wrong you can't handle  
13 it. My life is really a set of catastrophes.'

Patient no.10 starts describing herself as a good mother to her children. Two membership categories are used as mother and children, from the MCD-family. The consistency rule applies here as they are both from the same MCD. Mother-children relationship is a standardised relational pair. We also hear the children being the children of this mother and vice versa, they are therefore duplicatively organised.

Being a good mother is a category-bound activity of a mother, which presents her as morally adequate parent. We then hear category-bound activities tied to a category of an 'insightful, house-bound person' linked to the MCD-types of person, in lines 1-4, such as lacking in confidence, the need for a job and for being independent and responsible.

She shows that she has gained insight from the treatment programme when she states in line 2 what she realises 'now'. She repeats the use of 'now' in line 4 when she states that she has the confidence to get a job. She then proceeds by providing her explanations. A 'self-analysing person', another category to the MCD-types of person, emerges (lines 5-10) and category-bound activities include 'carrying anger', 'feel rejected', 'prove it to yourself', 'trapped in yourself' and 'trouble with relationships'.

We have a mother-children standardised pair again (line 5) where mother is heard, not mentioned. The interviewer is then reassured, in lines 5-6, that her anger is not directed

towards her children, thus maintaining her status as a good mother. She goes on describing how 'confident persons', an MCD, would behave (lines 10-11) such as attracting confident people which is a category-bound activity. The last MCD in this extract refers to a 'normal person'. Her reference to going into marriages is a category-bound activity tied to the category of normal person linked to the MCD-normal living. 'Something goes wrong' in the marriage and 'can't handle it' (lines 12-13) are category-bound activities to husband-wife standardised pair, heard but not mentioned. She is also skilfully analysing other people's marriages rather than hers, thus providing an explanation for the things that have gone wrong in her marriage. There is also an ambiguity in what she says, in lines 7-13, as she is analysing others rather than herself. She is in some ways analysing herself from the outside, a CBA of an 'insightful person'.

It is interesting to note the repeated use of 'you' and 'yourself' in relation to the category of self-analysing person. In Sacks's terms, she is making a hearably correct observation. A set of inferences are attached to this class of categories, implied by the use of 'you' and 'yourself', which are 'common knowledge'. Having described various disasters that characterise her life, she arrives at a logical conclusion when she sums up her talk by suggesting that her life is a set of catastrophies.



**Extract 21 - SR's letter no.51 (re: patient no. 10)**

1 SR: 'She was very pleased that the access to her son, ..., was  
2 increased over the weeks while she was here. He came to  
3 the unit on several occasions and seemed very well adapted  
3 and a lovely little boy, who had a good relationship with  
4 his mother. We hope that further progress will be made so  
5 that in .... .... may be able to leave his foster mother  
6 and return to ... ... intends to stay off alcohol  
7 completely and recognizes that this is the only sensible  
8 course for her. She has taken Disulfiram each night, and  
9 this has helped her to avoid impulsive responses to return  
10 to drinking.'

The Senior Registrar (SR), in this extract from his 'discharge letter' to the patient's General Practitioner (lines 1-2), starts presenting the patient as a morally adequate mother, pleased to be able to see her son more frequently (a category-bound activity to the category mother). However, mother is heard, not mentioned. Mother and son constitute membership categories and a standardised relational pair to the MCD-family, duplicatively organised and consistent, being from the same MCD. We also hear that ... is the son of this mother, thus we hear it as a correct observation which is repeated in lines 3-5, when ... is referred to as 'little boy'. The patient's moral adequacy is highlighted when the SR talks about 'a good relationship' (lines 4-5) which is a category-bound activity to the standardised pair mother-son. The use of 'we' in line 5 indicates an institutional voice. The SR is speaking with an objective, passive voice typical of staff in an institution, an organisation. This impersonal approach is similar to the patient's use of 'you'.

The SR then refers to ...'s foster home, an MCD (lines 6-7)

and foster mother-son is a standardised pair; consistency rule applies here as both foster mother and son are membership categories of the same MCD. The SR's statement, 'Return to ...', a category-bound activity, implies that the foster mother is only a temporary replacement of the mother. The patient is then described as a reformed alcoholic (lines 8-11), another MCD, and category-bound activities include the intention to stay off alcohol, the recognition that this is the only sensible course and taking Disulfiram each night to avoid returning to drinking. We hear again an institutional, passive voice here when he says 'this has helped her', in line 10, instead of admitting that he thinks it has helped her.

These extracts from the data relating to patient no.10 and the unit's Senior Registrar, are consistent in constituting the patient as a morally adequate and responsible parent and adult. There are some differences, however, which appear specifically in the use of category-bound activities. The patient's self-report uses CBAs conveying 'emotions' with insights, whilst the professional's report makes use of CBAs on symptoms and drugs.

However these two reports perform quite different functions. The patient's display of her moral responsibility shows that she is 'morally adequate and insightful' (that she has learned from the professionals). The SR's report, on the other hand, while also displaying the patient as a morally adequate individual has a different function, i.e. trying to secure

the General Practitioner's help and support to the patient following discharge from hospital. He therefore presents the patient as a morally adequate individual. These reports thus constitute each account-giver: the patient as an 'insightful person' capable of benefiting from the treatment programme, and the SR as a 'responsible physician' caring for his patient's well-being. They are both skilful; the patient refers to a class of categories by the use of 'you' and 'yourself' (lines 7-12), thus legitimising her behaviour by referring to a class of categories, requiring no defending, whilst the SR uses the institutional passive voice by the use of 'we' in line 5. He distances himself, making statements which seem 'objective'.

Patient's display of moral adequacy agrees with Baruch's argument on this kind of display by people in their encounters with health professionals. It also highlights Alasuutari's finding that alcoholism is viewed in Western cultures in moral terms, and we have seen that the patient and the professional both appeal to the patient's moral character. The patient also uses situated vocabularies of motive when she refers to her lack of confidence, the need to become independent, 'trouble with relationships'; these are acceptable motives in the psychologically oriented Treatment Programme.

The next two extracts also illustrate how MCD analysis shows patients' and professionals' skills in constructing the patient as a morally responsible adult. The Social Worker's

letter is addressed to the director of a 'dry house' applying for a place for this patient following his discharge from hospital.

**Extract 22 - patient no.1 (male)**

1 P: 'I'm 45 years old, I've been drinking virtually since I was  
2 allowed to, that is from the age of 17. In the early days,  
3 I just used to drink at weekends as most young people do.  
4 I got drunk a few times, it was just a question of growing  
5 up as most young lads do. There was never a question of  
6 women involved, it was just a good laugh and sometimes it  
7 ended up being drunk. That was purely with the lads as it  
8 were and it was the thing to do. I tended to drink  
9 just the weekends because I was studying hard at school.'...  
10 'The kids have been predominant on my mind. I couldn't  
11 possibly concentrate on my work because I was always  
12 thinking about the kids. I just wasn't giving 100% to my  
13 work, and the kids are a very big joy really. I haven't  
14 seen them for 4 years and the only possible way I can do  
15 that, I can achieve that is to stay dry, and to show the  
16 welfare officer that I can hold a job down again. I mean I  
17 held a job down, a labouring job but I wasn't happy doing  
18 it. But I'm no longer concerned about the pound note. I  
19 mean in the old days when I was in the oil industry, I  
20 really would like to get back in the oil industry, but it's  
21 not the money, it's the buzz you get out of working in that  
22 sort of environment.'

In this extract, patient no.1 starts by referring to his age as 45 (line 1) which indicates a class of category sets. It is inference-rich in Sacks's terms. It infers knowledge by members of society and locates him as a middle-aged, mature person. We have an MCD of 'stages of life' linked to drinking (lines 1-5). The economy and consistency rules apply here; the patient is the category presented in the stage of life as a teenager and as a middle-aged person. drinking from the age of 17, at weekends and getting drunk a few times are category-bound activities to a teenager.

He also presents himself as a law-abiding teenager by stating that he started drinking when he was allowed to. The age of 17 is a category-bound to the law-abiding teenager linked to the MCD-teenagers. It infers knowledge of a whole class of activities relating to teenagers. He implies, in lines 3-5, that his drinking at that stage needs no defending as he suggests that most young people drink. So we have an MCD-teenager which represents a class of categories which the patient is a member of. The reference to young people in line 3 provides an explanation for his drinking. Further CBAs to the stage of life as a teenager are given (lines 6-8) such as 'just a good laugh', 'ended up being drunk' and 'it was the thing to do'. The patient is also showing insight (lines 2-5) when he looks back; 'in the early days', 'used to drink at weekends as most young people do' and 'question of growing up' are CBAs to the category of an insightful person linked to the MCD-types of person.

Another interesting CBA 'no women involved' (line 6) emphasising drinking as a male activity is linked to the MCD-teenager with other CBAs in lines 3-8 mentioned above in relation to the stage of life of a teenager. Having established his 'normality' in relation to his teenage years, he then describes himself as a student (line 9) a membership category to the MCD-school. 'Studying hard', a category-bound activity, constitutes him as a responsible person. The economy rule applies here as one membership category is given i.e. the patient as a student.

We then have an MCD-family (lines 10-14) and membership categories such as kids and father are given; 'father' however is heard, not mentioned. Father and kids are consistent in being from the same MCD, are duplicatively organised and present a standardised relational pair. Category-bound activities here such as 'predominant on my mind', 'always thinking', and 'are a big joy' display the patient as a morally adequate parent. He then presents himself as a recovered alcoholic, an MCD (lines 14-16). As it is the only membership category given, the economy rule applies. CBAs include staying dry, holding a job down again. We then have a CBA referring to himself being not happy in a labouring job, tied to an MCD-aspiring person (lines 17-18). Then in lines 19-22, the desire to work again in the oil industry is heard as a CBA to the MCD-money grabbing person. We have here a category-modifier when he states that it's not the money (line 21) he is interested in, it's the buzz. The use of 'you', in line 21, implies that he is making a general observation which is unchallengeable. This is similar to the use of 'you' by patient no.10 as we have seen in the previous extract.

**Extract 23 - Social Worker's letter no.8 (re: patient no.1)**

1 SW: 'S.. was academically successful at school gaining 8 'o'  
2 levels and subsequently an ONC in engineering. He has  
3 worked as a freelance engineer and apparently has been  
4 successful, travelling widely in his work, but more  
5 recently, although still able to find work, has not been  
6 able to maintain it.'....  
7 'He continues to be very distressed by the break up of the  
8 marriage and by his inability to gain access to their 2  
9 young children.'

The Social Worker, in this extract, lines 1 and 2, uses the same MCD-school as the patient. Category-bound activities such as 'successful', 'gaining 8 'o' levels' and ONC in engineering constitute the patient as a morally adequate individual as the patient himself does with his own expression 'studying hard'. The SW is using an institutional voice, in line 3, when she refers to him as being successful but she says 'has been' rather than give her view. The institutional voice is heard again, in line 7, when she says: 'he continues to be very distressed', rather than saying this is what she thinks.

The patient is then presented as a worker, membership category to an MCD-employed people. The economy rule applies here as he, as a freelance engineer, is the only category given. CBAs refer to being successful, travelling widely and 'able to find work'. These hearably good qualities which the Social Worker attributes to the patient make up for what she has to say later, line 6, about his inability to maintain a job which is, thus, a category-modifier. She then uses the MCD-broken marriage (lines 7-9) with membership categories as the patient in the role of the father and the children, although the father is heard but not mentioned. She refers to his inability to gain access, a CBA which is causing distress thus constituting him as a morally adequate parent with expected motives.

Both extracts, patient no.1's and the Social Worker's,

display the patient as a morally adequate parent and a responsible, insightful person using in most instances similar MCDs and membership categories but quite different CBAs. As in the previous extracts, the patient's self-report emphasises feelings and insight whilst the professional's report points out symptoms such as distress and personality difficulties such as the inability to maintain a job.

The function of patient no.1's account is to show that he is a caring father, a morally responsible individual, hence worthy of help, and of the time and expenses required for his treatment. The Social Worker's emphasis on the patient's moral adequacy performs a different function. She is skilfully presenting him as a worthy applicant for the 'dry house', as her aim is to ensure a place for this patient. Her discourse has an impersonal format as that of the SR.

**Extract 24 - patient no.20 (male)**

1 P: 'I've learned more about myself and I've never really sat  
2 down and thought about myself or talked about myself. So  
3 the Programme has given me a chance to think about myself,  
4 my independence. I've also learned about my good and bad  
5 sides, you know. Staff have been very helpful on the  
6 course. I've seen a positive response from people, rather  
7 a response to that being alienated as someone who drinks too  
8 much. So it's helped me that way and I like getting on with  
9 people. I don't like it when something's getting in the  
10 way; the alcohol was. So when I look into the future, I'd  
11 like to give quite a bit of thought to the job I'm going to  
12 next, maybe develop another career and think about the  
13 things I wasn't thinking about, at 18. I want to take  
14 positive steps.'

This patient is describing himself as an insightful person, a membership category to the MCD-types of person. The category-



bound activities of this description include learning more about himself (line 1), his 'good and bad sides' in lines 4 and 5. The statement about learning more about himself implies the context, i.e. the 'Treatment Programme' in which he has been able to learn more about himself. This patient is also expressing the medical 'whole person' emphasis when he says that he can now talk about himself (line 2), which is a CBA to a category of person who has learned from the Programme linked to an MCD-alcoholic patients who benefit from treatment, hence displaying his moral adequacy. In lines 9 and 10, a CBA such as drinking when something gets in the way is offered, bound to a category of a psychological reason linked to an MCD-reasons for drinking.

He is categorising staff (an MCD) as being 'very helpful', thus constituting himself as a helpful person. Similarly, it is interesting to note that staff, in their letters, tend to constitute patients as being 'helpful to others', e.g. the SR's letter no.53, in extract 64, Chapter Nine, and the SR's letter no.51, extract 27 in this chapter. We shall see in extract 25, how the SR describes him as 'perceptive of difficulties of other people'.

Then, in lines 6-8, the display of moral adequacy continues with membership categories such as a 'friendly self' and 'getting on with people' as a CBA, linked to a an MCD-recovering alcoholic. Also a category of a morally responsible self, linked to the same MCD, is described in

lines 10-14, with CBAs such as 'looking into the future', giving quite a bit of thought to the job he is going to next, 'develop another career' and 'take positive steps'. This extract accomplishes the function of displaying the patient as a morally adequate person, who has learned from the Treatment Programme how to think and talk about his feelings.

**Extract 25 - SR's letter no.5 (re: patient no.20)**

1 SR: '...He was well accepted by other members of the group and  
2 as time went on he gained in insight and was able to express  
3 much better how he felt about things... He is intelligent  
4 and good humoured and was perceptive, both of his own  
5 difficulties and of difficulties of other people. He is  
6 intending to stay off alcohol altogether.'

The SR's letter, addressed to patient no.20's GP, also describes the patient in terms of a category of an insightful person (line 2) and as a friendly person, category to the MCD-recovering alcoholic, with a CBA in line 1, i.e. 'well accepted by the group'. Other categories referring to the MCD-types of person include an 'intelligent and good humoured person', a perceptive person (lines 3 & 4), and 'intending to stay off alcohol altogether' (line 6) which display the patient as a morally adequate individual. The SR also describes this patient as being perceptive of difficulties of other people, and, as mentioned earlier, the patient describes the staff as 'very helpful'.

Both accounts, patient's and the SR's, have the function of displaying the patient as a morally adequate person, capable of learning from the Treatment Programme.

However, the SR's account functions as a professional assessment of a patient's personality characteristics and his performance in the Programme. His account is given in a passive voice, as we can see in lines 5 and 6; the patient's intentions are reported in the third person 'he'. Thus, the SR is taking no position, but is simply reporting. Also, when the patient describes the staff as 'very helpful', he is using 'lay' terms, whilst the SR is using psychological terms to describe the patient such as having 'gained insight', as being 'intelligent' and 'perceptive'.

**b) FORMULATING PROBLEMS**

The following extracts illustrate the way that problems including drinking are formulated and presented by patients and professionals. Problems are mostly formulated in medical and psychological terms, highlighting the influence of psychology in modern medical discourse. These extracts will unavoidably contain statements which will refer to patients' moral adequacy, as patients and professionals are both engaged in 'moral' discourses, mentioned earlier.

**Extract 26 - patient no.10 (female)**

1 P: 'I have a problem actually. I didn't have a very good  
2 childhood with my mother and I find it very difficult to  
3 speak to anybody about her. I have talked to Dr.... about  
4 this and come to the conclusion that there's something  
5 very deep-rooted in there to do with my childhood. I have  
6 already expressed the wish to have psychiatric treatment.  
7 I can't speak about my mother without bursting into tears.'

In this extract, the patient presents a psychiatric and

emotional problem. In lines 1 to 3, Mother and daughter are membership categories from the MCD-family, and are a standardised relational pair, duplicatively organised. They are consistent as they are both from the same MCD. Category-modifiers here refer to her childhood not having been good and to her difficulty in talking about her mother. She describes her relationship with her mother in psychological terms and we hear her as showing insight, a CBA. We therefore have a membership category of insightful person with a psychological problem, linked to the MCD-types of person, and admitting having a problem (line 1) and a difficult childhood are CBAs.

Another CBA (line 3), the difficulty to speak about her implies her need for help. She expresses knowledge here as she knew who to talk to, and in line 4, she states that she has come to a conclusion, a CBA to someone capable of logical thought. The patient tells us that she has expressed the wish to have treatment which is a CBA to an the category of a responsible person linked to the MCD-morally adequate persons.

We also have here an MCD of 'people needing treatment', psychiatric treatment being a membership category with a CBA referring to her inability to speak about her mother. A category-modifier to mother-daughter standardised pair is given in line 7, i.e. 'without bursting into tears' which we would not normally expect, and which justifies her need for help.

**Extract 27 - SR's letter no.51 (re: patient no.10)**

1 SR: 'She has asked for a referral to a psychotherapeutic  
2 unit, so that she can explore her earlier circumstances in  
3 a deeper way than was possible on the alcohol rehabilitation  
4 programme.... She was a very pleasant person on the unit -  
5 always helpful to other patients and staff.'<sup>1</sup>

The Senior Registrar, in line 1, also refers to the patient's need for further treatment and he mentions the fact that she has asked for a referral to have treatment. She therefore is presented as a responsible adult. We have an MCD of people in need of treatment and the patient as a membership category. The economy rule applies here as she is the only membership category. A CBA refers to the patient's request for a referral. In lines 2-3, a membership category of an insightful person, linked to the MCD-types of person, is given as the patient is described wanting more insight into her early childhood. He also presents the patient as a member of the unit, CBA to the membership category-patient and the MCD here is the treatment unit. Patient, however, is heard, not mentioned; she is referred to as a person thus the attribute of being pleasant (line 4) is a personal attribute and not temporary as the status of patient would imply. Another CBA describes her as 'always helpful', thus she is displayed as a cooperative and helpful person despite her emotional difficulties. We have in line 5, a staff-patient standardised relational pair duplicatively organised and consistent as they both are from the same MCD. The SR, as in the case of other

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<sup>1</sup> This is another extract from the SR's letter no.51 referring to patient no.10.

professionals in the previous extracts, is using the passive, institutional voice (line 4), when he says 'she was a very pleasant person' rather than expressing her own opinion.

In both these extracts, the patient and professional talk about patient's psychiatric/emotional problem, however the patient emphasises the emotionality of her problem while showing competence in her appeal to logical thinking. The professional, on the other hand, describes the problem in psycho-analytical terms referring to earlier circumstances needing to be explored in a deeper way.

The patient's report recognizably shows insight into her early childhood experiences and recognition of further need for treatment has the function of demonstrating her need and worthiness for help. On the other hand, as the function of the SR's report is to persuade the General Practitioner that it is worthwhile helping the patient following discharge from hospital, the emphasis is on inter-personal relationships. She is described as a cooperative person who gets on well with people.

The basic feature that differentiates the patients' and the professionals' reports lies in the the fact that patients are presenting self-reports whilst the professionals are presenting reports on other persons.

Extract 28 - patient no.1 (male)

1 P: 'I've tried taking labouring jobs and I'm OK; all that is  
2 doing is just making myself stupid, making myself tired, and  
3 not really addressing the real problem, because I used to  
4 finish the labouring job and go home, have a couple of  
5 drinks in the pub but it's loneliness. It used to be  
6 work, now I've lost everything, I absolutely worked,  
7 now I'm lonely. Drink doesn't cure loneliness. The only  
8 thing that's gonna' cure my loneliness is to stay off the  
9 drink and start to enjoy again the things that I always used  
10 to enjoy both as a married man and a single man and that is  
11 a number of things. I'm very sport-minded, I like squash,  
12 table tennis, I like fishing.'

In this extract, lines 1-3, patient no.1 presents himself as a working man, an MCD, which conflicts with the MCD-ill person. CBAs include making himself tired, stupid. We have in lines 2-3 an MCD-intelligent person with a CBA referring to labouring work making him stupid and not addressing the real problem. Then in lines 3-7 a category of an insightful person emerges, linked with the MCD-types of person, with a CBA 'not really addressing the real problem' (line 3). The use of 'real' is emphasising his insightfulness. He is showing that he can see the real, underlying problem beneath the surface. He mentions ordinary activities, in lines 4-5, such as finishing the job and going home, having a couple of drinks in the pub, but he he shows insight again by recognizing the 'real' problem, i.e. loneliness. Other CBAs include 'it's loneliness', 'drink doesn't cure loneliness', 'lost everything'. We have an MCD of someone who intends to be a recovered alcoholic, in lines 7-12, and staying off drink, enjoying sports again, playing squash, table tennis and fishing are CBAs. These are also CBAs for a non-lonely person.

By stating that the real problem is loneliness and that drink doesn't cure it, he is giving an opinion which, following Sacks's suggestions, can be seen as a mediating device between client and professional enabling a discourse to take place. The professional in this case is the interviewer who is often addressed as 'doctor', thus perceived as a member of the treatment team.

**Extract 29 - Social Worker's letter no.8 (re: patient no.1)**

1 SW: '... is the only child of a rather over protective mother  
2 and rather disciplinarian father. The family seem to  
3 have had materialistic priorities and poor communication of  
4 feelings and ... was a very lonely child who has always had  
5 difficulty in establishing close relationships. ...'s father  
6 died in 1969 and his mother, who is in her 80's, retired  
7 from work about 2 years ago and is very involved with ...  
8 and with his drinking problem, a fact which bothers him  
9 intensely.'<sup>2</sup>

In this extract, the Social Worker describes the patient in hearably psychological terms. So we have an MCD of psychological explanations and 'over-protective mother' and 'disciplinarian father' are CBAs. At the same time, we have an MCD-family with mother-child and father-child are standardised pairs and the membership categories, mother, father and child are duplicatively organised and consistent as they all are from the same MCD. 'Over-protective mother' and 'disciplinarian father' present contrasting activities to the MCD-family. She continues with CBAs, in lines 3-5, to psychological explanations such as 'poor communication of

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<sup>2</sup> This is another extract from the Social Worker's letter no.8, referring to patient no.1.



feelings' and 'difficulty in establishing close relationships'. Membership categories to the MCD-family are given in lines 6-9 as mother, father and son which are consistent as they are from the same MCD and are duplicatively organised. Category-bound activities here include death of the father, retirement of the mother and the mother's involvement with the patient's drinking problem. The mother-son standardised pair presents contrasting activities such as mother's involvement which bothers the son. The mother's age is given as being in the 80's thus we have a class of category sets; it infers members' knowledge about old women and the mother's involvement with her son's drinking is seen as interference and a nuisance.

These extracts show how the patient is presenting his problems as personal/social problems while using psychological insights. The professional is presenting a psychological discourse with an institutional voice that appears to own the discourse. Both serve to diffuse the question of patients' drinking problem. As we will see in Chapter Nine, this agrees with the 'whole person' approach to illness in modern medical discourse.

The patient's self-description which defines him as an insightful person has the function of showing that he is capable of benefiting from treatment, thus worthy of help. The Social Worker's report on the other hand has the function of ensuring a place in a 'dry house' for this patient. She is

therefore presenting the patient as someone who has had an unhappy childhood with inadequate parents, hence deserving help and support. She is using standard concepts within the psychological discourse relating to 'causes of alcoholism'. The following two extracts from the interview with patient no. 2 and from the Senior Registrar's 'discharge' letter to this patient's GP, both illustrate the justifiable explanations offered for the onset of problem drinking, but perform quite different functions.

**Extract 30 - patient no.2 (female)**

1 P: 'Well, I started drinking socially when I first met my  
2 husband. I'd never drunk before that. I didn't know what  
3 drink was to be quite honest. I met my husband, we just  
4 went out to see some friends and he said: 'Would you like a  
5 drink?'. I just turned and said: 'What drink? I've never  
6 had a drink'. He said: 'I'll mix you something, half an  
7 inch of Dubonnet with some bitter lemon'. I thought that  
8 was quite nice. I then was drinking socially. It was about  
9 a year, 1981, until I really started to drink. I then got  
10 the taste of whisky. In 1981, I had a bad accident when I  
11 was arguing with my husband. He gets violent sometimes when  
12 he drinks; I had my hip broken, and had my hip replaced.  
13 My husband said: 'Why don't you have a couple of glasses of  
14 whisky to get some sleep', because I couldn't sleep at  
15 all, and I did; and from two glasses a day, went up to  
16 three glasses, four glasses a day. It mounted up until I  
17 was on a bottle a day.'

Patient no.2 explains how her drinking started through her relationship with her husband and provides intelligible reasons for her subsequent heavy drinking. The main features of this text centre around her inexperience with drinking and in relation to men and her ambiguity over the husband's violence, her passive role in the activity of drinking vis-a-vis her husband's active role in encouraging her to drink, and

the intelligible reasons she offers for her drinking. We hear about her inexperience with alcohol in lines 1 to 3 when she states that she had never drunk before she met her husband. This absence of drinking is category-bound to an 'inexperienced person'. Lines 3 & 4 refer to MCD-stage of life, when she was young and naive as she didn't know what drink was. Category-bound activities are given in lines 4 to 8, when she sees friends drinking and she is described here in a passive role receiving the drink whilst her husband is described as the active member in this interaction offering her a drink. The patient's naivety is emphasised again (line 5) when she asks : 'what drink?'. She is presented as a passive recipient of the alcoholic drinks offered to her; she is being acted upon.

The category of social drinker linked to the MCD-social drinking is then modified when she states that she really started to drink in line 9 which then provides a category-modifier to 'social drinker'. She says that she was drinking for taste, not need at that point. In lines 10 to 12, it is not clear whether it was an accident or an attack. So there is ambiguity here and an attack is indirectly implied but not stated. This is skilfully presented as she avoids talking directly about her husband's violence. She then offers an intelligible reason for drinking at night as she could not sleep, and drinking to sleep and to relieve pain are reasons linked to the MCD-alcoholic person.

There is a relational pair here 'violent husband - abused wife' as well as 'disloyal wife - wronged, innocent husband' which is heard but not stated directly. The suggestion to drink in this context comes from the husband again but he is seen as a caring husband emphasising her loyalty to him. She is therefore in a passive role when she talks about the reason for continuing her drinking. This is also a category-modifier to social drinking as this stated reason i.e. drinking to get some sleep, is not related to conviviality and sociability. In lines 14 & 15, we are expected to draw our own conclusions about her escalation to problem drinking (lines 15-17) as a process that happened but which was unintended. The skills involved here are clearly apparent in her display as a victim of circumstances, where heavy drinking was the inevitable outcome, thus evading any blame for her actions. However the avoidance of a direct statement regarding the husband's violence allows us to see her as a loyal wife.

**Extract 31 - SR's letter no.30 (re: patient no.2)**

1 SR: 'Mrs ... is a 58 year old married woman at present  
2 separated from her husband who is Spanish and lives in  
3 Spain. She is living with her mother and returned to her  
4 mother after discharge from this unit. She was born in  
5 Greenwich. Her father was a pipe fitter with the Woolwich  
6 Arsenal and was very much occupied with his work all through  
7 the war, so that ... does not remember seeing him before she  
8 was five. Her mother is a retired factory worker and is  
9 alive and well at the age of 70. She is the only child in  
10 the family. She remembers her childhood as happy,  
11 especially a family holiday which she enjoyed at the age of  
12 nine. She enjoyed school but was not academic and achieved  
13 no examinations. She left at the age of sixteen and has  
14 worked as a hairdresser on and off since then, including one  
15 job which lasted for seven years. She and her husband were  
16 together for 28 years but have now been separated for the

17 past year. Her husband had TB as a child and it seems had  
18 a very close relationship with his own mother in Spain.  
19 It was following her death that he became violent with  
20 ... and this violence on one occasion resulted in ... having  
21 a fractured hip. She had a hip replacement in 1981. She  
22 dates her drinking to the onset of violence in the  
23 relationship with her husband. She used alcohol to relieve  
24 her pain, as she found that the pain killers were not as  
25 effective. Her alcohol intake increased until she became  
26 dependent on it. Her pattern was to drink whisky on her  
27 own, often consuming 32 units a day. She has experienced  
28 morning shakes and fits and also reports auditory and visual  
29 hallucinations.'

The main features in the Senior Registrar's text also consist of intelligible reasons given for this patient's heavy drinking, the passive role which he adopts in his account, the ambiguity over her separation. But, unlike the patient's account, he refers to the husband's violence responsible for the patient's broken hip more directly. He displays himself as an objective reporter; this direct approach presents the patient as the injured partner who deserves the reader's sympathy. The patient's age implies a class of category sets, indicating a mature person who has been in a stable, married relationship (lines 1-2). We have an MCD-married couple, only husband is mentioned in line 2, and 'wife' is heard but not stated. There is an ambiguity as the separation in lines 2 & 3 is implied as being possibly inevitable as the husband lives in Spain, and the SR refers to her as 'at present separated', as a temporary situation. The escalation from light to heavy drinking (lines 15-17) is therefore justified and encouraged by her husband. Her moral adequacy is thus maintained. The SR however does not argue that the violence caused her drinking, he is stating (line 22) what she claims as she dates her

drinking to the onset of violence. He is speaking here with the institutional passive voice.

There is an MCD-family, in lines 3 & 4, with categories of mother and a daughter where daughter is heard, not stated and duplicatively organised. Then from line 5 to 10, the patient's childhood is described as being happy. The category 'father' is included as belonging to the MCD-family and CBAs such as being occupied with work and away from the family refer to the war. The mother is described as an old woman who has contributed to society by working in a factory, and now she is old but 'well' emphasising her state of health. Being old is implied as the stage of life here when common-sense knowledge tells us that one's health deteriorates. As part of stages of life, not only has this patient been a happy child, but she also enjoyed school (line 12). She then enters an adult stage when she leaves school at 16 and starts working as a hairdresser (13-15). Her stability is emphasised when referring to one job which lasted 7 years. Again her stable lifestyle emerges in lines 16-17, as the separation of one year follows a long married life of 28 years which makes up for this separation. The husband is introduced, in lines 17-20, as having suffered first in childhood with an illness such as Tuberculosis (TB), and later by losing his mother with whom he had a close relationship. There is another MCD-family here with categories of mother and son, duplicatively organised, but 'son' is heard, not mentioned. The husband's violence is presented with some compassion as it started following his

mother's death, a CBA. Patient's fractured hip (lines 20-23) is directly attributed to the husband's violence and her subsequent drinking is described with a justifiable reason, i.e. for pain relief as a substitute to pain killers which were ineffective (lines 23-25). The husband's violence here is a category-modifier to the MCD-married couple.

In lines 25-29, the onset of dependence on alcohol is described with 'chemical dependence' as an MCD. CBAs linked with the category of the alcoholic person are also given including the consumption of large quantities of alcoholic drinks, the experience of withdrawal symptoms such as the morning shakes, fits and hallucinations.

These two extracts both offer legitimate reasons for the patient's heavy drinking. The patient displays herself as a morally adequate individual whose heavy drinking is entirely understandable in the circumstances that she finds herself drawn into. Her ambiguity about the husband's violence helps to avoid being seen as a 'disloyal wife'. The SR is defending the patient's moral adequacy by presenting justifiable arguments for her drinking. The difference here relates to the blame attributed to her husband more directly than the patient does, when she refers to her husband's role in her drinking. The SR's account also differs in its terminology as the patient's drinking is described in a clinical presentation of an alcohol dependent person's behaviour.

The function of the patient's account is to offer justifiable reasons for her drinking and thus maintain her moral adequacy. The SR's account however has the function of securing her GP's cooperation in her follow-up following her discharge from hospital. Therefore he presents legitimate reasons for her drinking such as 'to relieve pain', describing her as someone who has suffered a great deal and her drinking was justified. We conclude from this account that she deserves to be helped.

Both account-givers are constituted with a passive voice. The patient's account, however, displays her as having a passive role in the development of her drink problem, whilst the SR assumes an institutional passive voice by referring to her problems and behaviour in the third person without personalising the issues and presenting them as his own opinion. His ambiguity over the patient's separation reflects the institutional avoidance of straightforward statements on matters that may discredit the patient. He lets the reader draw his/her own conclusions.

The SR's account includes statements about the patient's family and her happy childhood part of a life history, but which do not feature later in the text in her drinking history. This may serve to help us read his letter as an 'objective' account. By contrast, the patient's text differs in this context and the whole account relates to her drinking.



The next two extracts are from the interview with patient no.17 and his General Practitioner's referral letter to the unit's director. The General Practitioner's text selected for analysis represents the entire contents of the letter, whilst the patient's text is an extract from his account. MCD analysis shows how the patient and the professional are presenting reasons for drinking and patient's motivation to stop drinking is being emphasised.

**Extract 32 - patient no.17 (male)**

1 P: 'I'll have my own flat in a year's time, I know you should  
2 only think about today, but I think in five years' time I'm  
3 going to have money. People say to me: 'money isn't  
4 everything', but my God I'll feel a whole lot better,  
5 although I don't want to be miserable and rich.  
6 I've had the telly and the video repossessed, the gas was  
7 cut off and reconnected five months later, you know, all  
8 those things; so drinking was important then. It was the  
9 thing to do. I've been broken in loads of times, got my  
10 stereo stolen; I've sold my fridge and my freezer. It's  
11 gonna' be very hard. The programme is alright but it won't  
12 stop me from going to pubs; it can give you ideas on what to  
13 do. When I went to an AA meeting, everybody said 'Hi, my  
14 name is Fred, I'm an alcoholic'. I said: 'if you haven't had  
15 a drink for ten years, you're not an alcoholic'. They say:  
16 'well that first drink you see'; my argument is if you  
17 haven't been smoking for ten years, you don't call yourself  
18 a smoker; that first cigarette won't put you back on it.  
19 I think I'm an ex-alcoholic. I'm not an alcoholic any  
20 more, you know. I've been able to go without a drink for  
21 7½ weeks. I'll go through the rest of my life without  
22 drink, that's what I intend to do.  
23 I know patients come in here, they've got no chance, the  
24 first thing they want to do when they leave here is to go  
25 straight for a drink. They make excuses 'my ex-wife' or 'my  
26 ex-husband, you see', I mean I don't need an excuse to get  
27 drunk, I drink because I want to do it. You can think of  
28 millions of excuses to drink but the best thing to do is not  
29 to drink. One of the main reasons why I want to give up  
30 drinking is that it's painful when you wake up and it's  
31 embarrassing when you're with a girl.  
32 My GP wanted me to come here and he even phoned up to see  
33 how I was doing. He's the best doctor. I'm going to see  
34 him when I go to my 'dry house', just to say 'thanks'. I  
35 could always talk to someone here, it's a shame there isn't  
36 a magic pill, that would be a major medical breakthrough.

37 What annoys me is that alcohol is legal, more people die of  
38 alcohol and cigarettes than die of drugs.'

Patient no.17 presents himself as a knowledgeable and intelligent person who can argue in defence of his point of view. He gives intelligible reasons for his drinking i.e. financial pressures which he later rejects. In lines 1 & 2, he is giving a CBA, i.e. thinking only about today, to a 'practical person', but at the same time he is planning for the future (line 2). He is also expressing the philosophy of Alcoholics Anonymous, living one day at a time. He can be heard as a 'money-grabbing' individual in lines 3-4 but makes up for this, by repairing it with a preemptive strike (Cuff, 1980), by showing that he also knows the common-sense perception that money isn't everything and that it does not always bring happiness (lines 4-5), hence anticipating my response.<sup>3</sup>

We then hear CBAs describing the kinds of problems which arise from financial hardship (lines 6-11) relating to an MCD-victim of circumstances. These things that have happened to him are presented as being beyond his control and the inevitable outcome was to drink which is given as a justifiable activity in this context. These are intelligible reasons for his drinking. He then presents himself as an intelligent person, a category to the MCD-types of person, who can argue for his

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<sup>3</sup> This may seem to be self-repair (Schegloff, 1991) but as the transcript is not prepared based on 'CA' quality, it is not possible to assume it.

point of view. He again rejects AA philosophy, this time regarding the 'first drink', 'one drink, then drunk' (lines 14-18). He argues with examples such as a smoker who wouldn't call himself a smoker after having given up for many years. In lines 8 & 12, CBAs are given, tied to a 'practical and realistic' person, a membership category linked to the MCD-morally adequate persons. We then have a membership category of recovered alcoholic (lines 19-22), linked again to the same MCD, who intends to continue with sobriety (CBA) and he thus displays himself as a morally adequate individual. He also displays himself as an honest person who does not need excuses to drink, that he does it of his own free will (lines 23-28). He is preempting again my response about him making excuses for his drinking. He provides reasons for giving up drinking relating to pain probably due to withdrawal symptoms, and that it interferes with his relationship with girls. These are CBAs tied to the category of 'thoughtful person' which is linked to the MCD-types of person.

In lines 31-34, he is showing gratitude towards his GP, CBA tied to a 'morally responsible' person (MCD). This follows by a somewhat ambiguous statement about a magic pill (line 35) which seems contradictory to the display of the 'responsible' person. He then emerges as a 'knowledgeable person' with an objective view, in lines 36-37, and CBAs refer to his knowledge about morbidity and death regarding alcohol and drug use. There is also some repair work here (line 35) where he defines the 'magic pill' as a medical breakthrough.

Extract 33 - GP's letter no.9 (re: patient no.17)

1 GP: 'Thank you for taking this pleasant man back once again.  
2 He has been teetotal for the last 18 months. However,  
3 recent social pressures in the shape of maintenance costs to  
4 his estranged wife have pushed him once again to start  
5 drinking. He is at present consuming 9 brandies plus 5  
6 pints of beer per day. He is well motivated and has changed  
7 his career from catering, of which he has had many years  
8 experience, to now working in a local petrol station.  
9 One of the problems that I have had with him has been  
10 inability to get him off all medication during his period of  
11 abstinence. He was always taking at least 1 Heminevrin  
12 tablet a day.  
13 I would be very grateful if you have any suggestions how we  
14 could get him off all treatment once he has dried out this  
15 time.

The General Practitioner also gives intelligible reasons for this patient's drinking but emphasises only financial pressures due to his 'estranged' wife, who is presented as the cause for his drinking. Other features of this letter consist of the patient's good points and his motivation, and his problem with medication which is slightly ambiguous as it follows the favourable description of the patient.

The letter starts with a display of moral adequacy of the patient, with a membership category of a 'responsible and nice' person linked to the MCD-morally adequate persons. CBAs include 'pleasant man' and 'teetotal for the last 18 months'. However a category-modifier such as starting to drink in lines 3-5 follows the initial description with a justifiable reason given i.e. social pressures. He is in fact giving precisely the excuses that the patient rejects. We then hear in line 6 that the patient is well motivated (CBA) which implies that he is worth helping despite the fact that he is still consuming

large quantities of alcohol. This point is a preemptive strike as we know that alcoholics tend to have poor motivation for giving up drinking specially when they are going through a drinking episode as this patient is. He is therefore repairing his presentation of this patient as a heavy drinker in lines 5 & 6. The GP then talks about a problem he has regarding this patient, which is rather ambiguous as it is not clear whether this is a bad point or not. On the other hand this enables him to ask the Director of the Treatment Unit for some help and advice to deal with the problem of medication.

Both account-givers constitute the patient as a morally adequate person, worth helping and formulating his problem in terms of intelligible, justifiable reasons. The patient, however, is heard presenting the pressures as reasons for his drinking without mentioning maintenance costs to his wife which might then leads to question his part in the breakdown of the marriage. He is rejecting excuses whilst the GP is directly making excuses attributing patient's drinking to the maintenance costs to his wife. The use of the word 'estranged' is interesting here as it gives her a negative description, that something may be wrong with her.

Making excuses about oneself is a CBA tied to the category of 'irresponsible' person, thus the patient, by rejecting excuses, is emerging as a morally responsible person. On the other hand, making excuses about someone else does not make one 'irresponsible'; it shows understanding, forgiveness.

The patient's account has the function of displaying himself as a morally adequate person who intends to maintain sobriety, hence worth helping, whilst the GP's letter needs to persuade the unit's director to see his patient. The GP thus emphasises the patient's motivation to stop drinking, presents him as a nice, pleasant man who has intelligible reasons for his recent episode of drinking i.e. high maintenance costs to his wife.

The following two long extracts are from the interview with patient no. 5 and the Senior Registrar's 'discharge' letter to this patient's General Practitioner. MCD analysis shows how the patient and the professional are presenting reasons for drinking and the circumstances in which heavy drinking has developed. As these extracts are long, they give us an idea of the kind of life history presented by the patient and the SR.

**Extract 34 - patient no.5 (male)**

1 P: 'The context of my drinking goes back to my childhood. It's  
2 still hard to believe now, my father was a heavy drinker.  
3 I believe he was an alcoholic now but at that age group  
4 they're completely different drinkers. They had a lot more  
5 pain to suffer than we did, in the First World War. He was  
6 in constant pain, physical and also spiritually as well, and  
7 I could remember him as just being a person there. I never  
8 admired him and I couldn't really understand why my mother  
9 used to make sure none of us were around when he got back  
10 from work. He was never there. I was one of nine children,  
11 we weren't a close family. My mother ran the family and  
12 protected my father, you know, perhaps he drank for his  
13 health and when his health went he drank and he became  
14 violent, threw dinners at walls. I kept myself clear of  
15 drinks except for beer up until the age of 23, 24. I had  
16 some martinis once when I was 21 and I was violently ill  
17 then, that didn't put me off the drinking, it should have  
18 done when I come to think of it. When I was 34, I got a

19 posting overseas in the persian Gulf, there was no draught  
20 beer in those days, it was all canned beer and spirits.  
21 Beer was very expensive, we tended to drink pink gins and  
22 whiskies and things like that, and drink was our social  
23 life; it was parties and that's all we had to do. There  
24 were no cinemas, no theatre and it was too hot to play  
25 sports. I must have started to drink on a regular basis  
26 because I was drinking every day of the week as part of my  
27 job. We should talk to the ship's captains and officers and  
28 we ended up drinking.  
29 When I came back to London, I tried to live the same life as  
30 in the Persian Gulf. Again it was the signs that I was  
31 going onto the path of alcoholism. I had two jobs and in  
32 both I was asked to leave. Then I knew a person who was in  
33 the Police Force, he said: "Why don't you come into the  
34 Police Force?". Again, I tried the police and it became the  
35 continuation of my old life. After hours, we always knew a  
36 pub that was open and we had a few pints to relax before  
37 going home to wife and family, and this is what happened to  
38 me for 18 months and this became a 9 to 10pm at night  
39 drinking spree. The Police Force terminated when I was  
40 injured. I had a couple of back operations and I was  
41 discharged as being medically unfit. The lump sum I got  
42 went into an extension. I had good times, plenty of  
43 drinking, wandering around the streets, having drinks with  
44 my friends and this became a habitual thing. I got a couple  
45 of small jobs and again I went my usual way. Six years ago,  
46 my wife said: "I'm divorcing you", and she did. She  
47 divorced me and what she wrote, what the solicitor wrote  
48 about the circumstances of the divorce was such that I was  
49 horrified. I couldn't believe it. Is this the person you  
50 married, you know, to love and cherish and she wrote all  
51 that rubbish about me, and yet she did and I didn't oppose  
52 the divorce...  
53 To try and put my alcoholism into place, I don't believe  
54 it's hereditary although my father, as I said, might have  
55 been an alcoholic. I have other binge situations, eating  
56 cakes, chocolate; I've been drawn to at the present peaches.  
57 I wonder if this stems from my childhood where I was one of  
58 a large family, although I was no more deprived than others,  
59 because I've always been very proud of my fitness... So now  
60 I'm not numero uno in the sports clubs any more. But I've  
61 grown up, I'd have gin and scotch, this was the only thing  
62 I could excel at. I thought I could excel and that was  
63 outdrink everybody, little realising the damage it was doing  
64 to me and the damage it has done to me. The physical side  
65 I know is repairable to a degree, if I stay off alcohol. This  
66 is something I have to come to terms with, through my own  
67 analysis and help from other people.'

This patient is describing himself and his drinking history in the context of his parents. In lines 1-7, he is talking about

his father, hence we have a 'father-son' standardised relational pair (SRP) with 'heavy drinker' as a category modifier. We could see here the function of this SRP highlighting the drink problem common to both father and son. Although he appears to present his father as a problem drinker, he is hesitant in calling him 'alcoholic'. He says that he believes he was an alcoholic. He may be avoiding making a diagnostic statement as he is not qualified to do this. He is also showing some loyalty to his father by appearing to justify his heavy drinking as he and others in the First World War had 'a lot more pain' to suffer.

We then have a 'mother-father' relational pair which displays the father as an alcoholic with violent outbursts when drunk and the mother as supporting wife and mother who protected her husband and the children. The mother is heard to be a very loyal wife and a caring mother. 'I never admired him' in lines 7-8, is a category modifier again to the 'father-son' pair, and the patient is heard here as a disloyal son which is however understandable. The disloyalty however is minimised to some extent as he has first introduced the father as someone who has suffered a lot and one would inevitably feel sorry for such a person. It is also managed later as he appears to be a loyal and appreciative son to his mother. This is also a preemptive strike anticipating the interviewer's response to his statement about never admiring his father. In the 'mother-son' relational pair as in previous relational pairs mentioned above in this extract,



'son' is only heard, not stated.

We then hear CBAs such as keeping clear of drinks linked to a 'responsible person' who stays off strong drinks for quite a number of years. It is interesting here that he does not consider beer as drinking. He appears as a morally adequate person. His subsequent heavy drinking (lines 18-28) is described as an inevitable outcome of special circumstances. He describes drinking as part of the social life in the Navy due to the lack of other social entertainment such as cinemas and theatre. He justifies drinking spirits as he argues that beer was very expensive. Drinking pink gins and whisky are category modifiers to the 'responsible person' but these activities were part of the lifestyle in the navy and the use of 'we', in lines 21-23, implies that everyone else was engaged in drinking spirits and thus he is not heard as an irresponsible person.

He continues describing his heavy drinking as a social activity with the use of 'we' in lines 35-36, following his return to london. He mentions his wife and family, so we have an MCD-marriage here and 'love and cherish' are CBAs, but no link between his drinking and the divorce is provided. He is displaying his wife as a disloyal wife and he shows his cooperation in not opposing the divorce. In lines 30-31, we have a CBA linked to a membership category of 'insightful person' from the MCD-types of person, when he talks about the signs that he was going onto the path of alcoholism. He

appears having insight into his behaviour when his drinking is becoming alcoholic drinking. Then in lines 53-59 he is pointing out that he does not believe that his drink problem is hereditary, although he makes such an assumption available to the listener by referring to his childhood and wondering if all his other types of binges, such as eating cakes, chocolates etc, stem from it. This is subtle and ambiguous as he presents these possibilities without any direct statement of his belief. Again in lines 62-65, we have CBAs to an 'insightful person' when he talks about the damage caused by alcohol and the physical benefits of sobriety. He is heard as a self-analysing person which is a membership category to the MCD-types of person, in the last two lines, when he expresses the need to have help from others for his recovery as well as reliance on his self-analysis. He is also showing that he has learned from the programme how to rely on one's self-examination.

**Extract 35 - SR's letter no.16 (re: patient no.5)**

1 **SR:** Family History: Mr ... was brought up by his parents who  
2 are both now dead. He is the third in a family with one  
3 older brother and four sisters. Two of his siblings had  
4 epilepsy and one of his brothers died at the age of 4 from  
5 pneumonia. He was a war baby and describes people as being  
6 helpful to one another at that time. He felt particularly  
7 close to his mother, but describes his father as a sad  
8 character. His father died of emphysema at the age of 58.  
9 He believed that he had a serious problem with alcohol.  
10 Schooling and Employment: ... enjoyed school, both the  
11 academic and the sporting side. He gained six GSE's and  
12 left at the age of 17½ to join the Police Force. He was a  
13 Police Officer for 15 years, until his retirement on  
14 medical grounds in 1980. During this time he was attached  
15 to Navy Intelligence for 10 years and gained the rank of  
16 Detective Sergeant by 1978.  
17 Marriage: He married in 1959 when he was 23. His wife is  
18 a District Nursing Sister and they were divorced in 1984.

19 He remains very unhappy about this, and they have had  
20 periods of being back together under the same roof. His  
21 drinking has been the cause of the problems in the  
22 marriage. He has two children aged 26 and 24, and he does  
23 not feel his relationship with them is very good...  
24 Drinking History: He began drinking at the age of 18 and  
25 this became heavier over the years, largely associated with  
26 work pressures and his attempts to identify with the people  
27 he was working with. By 1978, when he had an injury to his  
28 back, he found that drinking spirits relieved his pain.  
29 Two years later he was retired and became bored and  
30 depressed and then drinking was a way of relieving himself.  
31 He has usually drunk cider and vodka, most often alone and  
32 at home, consuming as much as 60 or 70 units on a heavy  
33 day's drinking. He has tended to drink in bouts of 3 or 4  
34 days and has had periods of abstinence in between. As time  
35 went on he found that he could manage to stop drinking  
36 after one day of returning to it and reports that he has  
37 mostly been dry since the middle of last year. This should  
38 improve his prognosis, in view of the fact that he has  
39 cirrhosis of the liver. He has hypertension, for which he  
40 is being treated by the ... Hospital Clinic.  
41 He is a non-smoker. Following the injury to his back in  
42 1978, he had three vertebrae fused at operation, otherwise  
43 he is in good general health.  
44 Treatment programme: ... successfully completed the four  
45 week treatment programme without resorting to alcohol.  
46 There were a few occasions when he and his wife had unhappy  
47 telephone calls. In the past this would have been enough  
48 to precipitate him into further drinking, so he was pleased  
49 that he had resisted this useless way of coping. With his  
50 background in the police and the security of firm  
51 discipline and clear directions, he found working in the  
52 treatment programme quite difficult. He remained somewhat  
53 apart from the rest of the group, though he was eager to be  
54 popular and helpful. He recognises that he has always  
55 found it difficult to express his feelings, including  
56 within his marriage. We hope that he has gained from the  
56 time he spent in the Unit. He left us to return to his  
57 flat in London initially and then to explore the  
58 possibility of moving back with his wife, getting some  
59 local employment and living in the West Country. He is  
60 quite clear that he wants to be abstinent from alcohol. We  
61 wish him well.'

The Senior Registrar is presenting a life history with a 'case history-taking' structure which constitutes part of a psychiatrist's training. He does not use this formal structure consistently in all cases, nevertheless this is encouraged in the unit. The headings used in this case are

membership categories linked to a 'comprehensive and logical report' (MCD). There is a parallel here when he starts with the family background as the patient does in the previous extract. He refers to the patient as Mr ... , patient's surname, which indicates an impersonal, objective account. We have here an MCD-family with membership categories such as mother, father, brother and sisters. CBAs relate to both parents being dead, however there is a category modifier in relation to the brother who dies at the age of 4. We also hear standardised relational pairs such as mother-son, father-son where son is heard but not stated. In lines 6-7, the patient is described as a warm being with a close relationship with the mother. This makes up for what he says in the same sentence when he refers to the patient's description of his father as a sad character with a serious alcohol problem. The patient here is seen as a morally adequate person as he is feeling sorry for his father and he is not blaming him. It is interesting how the SR describes the patient and his relationship with his family without appealing to strong words as the patient does when he talks about his father's behaviour towards his wife and that he never admired him. The patient's description of his family background appears to be more lively than the SR's account.

In lines 10-16, The SR now refers to the patient by his first name, having presented a hearably objective account of the family history. This is a straightforward account of schooling and employment history but also displays the patient

as a morally adequate person as he enjoyed school, studying and the sporting side too. In lines 13-16, we also have CBAs linked to the category of 'responsible person' from the MCD-morally adequate persons, such as his work for 15 years in the Police Force, 10 years in the Navy and his achievement in the rank of Detective Sergeant.

When the SR talks about the marriage (lines 17-23), he reveals more about the wife than the patient does. There is a standardised relational pair here 'husband-wife', but husband is only heard in the text, not stated. He also blames patient's drinking for causing problems in the marriage. The patient does not attribute the marriage breakdown to his drinking. The SR is presenting himself as open and objective about this. He speaks in the third person, with an institutional passive voice; it is not necessarily what he thinks. Only in relation to the drinking as the cause of the marital breakdown, is the SR expressing his opinion as the alcohol specialist.

Although we hear that the patient's drinking has caused the marriage breakdown, this is repaired later in relation to the drinking history. Patient's heavy drinking is attributed to work pressures and his attempts to identify with the people he worked with. The SR dates the patient's drinking from the age of 18, however the patient does not consider beer drinking at that age as drinking, as we have seen in patient's account.

The justification for patient's drinking continues (lines 28-37) with intelligible reasons given for drinking, such as relief of pain, boredom and depression. The patient is also described as a drinker who has made efforts to stay abstinent. This account of patient's drinking is clearly a moral account, displaying the patient as morally adequate person. This is consistent with previous professionals' extracts where justifiable and intelligible reasons are given for patient's drinking.

The SR then displays the patient as a 'recovering alcoholic', an MCD, and CBAs linked to the category of 'responsible person' are given such as resistance to drink after an unhappy conversation with the wife. This is the appropriate behaviour for a recovering alcoholic. However, he refers to 'useless way of coping', a CBA linked to patient's past alcoholic behaviour. An optimistic future is described emphasising patient's determination to stay abstinent, his plans to try to get move back with his wife and to get a job, all being CBAs to a recovering alcoholic showing responsible attitude towards his future.

These two long extracts illustrate patients' and professionals' justifications offered for the drink problem, in the course of presenting a life history. The function of the patient's account is to display himself as a morally adequate person and that he has learned from the treatment programme to self-examine and analyse. The SR also presents

the patient as a morally adequate person and the function of his letter to patient's GP is to convince the GP that this patient is a morally good person, worth continuing with the help that he needs from him following discharge from hospital. The prognosis is also emphasised as being good as the patient has managed to have abstinence periods.

However the patient's account is a more lively and emotional account showing him as a victim of circumstances with an unhappy childhood, a heavy drinking father and an unhappy marriage with a disloyal wife. The SR's account differs in the way that it highlights the passive institutional voice regarding patient's personal life circumstances. But it also presents the consequences of drinking, as in the marriage breakdown, more directly which is consistent with a professional's acknowledgement that drinking does affect the marriage.

**Extract 36 - patient no.12 (female)**

1 P: 'Well, I never liked drinking because my father was always  
2 drunk. My mother hated drinking...I was living in Puerto  
3 Rico with my husband. We would go out most evenings and I  
4 started then drinking. I never really felt that it was a  
5 problem; I was just drinking with everybody else.  
6 We used to have people coming to the house and we used to  
7 have a dart match. They used to drink; I never felt that  
8 I needed to drink; so obviously I was drinking because I  
9 was upset. After a lot of violence, I finally left Puerto  
10 Rico after divorcing my husband. I stayed with my mother  
11 in England; I wasn't drinking then.  
12 I managed to get a furnished flat where I lived for three  
13 and a half years and I started again just having an  
14 occasional drink, sometimes it was sherry, sometimes it was  
15 Martini. Then things started to get very bad. My mother,  
16 she was very ill, she had cancer. This was giving me a lot  
17 of stress, and I got also depressed. But, in between,  
18 before she got totally ill, I met ... my second husband

19 who had a nervous breakdown and he committed suicide. We'd  
20 only been married for two months.  
21 So my drinking began. At first it was just wine at dinner-  
22 time and it gradually got more. I was trying to cope  
23 with my mother and my family; they didn't really want to  
24 see my mother in the state she was in. So I used to ring  
25 up everybody and have a drink afterwards. My mother got  
26 very very ill. She died in May 1980. I was then drinking  
27 a lot more.  
28 The best man at my second wedding, ... became my third  
29 husband. We moved from my flat to his flat. He became  
30 violent. We got married because we thought that would  
31 straighten everything. I couldn't cope with him. To get  
32 me cope with the day, I was drinking, and then it was  
33 really just to drink to stop all the shakes, the sweats,  
34 and everything, but I never enjoyed drinking. I hated it...  
35 Well, a lot of things have come out here in this course  
36 which I thought I would never talk about, or be able to  
37 talk about, and immediately if things upset me at home, I'd  
38 go for the bottle so that I don't really have to talk about  
39 it. Here we've been able to talk about things. I mean I've  
40 obviously got upset about certain things, and my anger I  
41 mean scares me, you know. I know it's something that I  
42 have to control, I have to know situations that's going to  
43 upset me and I mean like now, we're going out tomorrow and  
44 if there's an upsetting situation I obviously cannot go for  
45 the bottle.  
46 I am very apprehensive. I know I've got more support this  
47 time, and also from A.A. (Alcoholics Anonymous) of course.  
48 They've given me phone numbers as they say: "do not pick up  
49 the drink, pick up the phone".'

This patient formulates her drink problem in lay 'emotional'  
terms relating to the father's drunkenness and her mother's  
hatred towards drinking (lines 1-2), thus she starts with the  
MCD-family with father and mother as membership categories.  
She also expresses her attitudes to drinking and getting drunk  
from a moral stance throughout this text, thus displaying her  
moral adequacy. Category modifiers are also given in lines  
1-2 such as the father getting always drunk and the mother  
hating drinking.

From line 3 to 10, she starts talking about her husband; a



standardised 'husband-wife' relational pair (SRP) is given, linked to the MCD-married couple, where wife is heard, not stated. Category-bound activities, linked to categories of husband and wife, include going out most evenings (line 3), 'drinking with everybody else', 'people coming to the house' and having a 'dart match', which are normal activities of a married couple. Drinking with everybody else is a typical expression in most patients' accounts in the beginning of the interview, emphasising normality ; this has been discussed in Chapter Four, on the narrative structure of accounts. Rather than giving a personalised reason for her drinking, she is explaining in psychological terms such as drinking because she was 'upset' (lines 8 & 9). However there is ambiguity here as the listener does not know why she was 'upset'. It is left open to interpretation and allowing the interviewer to draw her own conclusions in the next sentence (lines 9 & 10) as she mentions that she divorced her husband after a lot of violence and left Puerto Rico. It is subtle as she does not directly refer to the husband being violent, but it is understood in the text that it is the husband and this is a category modifier. This ambiguity avoids her being taken as a disloyal wife.

She then shows respect for her mother, in lines 10 & 11, when she says that she was not drinking when she stayed with her mother. This is linked to line 2, where she states that her mother hated drinking. This is clearly a display of moral adequacy and is a category-bound activity linked to mother-

daughter relational pair (SRP) which is also clear in line 2, daughter being heard, not stated. Staying with the mother is another CBA to this SRP.

There is a temporary return to normality in lines 12 to 15 when she talks about getting a flat and starting to drink normally as we have seen in the 'narrative' structure. But this normality is ruptured as the mother gets ill. She then presents psychological reasons (lines 16-27) for her drinking such as stress and depression arising from the second husband's suicide and looking after the sick mother. She also emerges as a very loyal daughter and sibling as she reports that she was keeping contact with all members of the family during the mother's illness; this highlights her moral adequacy. She tells that her drinking escalates (lines 26-27) following the mother's death which is an intelligible, understandable reason. We have the second husband-wife relational pair (SRP) in this account in lines 17-20 and the husband having a nervous breakdown when they were married only for two months is a category modifier. Her subsequent drinking (line 21), appears to be legitimised and an inevitable outcome of tragic circumstances. By saying 'so' when talking about her return to drinking, she is linking her drinking as a consequence of her husband's suicide.

The third SRP-husband wife where again 'wife' is only heard in the text, is described in terms of the husband's violence (category modifier) but this time more directly attributing

the violence to the husband. Having highlighted her moral adequacy, she no longer is ambiguous about this. We then have CBAs such as shakes and sweats tied to an alcoholic going through alcohol withdrawal, linked to the MCD-dependent alcoholic. She again uses hearably emotional words to describe her drinking. As she tells about her mother hating drinking in the beginning of this account, she now says that she herself hated drinking (line 34). This highlights again her moral adequacy and she goes on formulating her problem in psychological terms. From line 35 to 45 she is attributing her drinking to being upset, to her anger and expressions such as 'I know it's something that I have to control'. Going for the bottle reportedly to avoid talking about things that upset her are CBAs linked to a membership category of self-analysing person (n.b. she prefaces her statement with 'I know'), linked to the MCD-types of person. At the end of this extract, she is indicating that she is aware of A.A.'s support and is appreciative, emphasising her moral adequacy.

The function of this account is to present the drink problem in lay 'emotional' and moral terms, linked to psychological motives acceptable in the clinical setting of the Treatment Programme. Thus patient no.12's account serves to highlight her moral adequacy.

**Extract 37 - SR's letter no.21 (re: patient no.12)**

1 **SR:** Family History: She was born in Somerset, her father was  
2 a printer who was a heavy drinker and left the family while  
3 ... was a child. Her mother died in 1980 at the age of  
4 65. She has three brothers and one sister who lives in

5 Australia...  
5 Childhood: She had tuberculosis as a child and spent  
6 considerable periods in hospital up to the age of 16. She  
7 had an interrupted schooling, no examinations and was  
8 unhappy, mainly because her mother was also ill and she and  
9 her siblings were in the care of Dr Barnardo's for several  
10 periods of time. She describes childhood tantrums, for  
11 which she was seen by a psychiatrist in 1966...  
12 Marriage: Her first marriage was to ... and this marriage  
14 ended in divorce eighteen years later. There are two sons  
15 of the marriage now aged 29 and 27 who live in the U.S.A.  
16 Her second marriage was to ... but this only lasted a  
17 couple of months and ended when he gassed himself in the  
18 car. Her third marriage was to ... who was divorced and  
19 had three children. This relationship ended in 1984, but  
20 since then they have been in touch with each other once a  
21 week. They seem to get on well, as long as they do not see  
22 too much of each other.  
23 Treatment Programme: ... was an active member of the  
24 treatment programme. She recognised that she had always  
25 made great efforts to cope with difficult situations,  
26 especially concerning her siblings when she was only a  
27 child herself. Her own needs often remained unmet. When  
28 she comes to the end of her resources she has found comfort  
29 in alcohol and a gap from responsibility. She has attended  
30 A.A., and her plan is to continue with this. She will also  
31 keep follow-up appointments at the ... clinic with Dr ...  
32 She is planning to visit her sons in the States in the  
33 summer. ... is a kind hearted person, who has had long  
34 period off alcohol. I saw a great improvement in her  
35 general togetherness on this admission, which points to a  
36 good prognosis.'

The SR is using the 'case history' approach in this letter as in the case of patient no.5. As mentioned earlier, this is a standard way of writing about a patient's medical history which is emphasised in psychiatric training. Whilst patient no.12 presents a hearably 'emotional' account, the SR's account appears to be an 'objective' account with a formal case history-taking structure (e.g. death of the mother in line 3 which appears much later in the patient's account).

The MCD-family is described in lines 1-5 giving CBAs such as the father being a printer as well as category modifiers such

as the father being a heavy drinker, and leaving the family when the patient was a child. This is followed by the patient's unhappy childhood experiences relating to her illness (TB), her mother's illness and her and her siblings's several periods spent at Dr Barnardo's home. The reader, i.e. patient's GP, can hear this as a standard life history of an alcoholic, characterised by tragic life events. This detailed account of the family background and childhood experiences present psycho-analytic themes of childhood as an MCD. Categories linked to this MCD include patient's and the mother's illness, and time spent at Dr Barnardos's. Following the unhappy family and childhood background, the reader is given an 'objective' account of this patient's three marriages (lines 13-22). We have three SRP-marriages with CBAs such as the divorce from the first husband and category modifiers such as the second husband gassing himself. The strange relationship with the third husband is described as fine, as long as they do not see too much of each other, and no reference is made to the husband's violence. The function of this skilful presentation of patient's life history is to show that patient's unhappy childhood explains to some extent the subsequent drink problem. The husband's violence, which is not referred to by the SR, may imply the patient's role in producing this violence. Thus the emphasis is on tragic childhood experiences rather than marital violence.

When talking about the Treatment Programme (lines 23-36), he presents this patient as an insightful and caring person,

membership categories tied to the MCD-types of persons. CBAs include her recognition of her efforts to cope with difficult situations and sacrificing her own needs as a child for the welfare of her siblings. These are powerful statements emphasising the patient's moral adequacy. He then offers intelligible reasons for her drinking such as finding comfort in alcohol and a gap from responsibility, implying that she had far too much responsibility to cope with when she herself had needs to be met (lines 27-29).

We then have CBAs such as her plan to continue attendance at A.A. meetings, to keep follow-up appointments, her planned visit to see her sons linked to the MCD-recovered alcoholic. She is described as a morally responsible person and in the next sentence as a kind-hearted person who is also capable of maintaining sobriety for long periods showing her reliability in staying abstinent following her discharge from hospital.

He uses the third person, in the institutional passive voice when talking about the patient's plans, however this is changed in lines 33-36 where he is giving his opinion which strongly expresses his assessment of this patient's prognosis. This emphasises that she is a good candidate for continued help.

The function of this letter, as in previous 'discharge' letters, is to persuade the patient's GP that it is worth helping this patient. It is important to secure GP's

cooperation in providing help following the patient's discharge from the Treatment Programme. This is achieved by highlighting the patient's understandable reasons for drinking, her moral adequacy and her reliability regarding maintenance of sobriety. The SR is formulating this patient's drink problem in an institutional passive voice and a formal case history-taking structure emphasising her moral adequacy compared with the patient's lay 'emotional' and moral account.

**Extract 38 - patient no.13 (male)**

1 P: 'I first started in the Forces. I spent about 10 years in  
2 the Army. But it was social drinking to start with, you  
3 know, 4 pints in the evening. That was from 1965-1975. I  
4 got married after that. Then I just carried on, sort of  
5 social drinking, 5 or 6 pints, you know. That carried on  
6 for 5 years until I got divorced. I think it just built up  
7 to 10-13 pints a day. Then I got detoxed; I dried myself at  
8 home too. It's just been a vicious circle. The longest  
9 period I've been off it, is about 6 months. I haven't been  
10 able to work because of the drink. I just think it's  
11 because I'm very anxious that I drink. Most of my family  
12 are the same. Well, I mean in Scotland they're very heavy  
13 drinkers, up there. My family have all been very anxious  
14 as well. My brother had a drink problem. My father had a  
15 drink problem.  
16 We've had lectures from Dr... on this course. Some people  
17 say it's a disease, some people say it's not. I know it's  
18 an addiction. You use Heminevrin to come off the drink,  
19 then you get used to the Heminevrin. It becomes a problem  
20 as well, so you drink to come off the Heminevrin. I am  
21 sober now, but I've got nowhere to go. I need a flat, and  
22 I would like some more material things. I think I need to  
23 go to college and get some more qualifications, I also need  
24 a holiday.'

Normality features in the beginning of this extract (lines 2-5) with a social drinker as a membership category linked to the MCD-normal lifestyle. Category-bound activities include drinking 4 pints in the evening, 5 or 6 pints (lines 2 & 4). The use of the expression 'you know', in line 4, indicates

that he assumes that I share with him the knowledge of the activities of a social drinker. This was a common usage also encountered by Baruch (1981) in his interviews with parents of children with congenital heart defect.

Another MCD 'marriage' is given where husband as a category is heard, not mentioned, with social drinking included again as a CBA (lines 3-5). Heavy drinking, i.e. 10-13 pints a day follows his divorce (lines 5-6), heard as an important life event which conveys members' common sense reasoning. In lines 6-7, he mentions his detoxification. However, he also talks about drying himself out at home too, appearing to have made an effort to deal with his problem, thus displaying himself as a morally adequate individual. He then talks about a 6-month period of sobriety as a maximum period, and links inability to work to his drinking which are both part of an alcoholic's life history, and are CBAs to the category 'alcoholic' linked to an MCD-life history resulting from an addiction.

A psychological motive, i.e. 'anxiety', is given for his drinking as well as his father's and brother's drinking, which is again a CBA to the membership category 'alcoholic' (lines 10-14). We also hear membership categories such as father and brother linked to the MCD-family but with category modifiers referring to their drink problem, resulting into a lively and dramatic account. He does provide a justification however for his and his family's drink problem by saying that in Scotland they're all heavy drinkers (lines 11-12), thus legitimising



familial heavy drinking. By offering a psychological motive for his drinking, he is also presenting himself as a self-analysing person, a membership category to the MCD-successful member of the Treatment Programme. The latter is characterised by its emphasis on looking inwards, analysing one's emotions and psychological reasons for drinking.

His account of the arguments about whether alcoholism is as a disease or not and his own stance relating to addiction, makes him appear as someone who listens to the doctors on the treatment course (lines 15-17), an MCD to which these arguments are categories linked to.

He then emerges as an insightful person, a category linked to an MCD-people with problems, in lines 17-19, where he shows that he is aware that Heminevrin can become a problem too. The use of 'you' in lines 17,18 & 19 infers a pattern that applies to other drinkers too, and not only to himself. However there is some ambiguity in line 19 when he states that one drinks to come off the Heminevrin. This statement, in clinical terms, negates the object of taking Heminevrin, a tranquiliser, which is to help in the maintenance of sobriety. However, the patient is talking in lay terms about the interplay between dependence on alcohol and Hemonevrin. This is conveyed in the expression 'vicious circle', in line 7, in relation to drinking and detoxification.

Category-bound activities are given, in lines 20-23, to the

category of the 'recovering alcoholic' linked to an MCD-an alcoholic. These CBAs include patient's current sober state, need for a flat, more material things to furnish it with to make it look like a normal lifestyle. An ambitious self emerges too as another category linked to the category of the recovering alcoholic, with the expressed need for more qualifications (line 22). Finally another CBA linked to the same category is given as a need for a holiday, an activity again related to a normal lifestyle.

This account has the function of conveying the moral adequacy of the account-giver whose normal drinking as part of his life-course is ruptured by divorce and anxiety defined as a familial characteristic. His drinking is thus legitimised.

The following extract is taken from the Social Worker's letter written to a Housing Department asking them to provide accomodation to this patient.

**Extract 39 - Social Worker's letter no.6 (re: patient no.13)**

1 SW: 'Mr.... first applied for housing with you a few months ago  
2 as he was living in a bed and breakfast accommodation.  
3 However, he has now lost this accommodation due to  
4 difficulties arising over a recent drinking episode which  
5 resulted in his re-admission to our unit for  
6 detoxification from alcohol. He then went through our  
7 Treatment Programme which he has almost completed now, and  
8 is distressed at being rendered homeless due to his  
9 drinking. Whilst we are willing to try to make short term  
10 contingency plans for him, it does seem in this young man's  
11 interest to have the security of his own accommodation in  
12 the longer term, something which he has not had for 5  
13 years.  
14 Mr.... is a rather introverted, pleasant young Scotsman  
15 with a strong family history of alcoholism as both his  
16 father and his brother are problem drinkers. He is still  
17 in contact with his mother and father and has siblings  
18 living in Scotland whom he telephones quite regularly.

19 It seems Mr....'s problems began when his marriage broke up  
20 5 years ago. Whereas he had been a young man with a great  
21 deal of stability in his life i.e. relationship, house,  
22 job, motor bike, family pets etc., he suddenly lost all of  
23 this and became an excessive drinker and a loner and it was  
24 not until late last year that he first sought help. By  
25 then he had become chemically dependent on alcohol and  
26 unable to stop drinking without appropriate medication.'

The Social Worker's account is characterised by a formulation of this patient's needs in terms of owning his own accommodation to restore some stability lost due to his drinking, and by a display of this patient's moral adequacy. Institutional formality is apparent when she refers to the patient by his surname and addresses him as Mr..... This is repeated in lines 14 and 19. She shows this patient to be a responsible person, in line 1, referring to his application for housing. A 'responsible person' is a category modifier to the category 'alcoholic' linked to an MCD-'person with an addiction', thus highlighting patient's moral adequacy. When she talks about him losing his bed and breakfast accommodation, she is subtle in trying to avoid directly blaming him for his drinking. Thus she attributes the loss of accommodation to difficulties arising from a recent drinking episode. She is emphasising this patient's need for help (lines 8-9), hence 'care' as well as 'personal responsibility', by pointing out that he is distressed at being made homeless, as reasons for help, which she nevertheless attributes it to his drinking. She also emphasises his need for security and stability (lines 10-13) as he is a young man who has not had his own accommodation for 5 years. She points out that as he is a young man, his longer

term interest needs to be taken into account.

The patient is described in moral terms (lines 14-24) when she refers to his relationship with his parents and siblings. The patient and his siblings are categories linked to the MCD-family. Standard relational pairs (SRP) are given with CBAs such as being in contact, telephoning regularly (lines 17-18). He is described as a pleasant young man (line 14), thus a socially acceptable person. He is shown to have loyalty and close links with his family and his alcoholism is described as part of his family history, thus minimising patient's own responsibility for his drink problem.

There is an institutional avoidance in linking the problem to an event such as the marriage breakdown, by the use of 'It seems' in line 19. A marriage breakdown may imply blame to both partners. This is similar to patients' ambiguity sometimes about their relationships with their spouses. Patient no.2 (Extract 30) for instance, as we have seen earlier, is ambiguous about her injury, trying not to link the husband's violence directly to her injury, as she may be implicating perhaps her role in the relationship where her spouse exercises violence.

The Social Worker also lists all the things associated with normality and stability in the patient's life suddenly ruptured by the onset of excessive drinking (lines 20-23). She is careful here not to blame the patient for his excessive

drinking, hence the use of 'suddenly' which highlights the severity of this loss of a normal lifestyle, rather than patient's responsibility for it. He is also described as a lonely person who is not in the habit of asking for help, as she states that he first sought help 'late last year' when he had become chemically dependent on alcohol and needed medication to stop drinking (lines 23-26).

Although these two extracts are characterised by displays of patient's moral adequacy, they perform different functions. The patient's account legitimises his drink problem and displays the patient as a member of the Programme who has benefited from the course. He expresses his knowledgeability on various debates concerning problem drinking, and his plans to return to normality. However, the Social Worker seeks to persuade the Housing Department to provide accommodation to this patient, by arguing that that this man deserves to have some stability restored in his life.

**Extract 40 - patient no.19 (male)**

1 P: 'When I felt anxious again, I started drinking again. Then  
2 drink turned into seven evenings a week, then I started  
3 drinking in the mornings to calm myself down before going  
4 out to work. It progressed from there over the next two  
5 years...I would say that the anxiety side of it, it does  
6 take all that away.  
7 It's obvious it's my fault for drinking, you can't blame  
8 someone else but I believe in taking up activities. When I  
9 go out, when I leave here on Saturday I'll be starting work  
10 on Tuesday morning, back as a chef. I want to go back to  
11 being a chef, start playing golf again and start jogging  
12 again.  
13 I want a steady relationship. I want to sort my life out,  
14 start enjoying life again. Last three years, I wouldn't  
15 say I was enjoying it, it was just an existence, being  
16 there. Even if you haven't drunk for a month, you're just

17 being there, no enjoyment. You don't want to go out in  
18 case you start drinking again, so you sit indoors all the  
19 time. That's no life for anyone, and I think a steady  
20 relationship is one of the high points. I will keep away  
21 from pubs, that's one thing I'll do for a while anyway, see  
22 how I'll get on, on that front, because I don't think it's  
23 a good idea at the moment to just walk into a pub and  
24 expect to pick up orange juice, that sort of thing. So  
25 that's an area I'll be avoiding, parties i'll be avoiding  
26 unless it's a wedding, something like that, a family  
27 wedding which I'll go to, 'cause whenever I go to them, I'm  
28 usually 'dry' anyway, so then I don't drink.'

A different extract from this patient's interview was reported in Chapter Four, where the patient formulates his drink problem in terms of anxiety attacks. This patient formulates his problems in psychological terms. He offers psychological reasons for drinking, a membership category to the MCD-reasons for drinking, and CBAs include 'anxious again' (line 1), 'calm myself down' (line 3) and 'the anxiety side of it' (line 5). He also shows insight in line 7, when he accepts responsibility for his drinking, a CBA to the category of an insightful person (linked to the MCD-types of person).

From line 8 onwards, he describes himself as a 'recovering alcoholic', an MCD with a category of a morally responsible self. CBAs for this category include 'taking up activities' (line 8), 'starting work' (line 9), 'start playing golf again' (line 11), 'a steady relationship' and 'sort my life out' in line 13, 'enjoying life again' (line 14), 'you don't want to go out in case you start drinking again' (lines 17 & 18) and keeping away from pubs (lines 20 & 21). The last CBA is taken up again when a category of an insightful person is given again, in lines 22-24, linked to an MCD-types of person. The

category-bound activity here refers to avoiding pubs due to social pressure for drinking alcohol instead of orange juice.

Other CBAs include avoiding parties (line 25), but not weddings emphasising his moral adequacy in fulfilling his social and family obligations. He points out that he would be 'dry' when attending important family activities such as weddings. Thus, in this extract, the patient presents his drinking in psychological terms such as anxiety, and describes himself as a responsible, recovering alcoholic, displaying himself as a morally adequate individual.

**Extract 41 - SR's letter no.32 (re: patient no.19)**

1 SR: '...Arrangements were made for him to be admitted on the  
2 16th ..., but unfortunately he had been drinking at that  
3 time and so was offered further follow-up appointments,  
4 leading eventually to a dry admission on the ... ..  
5 Family History: ... was born to Irish parents, who are  
6 living in .... His father is alive aged 62 and is a  
7 builder. His mother is 53 and works as a cook. He has  
8 three brothers and one sister and is himself the second  
9 youngest. He was brought up by his parents and had a happy  
10 childhood. In some ways, even as an adult, he is looked  
11 after as if he were a child and often indulged.  
12 Schooling/Employment: ...He had played truant on a regular  
13 basis and achieved no exams. He later went to college for  
14 four years and was successful in getting his City & Guilds  
15 in Catering and a further qualification as a chef and  
16 Catering Manager. He has worked for ten years in the  
17 catering industry, but because of his drinking he has not  
18 had a job for the last nine months. He has, however, not  
19 claimed any benefit in this period as his parents have been  
20 ready to support him. He lives at home and has been able  
21 to get supplies of alcohol with the money his parents give  
22 him.  
23 Drinking History: ...His first choice is Vodka and he at  
24 first thought this was useful to settle his anxiety,  
25 especially when family relationships deteriorated and he  
26 was unemployed. He has experienced morning shakes and  
27 amnesic episodes while in a bout of drinking.  
28 Treatment Programme: He was shy and quiet, especially at  
29 the beginning and found it difficult to work in groups.  
30 However, the time away from home, away from drink and being

31 with other people has enabled him to think about what he  
32 wants to change in his own unsatisfactory life. He came to  
33 the decision that he would stay off alcohol altogether, go  
34 back to work and ultimately work towards having his own  
35 business and house.'

The SR is also formulating this patient's drinking in psychological terms, i.e. relief of anxiety, a term used by the patient, but, in addition, he also describes the problem in terms of deteriorating family relationships. In lines 1-4, the SR is pointing out an important rule of the Alcohol Treatment Unit which refers to admitting an alcoholic patient to the 4-week Treatment Programme only when he/she is 'dry', i.e. stopped drinking.

An MCD-Family is given, in lines 5-11, where membership categories of father and mother are referred to (lines 5-7) and CBAs are given such as their ages indicating mature, older parents. Siblings, i.e. three brothers and a sister, are also mentioned (lines 7-9). An MCD-stages of life is given (lines 10-11) with categories such as childhood and adulthood. The SR is skilfully describing the way that this patient is treated by his parents; although an adult, the patient is treated as if he were a child, being indulged by the parents. Thus, the parents are blamed for spoiling their son, but this is done in a rather subtle way, following a statement about a happy childhood (lines 9 & 10).

In the section on schooling/employment, despite this patient's bad school record, i.e. truancy and no exams achieved (lines



12 & 13), the SR describes him as a successful person, a category to an MCD-morally adequate persons, and CBAs include getting a City & Guilds in Catering and a qualification as a Chef and Catering Manager. Another category to the same MCD include working for ten years in the catering industry (lines 16 & 17) showing some stability.

The parents are again held responsible in skilful ways for this patient's drinking. At first, the parents are described as having been ready to support their son financially, but on the other hand, we are told that he has been able to buy alcohol with the money given to him by his parents.

When describing this patient's reasons for drinking, the SR is giving a psychological category, i.e. to settle his anxiety, as the patient does, but he adds CBAs to anxiety, such as deteriorating family relationships and patient's unemployed status (lines 24-26). This is interesting as the family is again blamed for patient's drinking. Membership categories such as 'morning shakes' and 'amnesic episodes' are given (lines 26-27), which are linked to the MCD-physical dependence on alcohol.

From line 28 to 32, the SR is displaying the patient as a morally adequate person, an MCD to which the category of wanting to change his lifestyle is linked, and he can do this as he is away from home. There is an implication here that the patient's shyness and difficulty in working in groups

(lines 28-29) are overcome as a result of being away from home (lines 39-40), described skilfully by the SR. The category of a responsible person linked to the MCD-recovering alcoholic is given (lines 32-35) with CBAs such as the decision to stay off alcohol, go back to work, and work towards having his own business and house.

Both account givers, the patient and the SR, are formulating drinking in psychological terms, i.e. relief of anxiety. However, the patient is displaying his moral adequacy regarding reasons for drinking, by accepting personal responsibility for his drink problem. On the other hand, the SR following the formal case history-taking format, in this letter, is attributing this patient's drinking to the way that his parents have treated him. Thus he is displaying the patient as a morally adequate person as he is able to do well and plan for a change of lifestyle, only when he is away from his parents. The patient, however, does not blame his parents as he would have appeared as being 'disloyal' to his parents, and as offering a mere excuse for his drinking. Instead, he assumes responsibility for his drinking by saying that it's his fault (extract 40, line 7). Patient's moral adequacy is therefore displayed in different but equally skilful ways by the patient himself and the SR.

**Extract 42 - patient no.15 (male)**

- 1 P: 'What can I say, the first drink I had was when I was 13,
- 2 but that was only to be like one of the lads, you know.
- 3 Then I went to work for my dad, and no drinking then at
- 4 all. Then I left and went into the Air Force. I was there

5 for 3 years, and in that 3-year period, it was very very  
6 heavy drinking. I mean I was doing a job in the Air Force  
7 but at the same time we had access to drink because I was  
8 a steward. So it was natural that we were drinking all the  
9 time. Then I came out of the Air Force, and the drinking  
10 continued. I got married, but I didn't have a problem as  
11 such. I could sort of hold down a job, but the drink was  
12 still there. Obviously the drink was there all the time.  
13 At the same time, you didn't notice that you had a problem  
14 or anything like that. Then I was a Deck Hand in the  
15 Merchant Navy for a couple of years; more drinking again.  
16 There's no cure for alcoholism, I know that. I've just got  
17 to accept the fact that I've got an illness and I'm stuck  
18 with it.'

We have seen how this patient talks about strains and stresses in relation to his drink problem, in the previous section on the 'narrative'. This extract precedes the one in the 'narrative' in the interview transcript.

The patient is formulating his drink problem in medical terms, and provides the medical concept of alcoholism as an illness. This extract, which is the beginning of the account, starts with normality, the common theme in study patients' accounts. He starts with an MCD-"young people" and drinking is given as a category-bound activity of membership categories of young people, and he too is a member. This is part of a display of moral adequacy, indicating that at some point in his life he was drinking normally. The expression 'you know', in line 2, shows that the patient thinks that I share with him the common sense knowledge about activities of young people which includes drinking. The display of moral adequacy continues in lines 3-4, where we have a father-son 'standard relational pair' (SRP). Working for his father is a category-bound activity to the father-son SRP. He points out that he did not

drink at all, when he was working for his father. He shows respect for his father, thus displaying himself as a morally responsible person.

From line 4 to 15, he gives legitimate reasons for his heavy drinking. He starts with the Air Force, hence we have an MCD-people working in the Air Force, and heavy drinking is given as a category-bound activity to the category of 'steward'. He states that it was natural (line 8) to drink all the time. It was therefore an accepted norm. He justifies continuing with the heavy drinking habit, when he marries, and then in the Merchant Navy. Again heavy drinking is given as an accepted habit and a CBA for a Deck Hand linked to the MCD-people in the Merchant Navy. He emphasises that heavy drinking was not considered to be a problem (lines 13 & 14). His drinking is thus legitimised.

In the last few lines (16-18), a membership category of a knowledgeable, sensible person is given, linked to an MCD-morally responsible persons. CBAs linked to this category include statements about the lack of any cure for alcoholism, his acceptance of the medical disease concept, and his acceptance of the permanent nature of this illness as a chronic illness. He emphasises his knowledgeability by saying 'I know that' (line 16). He is therefore formulating his drinking in medical terms, acceptable in the Treatment Unit, and is giving legitimate reasons for his heavy drinking.

Extract 43 - SR's letter no.23 (re: patient no.15)

1 SR: '... has been living in his present flat for the last two  
2 years on his own. His son is in long-term care in a ...  
3 home. He has attended a day centre regularly and was  
4 intending to resume doing this after his time here. ...  
5 has been under a lot of strain, trying to cope with his  
6 handicapped son. Drinking has given him some relief. But  
7 he plans to remain abstinent from alcohol. He has remained  
8 abstinent for very long periods and has lived in a stable  
9 manner.  
10 ... was a friendly person to have around the ward and was  
11 consistently helpful to all other patients whatever their  
12 needs might be. He was expert at avoiding conflict and had  
13 worked out his own way of adapting to life and other  
14 people. In view of his success in overcoming his drinking  
15 problem and his unremitting care and affection towards his  
16 handicapped son and his helpfulness to others in the day  
17 centre, I believe that the Treatment Programme will have  
18 provided him with a month off duty. He plans to attend our  
19 Reunions at ... and keep in touch.'

The SR gives a father-son relational pair (SRP) in lines 2-4. The strain resulting from coping with the handicapped son is a category modifier to the father-son relational pair (lines 5-6) and it helps to legitimise the drinking. The SR describes this patient's drink problem in psychological terms, as a relief from 'strain'.

An MCD-morally responsible persons then follows, and category-bound activities are given from line 7-19, linked to the patient as a category of a morally responsible person. These CBAs include describing the patient as a 'friendly person', 'helpful to all other patients', 'expert at avoiding conflict', 'unremitting care and affection', 'helpfulness to others'. The whole paragraph functions as a display of the patient's moral adequacy.

The SR's letter written to the patient's GP, highlights this skilfully. As mentioned earlier, this is important as the GP needs to be persuaded that it is worthwhile helping this patient, following discharge from the Treatment Unit. The drink problem is described in psychological terms, as a relief from strain, whilst the patient formulates his drinking problem in medical terms, as an illness, acceptable in a medical setting (Mills, 1940).

Both the patient's account and the SR's letter are displays of moral adequacy, skilfully accomplished. The difference, however, is in the emphasis. The patient emphasises the normality of his heavy drinking in drinking subcultures such as the Air Force and the Merchant Navy, thus legitimising it. But, the SR is emphasising this patient's pleasant character and helpfulness to others, as well as his caring relationship with his handicapped son and the strain from having to cope with the situation. This is an appropriate vocabulary as it is addressed to a GP.

In conclusion, this section has shown, through the MCD analysis, how patients and professionals, in this study, accomplish their talk in competent and skilful ways. Patients' talk functions to display moral adequacy; legitimate reasons for their heavy drinking are provided in psychological and medical terms skilfully, using the appropriate vocabulary for the Treatment Unit with a medical and psychological orientation. Problems including drinking are formulated again

in medical and psychological terms.

On the other hand, alcohol professionals' letters function to persuade patients' GPs, director of a 'dry house', a solicitor, or a Government official, to give help and support to patients in the community, on discharge from the Treatment Unit. They therefore display the patient as a morally adequate individual who is worth helping. Also GPs and Hospital Registrars, when referring patients to the Treatment Unit, display patients, skilfully, as morally adequate individuals with a dramatic life history, worth being helped. Whilst patients often give an emotional account, professionals' letters have a tendency to display a passive, institutional voice, thus avoiding to express a personal opinion.

The MCD analysis has been useful in demonstrating how patients and professionals describe drinking problems by using skilfully categories and collection of categories to accomplish an intelligible talk. It also highlights ways in which they are engaged in 'moral talk'.

I shall present, in the next section, some simple tabulations of MCDs, membership categories, category-bound activities and category modifiers with the aim of highlighting the consistency of descriptions throughout patients' and professionals' discourses.

## Chapter Six: Simple tabulations

A simple counting method of analysis will be used, in the second part of this section, by means of MCD analysis of the whole sample of patients (N=40) and on health professionals' letters (N=155). The latter comprises 80 Senior Registrar's discharge letters, 23 Social Worker's letters addressed to directors of 'dry houses', to solicitors or to Government departments, 30 General Practitioners' and 22 Hospital Registrars' letters of referrals. However, some issues concerning quantitative and qualitative research methodology will first be introduced.

### i. Issues relevant to quantitative/qualitative methodology

Each type of research has undergone criticisms since the 1950s and 1960s. Qualitative research has been viewed as a minor methodology, important in the exploratory or pilot stage of a study where statistical tests are primary to data analysis (Selltitz et al, 1964). The critique of quantitative research, since the 1950s has been well documented. C. Wright Mills (1953) called much of quantitative research, 'abstracted empiricism' lacking a theoretical basis. Later, Blumer (1968) points out that attempts to establish correlations between variables ignore ways in which these variables are defined by the people under study.

Again in the sixties, Cicourel (1964) argued that mathematical methods of measurement in survey research did not take into



account the common-sense practical reasoning used by both researchers and respondents. Cicourel suggests that social inquiry begins with reference to the common-sense world of everyday life, and that measurement presupposes a bounded network of shared meanings, i.e. a theory of culture. The measurement of social facts often assumes that certain behavioural, value, or ideological attributes are operative. He argues that problems of measurement can be viewed from the perspective of the sociology of knowledge: the world of observables is not simply 'out there' to be described and measured with the measurement system of modern science. He points out that the course of historical events and the ideologies of a given era influence what is 'out there' and how these objects and events are to be perceived, evaluated, described and measured.

Silverman (1985) points out that the popularity of quantitative research started to decline in sociology in parallel to the decline in survey research after 1965. He suggests that whilst other professionals, like psychologists, economists, clinicians and administrators, were inclined to discount any research not based on counting, sociologists after this date tended to feel rather awkward about carrying out statistical tests of significance.

A coherent alternative to the quantitative/qualitative polarity is explored by Silverman (1993). He points out that qualitative research can cover a wide range of research styles

and can even be co-opted back into the positivist tradition. Qualitative methodology is indeed being adopted in areas where quantitative methods have been predominant for many years such as market research and in public health studies regarding needs assessment in the population. However, as Silverman argues, this new fashion is directed towards open-ended interviews and lacks a clear analytical basis in social theory.

Silverman suggests that the polarities around which the qualitative/quantitative distinction is based need to be deconstructed. Why for instance can we focus on only meanings but not structure? He suggests that some simple counting techniques in qualitative research can support the analysis by showing how consistent the units of analysis are across the sample.

This relates to the methodological debate centring around the relation between 'how' and 'why' questions of social order, discussed by Silverman and Gubrium (1994). They argue that initially one needs to pay close attention to how participants locally produce or enact contexts for their interaction. After answering the 'how' question, one can then move on to 'why' questions to explain the place in everyday life of structural or cultural constraints.<sup>1</sup>

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<sup>1</sup> The debate between ethnomethodologically oriented ethnographers and conversation analysts about the role of context in institutional settings will be discussed in greater detail in Chapter Seven, when explaining the findings of this study.

In my study, I have first asked the 'how' question relating to alcoholic patients' accounts and professionals' letters. The narrative structure (Chapter Four) and the MCD analysis (Sacks, 1972) answer the 'how' question describing respondents' appeals to structural features and their skilful ways of talking about their problems and achieving moral adequacy. Patients' and professionals' discourses are characterised by ambiguity, and the deviant cases (Chapter Four) found in this study highlight the different skills that people use to achieve moral order, showing that we are not 'cultural dopes'.

The 'why' question is asked only after having described how respondents were accounting for the moral order and achieving their moral adequacy. This stage attempts to find explanations, by arguing about issues concerning gender differences and examining the modern medical discourse that seems to provide a context for the data.

Some simple counting methods applied to the data, using Sacks's Membership Categorisation Device (Chapter Five), are meant to enhance the reliability of the data. They help to show the consistency of the membership categories across the interviews and professionals' letters.

Therefore counting membership categories in this study does not treat categories as variables telling the truth about the natural and social world. It treats them as categories that

participants skilfully use to describe themselves and the social world.

#### ii. Analysis by simple counting techniques

The analysis applied to the data, in this section, is based on simple counting techniques which offers a chance to the reader to have a sense of the flavour of the data as a whole and allows the researcher to test and revise the findings of the qualitative analysis, thus providing a 'new style' to the 'old clothes' (Silverman, 1985).

Narrative coding involves summarising and interpreting units of analysis. It illustrates the recurrent themes of these accounts. The task of counting methods lies therefore in examining the structural units of narratives and their generality across the accounts which are made intelligible through a shared discourse.

However, some comments on the use of counting are in order. *First*, the aim of the analysis of 'membership categories' in this section is simply to illustrate the consistency and reliability of emerging themes and the structural organisation of the narratives. Counting refers to the use of categories by respondents, not to variables. *Second*, no claim is being made regarding the interviewees' responses as true or false accounts of any particular reality, nor is any attempt made to find deeper causes offering explanations. Silverman (1993) points out that in the analysis of texts and interview data, even if

we searched for non-linguistic social 'realities' such as social class and gender, our raw material is inevitably the words written in documents or spoken by interview repondents. *Third*, no essential quality is being attributed to the data and the results of counting techniques do not alter the status of stories as displays of cultural formulations of drink problems presented in such a way which reflects patients' ability to accomplish intelligible situated accounts.

The relevance of coding and analysing narratives may be clearly understood by exploring the generality of the structure of patients' and health professionals' discourses in the reconstruction of life experiences and in descriptions of self and others. The process of coding will also highlight the use of vocabularies of motives situated and acceptable and locally available in the medical context of the Treatment Programme (Mills, 1940).

The membership categorisation device used by patients in the reconstruction of their life experiences illustrates clearly the displays of moral adequacy discussed earlier. Category-modifiers when used in the appropriate context do often help highlight patients' moral character and mostly give the text a lively character. They also make it an interesting story drawing the listener's attention.

Patients also show how competent they can be as account-givers as well as informed individuals capable of presenting an

intelligible account of their drink problem and their life experiences. They often indicate that they have acquired the medical knowledge regarding alcoholism which will enable them to cope with the drink problem in the future. They express a desire to return to normality, settle down and resolve their problems (Chapter Four).

Their confidence in their ability to talk about their feelings and relationships indicates their ability to use the modern medical approach of the 'whole' person as a subject for medicine (see Chapter Nine), hence presenting themselves as intelligent and self-analysing individuals. Membership categories and their associated activities used by patients in the organisation of their talk produce, orderliness and an exciting and at the same time a dramatic effect.

Some categories in a collection may not be present in all the accounts and often frequency distributions of activities may overlap as more than one activity may be associated with the same membership category.

#### Patients' accounts

Tables 1A to 1C list frequency distributions of membership categories, category-bound activities and category-modifiers used in patients' accounts. Overlaps in frequencies of categories are inevitable, as more than one category often applies to the same patient.

TABLE 1 - MEMBERSHIP CATEGORIES, CATEGORY-BOUND ACTIVITIES (CBA) AND CATEGORY-MODIFIERS (CM) DESCRIBED IN PATIENTS' ACCOUNTS. N=40

TABLE 1A:

COLLECTION: FAMILY

Membership Category	CBA	Frequency	CM	Frequency
Father	Died (before child)	23	Killed	1
			'Didn't care about me'	2
			Violent when drinking	8
			Heavy drinker/ alcoholic	27
Mother	Died (before child)	27	Seriously ill	2
			Loving/caring	6
			Got on well with patient	5
Step-parent	Did not get on with patient	2	Depressed	4
			Grandparents	Died
Child	Happy	4	Unhappy	31
			Fostered	2
			In children's home	2
Brother			Died or killed	3
			In prison	1
			Heavy drinker/ alcoholic	24
Sister	Supportive	3	'She's always there for me'	1
			Died	4
			-----	
<u>Relational Pairs</u>				
Mother-Father	M/F left M/F	21	Frequent rows	7
			M/F remarried	16
			Divorced	26
M/F-Child (patient)	Looked after child	5	Get on well	5
			M/F rejected C.	2
Step-parent-Child (patient)			No contact	15
			No contact	2
Brother-Brother (patient)	Close	1	Sp/C.did not get on	2
			No contact	19
Brother-Sister (patient)	Get on well	3	No contact	8
			Sister-brother (patient)	Get on well
Sister-Sister (patient)	Got on well	1	No contact	8

**COLLECTION**

<u>Category</u>	<u>CBA</u>	<u>Frequency</u>	<u>CM</u>	<u>Frequency</u>
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**SCHOOLING**

Examinations	Passed exam. (`O'/'A' levels)	14		
	Passed none	2		
	City & Guilds Secretarial	11 6		
Life at school	Happy	29	Unhappy	12
			Expelled	1

**EMPLOYMENT**

Employee	Enjoyed/liked working	30		
Employer	Good/hard worker (patient)	11	Sacked patient/ due to drinking	14
			'Was like a father to me'	1

**MARRIAGE**

Husband (patient)	Divorced/ separated	18		
	Remarried	1		
	Wife left with the children	8		
	Wife threatens to leave	5	Wife-heavy drinker	2
	Cares for wife	4	Got aggressive when drunk	2
Wife (patient)	Divorced/ separated	4		
	Remarried	2		
	'been a good wife'	3	Violent husband Husband-compulsive gambler	7 1
Children	Happy	18	Fostered	2
			In care	1
			Died	2
			Mentally handicapped child	1

**RELATIONSHIPS**

Girlfriend	Gets on well with patient	1	Threatens to leave	1
	Supportive	1	Split up	2
Boyfriend	Gets on well	2	Violent Heavy drinker	1



Table 1A above includes the following collections: family, schooling, employment, marriage and relationships. In the 'family' collection, just over half the sample has reported the death of a father (N=23) and a mother (N=27), which are category-bound activities as we expect parents to die before their children.

The majority of patients (N=31) have described their childhood as being unhappy (category modifier). This has the effect of producing sympathy for the patient, in the listener, and as a result, the drink problem becomes more understandable. We have seen in the qualitative analysis that childhood was mostly described as being unhappy.

Other category modifiers in relation to membership categories, in the 'family' collection, characterise a dramatic account on fathers, brothers. More than half the sample has reported having a heavy drinking/alcoholic father (N=27) and brother (N=24). This is consistent with the qualitative analysis where a heavy drinking father or brother is mentioned more often than any of the other category modifiers.

The second part of the collection-Family lists standardised relational pairs (SRP) featuring in patients' accounts. Reports of divorce (N=26), remarriage of a parent (N=16) and one parent leaving the other (N=21) were common utterances in the accounts. This reflects a 'broken home' which enhances the listener's understanding of the subsequent drink problem.

A cumulative dramatic effect is emerging here, as earlier we have seen that most patients had described their childhood as being unhappy. This effect continues building up as we shall see in the rest of the Family-collection. Just over a third of the patients (N=15) mentioned having no contact with their parents, a further 19 male patients mentioned having no contact with their brothers, 8 female patients with their brothers, 9 male patients with their sisters and 8 female patients with their sisters. No contact with parents and/or siblings adds to the dramatic effect mentioned above.

Moving on from the dramatic family experiences in childhood, we see that in Schooling-collection, 29 patients have talked about school life as happy. This reinstates some normality in their past (see Chapter Four).

In the case of employment, 30 patients have said that they enjoyed their work, and 11 described themselves as good/hard workers. This may seem inconsistent with a heavy drinking career, nevertheless it does display these patients as being morally adequate.

With reference to patients' reports of their marriage, it is interesting to note that all those who talked about their children (N=18), nearly half the sample, described them as being happy. This is in contrast to their reports of their own childhood described as unhappy (N=31). This is another instance of moral adequacy; their children's happiness helps to display them as morally adequate parents. A considerable

number of dramatic life-events relating to their marriage(s) have been reported by patients. Eighteen male and 4 female patients have mentioned their divorce, and a further 13 male patients have talked about their wives threatening to leave or about leaving them. Violence of husbands is mentioned by 7 of the 11 females included in the sample, and one female has described her husband as a compulsive gambler.

All the life-events reported by patients in the collection-Family, such as parents' or their own divorce, death of a parent, sibling or child, threats to leave the marriage, have thus produced a dramatic narrative in which the patient emerges as a morally adequate person. These life events reinforce the inevitability of the rise of patients' drink problem.

It is worth discussing here a different approach to life-events, i.e. a quantitative approach in Brown and Harris's study (1978) of the social origins of depression in women. Brown and Harris were concerned with examining the role of life-events on the onset of depression. The conclusion they derived suggests that severe events, defined as those with marked or moderate long-term threat, cause depression in women. Besides depression, which was the main interest, they also examined the causal role of life-events in schizophrenic patients. The proportion of events involved in a causal effect was 50% for schizophrenic patients, 49% for depressed patients and 57% for women developing depression in the

general community. Brown and Harris define long-term effect of an event by a period of 38 weeks or in some cases up to a year following the event. Patients in this study refer mostly to events such as the death of a parent or husband, or the break-up of a relationship, preceding immediately their heavy drinking episodes. An example can be seen in the following extract:

**Extract 44 - patient no.12 (female)**

'I was trying to cope with my mother and my family; they didn't really want to see my mother in the state she was in. So I used to ring up everybody and have a drink afterwards. My mother got very very ill. She died in May 1980. I was then drinking a lot more.'

This patient is talking about the escalation of her heavy drinking to the illness and later death of her mother. Her drinking is described here as a direct result of looking after her dying mother and her subsequent death. Her drinking is legitimised this way and her moral adequacy is thus emphasised.

Brown and Harris's approach reflects members' common-sense reasoning in making a causal link between an event and the subsequent problem or illness. Schutz (1964) defined the individual's common-sense knowledge of the world as a system of constructs of its typicality. All interpretation of this world is based on a stock of previous experiences of it, our own or those handed down to us by parents, teachers or friends, and these experiences in the form of 'knowledge at

hand' function as a scheme of reference. He suggest that only a small part of this knowledge originates within our own experience, whilst the greater part is socially derived. He also makes a distinction between common-sense and scientific constructs. Common-sense constructs take a stock of socially derived and socially approved knowledge for granted. The social scientist, however, considers his/her position within the social world and the system of relevances attached to it as irrelevant for scientific undertaking. This stock of knowledge is of quite another structure than that which man in everyday life has at hand, thus the social scientist is guided by an entirely different system of relevances. The scientist takes for granted what he defines to be a datum, and this is independent of the beliefs accepted by any in-group in the world of everyday life. He has to interpret human interaction patterns which he observes in terms of their subjective meaning structure. Brown and Harris interpret their respondents' reports of their illness and life experiences from a perspective of common-sense relevances.

In contrast with Brown and Harris's approach concerned with the causal relationship between life-events and depression, which neglects patients' common-sense reasoning, life-events reported by patients in this study are seen as skilful ways to produce a dramatic effect. Descriptions of such life-events also provide a plausible explanation for the subsequent development of the drink problem, which is thus legitimised and becomes the inevitable outcome of tragic circumstances.

The Moral-Collection in table 1B, on the next two pages, lists those statements made by patients which constitute displays of moral adequacy. As mentioned in Chapter Four 'The narrative', all patients have made statements emphasising their moral adequacy. There is an overlap of these categories in patients' accounts as more than one category is often given by the same patient.

**TABLE 1B: COLLECTION: MORAL**

Membership Category (frequency)	CBA	Frequency	CM	Frequency
Good at sports (N=18)	tennis			
	football			
	netball			
Good in music (N=3)	Piano	2		
	Guitar	1		
Caring parent (N=21)	Looks after the children	16		
	'Would never hurt my children'	5		
Caring person (N=26)	Cares for spouse	24		
	'Would never hurt anyone'	4		
Perfect student (N=1)				
Pacifist at heart (N=1)	'I don't fight'			
	(N=1)			
	not a violent bloke (N=1)			
Has drunk normally (N=40)	Eg. 'as most young people do'			
Intends to study at college(N=4)				
Has become able to talk about difficulties (N=36)	Eg. Shyness, anxiety			
	lack of confidence relationships feelings, emotions			
Has become knowledgeable about effects of alcohol on the body and brain (N=37)	Damage to the liver	29		
	Damage to nerves	15		
	Damage to the brain (wet brain)	30		
Plans for the future (N=37)	Avoid pubs	14		
	Look for a job	35		
	Get a place to live	15		
	Get back with wife &/or children	8		
	Settle down	11		
	Make some changes	17		

**COLLECTION**

<u>Category(frequency)</u>	<u>CBA</u>	<u>Frequency</u>	<u>CM</u>	<u>Frequency</u>
Learned from(N=37) the Treatment Programme	Gained insight into his/her emotional problems	12		
	Gained in confidence	26		
	Better able to cope	36		
	Can now say 'no'	2		
	Determined not to drink again	28		
	May drink socially but never heavily	14		
	Have a normal life again(return to normality)	20		

**COLLECTION: DRINKING HISTORY**

Normal teenager/(N=40) normal drinker	Drank socially at weekends	28		
	Drank in pubs with friends/ mates	26		
Continuous/heavy drinker (N=40)	Drinking got out of control	28	'It helped me'	2
	Couldn't stop drinking	16	'It gave me confidence'	4
	Needed help	37		
Managed to stay abstinent for long periods(N=22)				



Table 1B indicates that almost half the sample (N=18) has mentioned being good at sports such as tennis, or football, or netball. Sixteen patients stated that they cared or looked after their children, and more than half the patients (N=24) stated that they cared for their spouse.

Normal drinking as part of a teenager's lifestyle, going to pubs at weekends, drinking at parties, features in all accounts. This is interesting as it sets the account on a normal life-course, emphasising normality of patients' lifestyle, not differing from anyone else's, at some point in their lives.

Most patients (N=36) expressed that they had now become able to talk about their difficulties such as shyness, anxiety, lack of confidence, relationships, feelings and emotions. Knowledgeability about the effects of alcohol on the body was also talked about by most patients (N=37). The possibility of or the actual damage to the liver was mentioned by more than half the sample (N=29), and 15 patients mentioned neurological damage. In addition, 30 patients talked about effects of alcohol on the brain and some of them used the accepted vocabulary for this in the Treatment Programme, i.e. 'wet brain'. Plans for the future were also expressed such as avoiding pubs (N=14), looking for a job (N=35), getting a place to live (N=15), settle down (N=11) and making some changes (N=17).

Becoming able to talk about their difficulties, becoming knowledgeable about the effects of alcohol, and making plans for the future all help display patients as intelligent and morally adequate individuals, and show that they have benefited from the Programme. Patients (N=37) further show that they have learned from the Treatment Programme. Gaining insight into their emotional problems is mentioned by 12 patients, gaining confidence by 26 patients, 'better able to cope' by 36, determined not to drink again by 28. The possibility of drinking again but socially was mentioned by 14 patients and return to a normal life by 29.

Drinking history-collection shows that all patients referred to a normal drinking stage in their lives, weekend drinking (N=28) and/or in pubs with friends (N=26). Continuous/heavy drinking was also reported by all patients, 28 patients referring to their drinking having got out of control, 16 describing loss of control (couldn't stop drinking). Nearly all patients (N=37) stated that they needed help. Twenty-two patients also reported that they had long periods of abstinence.

Drinking history indicates a normal drinking as well as heavy drinking periods in patients' lives. Normal drinking constitutes display of moral adequacy as we have seen in Chapter Four.

Table 1C, on the next page, lists the socio-psychological and medical reasons given for drinking, by study patients, highlighting further their moral adequacy. These are given in straight frequencies, but there is an overlap across the accounts, as all patients have offered one or more of these reasons.

**TABLE 1C:**

Category                      Frequency      CBA      Frequency      CM      Frequency

**SOCIO-PSYCHOLOGICAL AND MEDICAL REASONS**

Dominant parent	2				
Got the habit in the Army	2				
To cope with stress	35				
To cope with feelings of anger, frustration, hatred	13				
Violent husband/lack of confidence	3				
Anxiety/tension	24				
Depression	12				
Lack of confidence	25				
Loneliness	29				
Loneliness/insecurity	1				
Boredom	13				
Inadequacy/immaturity	1				
Alcoholism as an illness or disease	36				
Alcoholism as an illness and as personal responsibility	34				

Most patients have mentioned inability to cope with stress (N=35) as a reason for drinking, or defined alcoholism as an illness (N=33). Inability to cope with feelings of anger, frustration, hatred were given by 13 respondents. In addition, 24 patients have mentioned anxiety/tension, 25 have mentioned lack of confidence, 29 loneliness or insecurity, and 13 have given boredom as a reason for drinking. Alcoholism as an illness or disease is described by 36 patients and 34 patients have described it as an illness as well as personal responsibility, indicating some ambiguity which will be discussed in chapter nine. These expressed reasons for drinking illustrate the predominance of psychological and medical explanations which are part of the acceptable vocabulary of the Treatment Programme (see Chapter Four).

The figures in tables 1A to 1C, resulting from simple counting techniques, provide support to the qualitative analysis. MCD categories, in the qualitative analysis, used in patients' discourse relating to dramatic life events and displays of moral adequacy are shown to be consistent throughout the accounts by means of simple counting techniques.

The structural analysis of the narrative (Chapter Four) is also supported by this counting method indicating a considerable degree of consistency across patients' accounts. Tables 1A to 1C show that the emphasis on normality is found in all the accounts. It is also clear that most patients present a dramatic and eventful past and offer psychological reasons for drinking

which predominate the accounts. The psychological orientation as a predominant aspect of modern medical discourse will be discussed in Chapter Nine.

There are a few exceptions, in this study to presentations of a dramatic past and the psychological motives given for drinking. Three cases were discussed in Part II, on the 'narrative' structure as being deviant cases. Two of these cases differed from the rest due to their refusal to label themselves as 'alcoholic', whilst describing themselves as morally adequate individuals. In addition to this denial, patient no.16 however also does not present a dramatic past, nor does he offer any psychological motives for his drinking.

Thus, this reflects Alasuutari's (1990) suggestion that alcoholism is considered as a moral matter in Western cultures. It also emphasises Durkheim's (1974) and Schutz's (1964) views about the social world constructed by members in moral terms. Counting has therefore confirmed the uniformity of moral displays of adequacy by study patients as well as consistency of themes such as the emphasis on normality. The diversity of 'talk', on the other hand, highlighted by deviant cases indicates that we are not 'cultural dopes' (Garfinkel, 1967), and do not talk about ourselves and our experiences in exactly the same ways.

The following pages will present the results of counting MCDs, membership categories, category modifiers and category-bound activities in professionals' texts extracted from letters. Some

comparisons will be made, based on these findings with those based on counting in patients' texts.

Professionals' letters include the Senior Registrar's 'discharge' letters addressed to patients' general practitioner, and the Social Worker's letters to directors of 'dry houses', to solicitors or to Government departments such as Housing. GPs' and Hospital Registrars' referral letters, referring patients to the Unit, addressed to the director of the Alcohol Treatment Unit will also be included.

Tables 2A to 2C on the next pages list frequency distributions of membership categories, category modifiers (CM) and category-bound activities (CBA), used in the Senior Registrar's letters, written to patients' GPs, following discharge from hospital. These letters include information about the treatment received, patients' life history and drinking experiences, often in a case history-taking format. Category modifiers help the patient emerge as a victim of an unhappy environment, an environment which may include an alcoholic parent, family violence and dramatic events such as illness, death, divorce, loss of job.

Frequencies of categories may overlap, as often several categories, within a collection, may apply to the same patient. I examined 80 such letters; some of these refer to patients included in this study. The Senior Registrar's expectation of the GP is to follow-up patient's progress in maintaining sobriety and provide help and support, following discharge from hospital.

TABLE 2 - MEMBERSHIP CATEGORIES, CATEGORY-BOUND ACTIVITIES (CBA) AND CATEGORY MODIFIERS (CM) DESCRIBED IN THE SENIOR REGISTRAR'S LETTERS. N=80

TABLE 2A:

COLLECTION: FAMILY

Membership Category	CBA	Frequency	CM	Frequency
Father	Died (before child)	43	Killed	2
			Distant	1
			Poor relationship with patient	2
			Violent when drinking	10
			Heavy drinker/alcoholic	54
			Heavy smoker	3
			Warm & smothering	1
Mother	Caring Got on well with patient	5	Depressed	3
			Alcoholic	21
			Seriously ill	1
Step-parent	Died(before child) Did not get on with patient	39	Took an overdose	1
Grandparents	Died	4	Brought up patient	3
Childhood	Happy	11	Unhappy/Disturbed	69
			Fostered	2
			In children's home	2
Brother			In prison	1
			Heavy drinker/alcoholic	22
Sister	Worried about patient	2		
			Died	3
-----				
Relational Pairs				
Mother-Father	M/F left M/F M/F remarried Divorced	15 12 10	Frequent rows	5
			F.used to hit M.	4
M/F-Child (patient)	Took care of C. Got on well	4 2	Ambivalent/strained relationship	9
			M/F rejected C.	2
			Little contact	28
Step-parent-Child (patient)			Little contact	9
			Sp/C.did not get on	1
			Little contact	6
Brother-Brother Close (patient)	Got on well	2	Little contact	8
Sister-brother (patient)	Get on well	1	Poor relationship	3
Sister-Sister (patient)	Got on well	1	Little contact	3



COLLECTION

Category	CBA	Frequency	CM	Frequency
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SCHOOLING

Examinations	Passed exam. ( 'O' / 'A' levels)	11		
	Passed none	64		
Further Exam.s	City & Guilds	5		
	Secretarial	2		
	Degree	3		
Life at school	Happy	13	Unhappy	69
			Hated	3
			Expelled	1

EMPLOYMENT

Worker	Good/hard worker	54	Lost job due to drinking	9
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MARRIAGE

Husband (patient)	Left wife	6			
	Divorced	31			
	Remarried	17			
	Gets on with the children	2	Abusive/violent		
	In financial difficulty	15	aggressive	4	
Husband (patient's)	Left wife	11	Heavy drinker	18	
			Violent (past or current)	34	
	Remarried	5			
Wife (patient)	Divorced	48			
	Remarried	26			
Wife (patient's)	Left husband	37	Heavy drinker	8	
			Threatens to leave	25	
				Resents Husband's drinking	1
				Died from o/dose	1
Children	Well looked after/ doing well	32	Fostered	3	
			In care	2	
			Died	3	
			Handicapped child	1	

RELATIONSHIPS

Girlfriend	Gets on well with patient	8	Threatens to leave	3
	Supportive	3		
Boyfriend Homosexual partner	Gets on well	2	Violent	2
	Gets on well	2	Guilt feelings	1

Table 2A, on pages 18 and 19, indicates that a great variety of categories, category modifiers and CBAs are used. Collections of categories include the following: family, schooling, employment, marriage and relationships. As mentioned earlier, these letters are often written in a life history-taking format consistent with psychiatric training. Categories are similar to those used by patients in their accounts, as discussed earlier, however, a more detailed dramatic and vivid family background characterised by violence, heavy drinking and divorce is presented in the SR's letters.

CBAs relating to patients' parents, such as death, are given in about half the SR's letters; 43 fathers' deaths and 39 mothers' deaths are mentioned. Over half (N=54) the letters include fathers' heavy drinking or alcoholism, and a quarter (N=21) include mothers' alcoholism.

Patients' childhood is mostly described as being unhappy or disturbed (N=69), and standardised relational pairs indicate that 28 patients had little contact with their parents. Category modifiers such as poor relationships or very little contact with siblings are included in some letters (N=20).

With reference to schooling, most patients' experiences are described as unhappy (N=69) and 3 patients are reported as having hated school. These category modifiers help the patient to appear as a victim of unhappy circumstances.

Many patients (N=54) are presented as good/hard workers, thus emphasising their moral adequacy. SR's reports of patients' marriages and marital relationships are characterised by dramatic life events such as divorce, threats to leave the marriage, and remarriage. However, when children are mentioned, SR's comments are mostly favourable to patients. Of the 41 cases where the children are mentioned, in 32 reports they are described as being well looked after or doing well, thus highlighting patients' moral adequacy as parents.

In terms of patients' moral character, table 2B, on the next page, lists frequencies of membership categories, CBAs and category modifiers used in the SR's letters addressed to GPs. Table 2B also lists frequencies of categories used in descriptions of reports of patients' drug/alcohol history. Table 2C, following table 2B, lists frequencies of categories used in descriptions of patients' mental state and socio-psychological reasons offered for drinking.

**TABLE 2B:**

**COLLECTION: MORAL**

Membership Category(frequency)	CBA	Frequency	CM	Frequency
Popular(N=55)	Got on well with staff/patients	48		
	Made positive contribution to Treatment Group	14		
	Sympathetic/active/enthusiastic/serious member of the Group	34		
Likeable (N=48)				
Friendly (N=54)				
Thoughtful & sensitive (N=2)				
Interesting (N=23)				
nice/kind/good sense of humour (N=25)				
Neatly dressed (N=2)				
Good at sports (N= 9) (tennis, football)				
Successful (N=6)				
Ambitious (N=12)				
Good/hard worker (N=54)				
Caring parent (N=31)	Worries about his/her children	23		
	Looks after child's needs	11		
Cooperative/ responsive (N=34)	Fitted in well on the Programme	7	Did not relate to staff/patients	5
	Helpful to others	3		
Intelligent (N=9)				
Ambitious/high ideals (N=7)				
Was able to articulate difficulties (N=62)	Eg. Able to talk about shyness, anxiety, lack of confidence, relationships		Stayed 'inhibited' throughout the Progr.	2
			Denied having a drink problem	5

**COLLECTION**

Category (frequency)	CBA	Frequency	CM	Frequency
Benefited from educational/ interactive aspects of the Programme (active participants) (76)	Was able to look at his/her life	19		
	Gained insight into his/her emotional problems	72	Needs further Counselling	3
	Gained in confidence	36		
Motivated to stay off alcohol (80)	Plans to make changes in his/her lifestyle	42		
Prospects for the future (74)	Hopeful he/she will be able to cope with his/her problems	72	Not hopeful about his/her future	2

**ALCOHOL/DRUG HISTORY**

Chemical dependency on Alcohol (78)	Shakes, sweating	78		
	Relief drinking	61		
	Fits, D.T.s, hallucinations	10		
	Amnesia	48		
Drug dependency (12)				
Heavy/addicted smoker (35)	30/40 cig.s daily	29	Intends to reduce quantity	5
Detox (78)	No. previous detox	45		
	Quick/ uncomplicated	65	Long/ Complicated	14
Treatment programme (69)	No. prev. progr.	14		
	Did well on the programme	66	Failed to benefit	3

**TABLE 2C:**  
**COLLECTION**

<u>Category</u>	<u>Frequency</u>	<u>CBA</u>	<u>Frequency</u>	<u>CM</u>	<u>Frequency</u>
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**MENTAL/PSYCHIATRIC**

Anxiety/panic attacks	64				
Guilt feelings	3				
Depression	41				
Obsessionality	3				
Sleep difficulty	9				
Memory difficulty	6				
Suicide attempt	23	Overdose	20	Cry for help	1
		Slashed			
		wrist(s)	3		

**SOCIO-PSYCHOLOGICAL MOTIVES**

Low self-esteem	5				
Lacking in confidence	8				
Rebellion against father	1				
To cope with:					
Stress	48				
Anxiety	51				
Depression	36				
Loneliness	15				
Sexual problems	1				
Problem in relating to					
people	3				

High frequencies, in table 2B, relating to patients' character such as being popular (N=55), likeable (N=48), nice/kind (N=25), sympathetic/active/enthusiastic (N=34), friendly (N=54) and caring parent (N=31) indicate the emphasis on moral adequacy. Display of moral adequacy by the SR is a skilful and persuasive way of obtaining GPs' cooperation in helping patients in the community, following discharge from hospital. Negative descriptions are only given in a minority of cases, such as not relating to staff/patients (N=5).

With reference to the treatment programme, most patients are described by the SR as having benefited from it and as active participants (76). The majority of patients included in these letters are described as having gained insight into their emotional problems (N=72), and, in all of the 80 letters, patients are described as having the motivation to stay abstinent.

Regarding the future, the SR expresses mostly his hopefulness in the ability of patients to cope with problems (N=72). When reporting on the drug/alcohol history of patients, the SR talks about drug or alcohol dependency, heavy smoking, and withdrawal symptoms such as shakes (N=78) and relief drinking (N=61) included in most letters.

Table 2C indicates high frequencies for reported mental states such as anxiety (N=64), depression (N=41) and suicide attempts (N=23). Motives offered for drinking by the SR are mostly

psychological such as coping with stress (N=48), with anxiety (N=51) and depression (N=36). This is consistent with the psychological orientation in modern medical discourse (Armstrong, 1983) which will be discussed in Chapter Nine.

As in patients' own accounts, the drink problem is not the focus of the discourse in the SR's letters. The patient is reconstituted as a 'whole' person whose family and marital relationships need to be considered and it follows a similar logical and chronological sequence of events which present a life-course. The patient is praised for being able to articulate his/her difficulties, express feelings, similar to a 'confessional talk' (Foucault, 1979).

Frequencies of categories in tables 2A to 2C highlight the dramatic aspects of patients' childhood, family and marital history described by the SR; this helps to justify patients' drink problem which then appears as an inevitable outcome of tragic circumstances. High frequencies in these tables, relating to dramatic events and to displays of patients' moral adequacy confirm the consistency of the use of categories by the SR in his letters to GPs. SR's positive approach to patients' future also stresses patients' moral adequacy in convincing GPs that patients have made an effort and benefited from the treatment programme, thus they will be able to cope with future problems.

Counting the MCD categories in SR's letters, in this section,



has therefore reinforced the use of categories to justify patients' drinking and the displays of moral adequacy, by showing consistency across these letters. However, of the 80 'discharge' letters, analysed in this study, 4 were found to deviate from the 'usual' letter which emphasises patients' benefits from the programme and their active participation.

In these 4 deviant cases (letter no.s 4,10,36,52), no acceptable reasons for drinking are offered; patients are nonetheless displayed as morally adequate individuals, as they are all described as highly motivated to stay off alcohol. Again the SR is skilfully highlighting patients' moral character, and trying to convince the GP that it is still worthwhile to provide support and help to these patients. This is similar to deviant cases found in patients' interviews, where moral adequacy was also a common feature.

The following extracts illustrate these deviant cases:

**Extract 45 - SR's letter no.4:**

'...it became fairly clear that he was unable to share anything other than the most superficial things with anyone...there were many discrepancies in his history and there was much, probably of an anti-social and criminal nature, which he has not shared with any of us. I suspect that if one wished to make a personality diagnosis that it might lie in the realms of hysterical psychopath. In these circumstances, it may be not surprising that I will say that I think his prognosis is likely to be poor. However, he certainly voices an intention to remain abstinent.'

The SR is reporting on the patient's intention to stay abstinent; he is not committing himself to whether he believes

that the patient will stay abstinent. The SR's conclusion of this patient's prognosis is that it is likely to be poor. He arrives at this conclusion as the patient appears to be resistant to talk about his life experiences. The patient appears to be uncooperative as he would not 'share' his life history with anyone.

However the SR mentions the patient's intention to remain abstinent, thus emphasising his moral adequacy. It is particularly skilful as the patient is described as voicing an intention. He seems to have kept quiet and resistant to speaking about his life history, but he has spoken about remaining abstinent.

In the letter no.10, another deviant case, the SR states that the patient has not been a 'particularly active participant' and that his involvement in the programme has been limited, and he probably has not gained from the experience. However the patient is described as highly motivated to 'stay off alcohol', thus displayed as a morally adequate person. In the other two deviant cases, letter nos. 36 and 52, the patient is described as quiet and unwilling to talk and participate in the programme, but motivated to staying abstinent, hence morally adequate.

These four deviant cases which refer to a different type of letter written by the SR to patients' GP, show that the SR does not write the same kind of letter in every instance as a

'cultural dope', in Garfinkel's terms (1967). They illustrate the SR's skills in trying to persuade patients' GPs that it is worthwhile helping patients on discharge from the Treatment Unit, as he does not present a good prognosis for every patient.

Tables 3A to 3C list frequencies of membership categories, CBAs and category modifiers used in the Social Worker's letters (N=23) addressed to directors or managers of 'dry houses', to solicitors or Government departments such as housing. The structure of these letters, as in the case of the SR's letters, often follows a case history-taking format. Table 3A, on the next two pages, includes MCDs relating to family background, schooling, employment, marriage, relationships and social/financial problems. Some overlap between categories and CBAs is inevitable as in patients' and SR's letters, as multiple categories or activities often refer to the same patient.

TABLE 3 - MEMBERSHIP CATEGORIES, CATEGORY-BOUND ACTIVITIES (CBA) AND CATEGORY MODIFIERS DESCRIBED IN THE SOCIAL WORKER'S LETTERS. N=23

TABLE 3A:

COLLECTION: FAMILY

Membership Category	CBA	Frequency	CM	Frequency
Father	Died(before child)	9	Strict & smothering	1
	Helpful attitude	1	Did not get on with patient	9
	Remarried	2	Violent when drinking	2
	Left home	2	Heavy drinker/ alcoholic	11
			Rejected child	4
Mother	Loving	4	Warm & smothering	1
	Got on well with patient	3	Unwilling to have him back	1
	Died(before child)	12	Could not cope	2
			Heavy drinker/ alcoholic	6
			Rejected child	5
			Caring but over-protective	3
		Depressed	1	
Step-parent	Did not get on with patient	1		
Grandparents	Died	1	Brought up patient	1
Child (patient)	Normal/Happy	7	Unhappy	16
	Close to parents	2	Fostered	4
	Loved mother deeply	1	In care	2
	Loved by parents	2	Separated from parents	5
Brother			Died or killed (patient shocked)	3
			Heavy drinker/ Alcoholic	4
Sister	Supportive	1	Not close to patient	1
	Looked after patient	1	Has no contact with patient	2

COLLECTION

<u>Category</u>	<u>CBA</u>	<u>Frequency</u>	<u>CM</u>	<u>Frequency</u>
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SCHOOLING

Examinations	Passed exam. ( 'O' / 'A' levels)	6		
	Passed none	17		
Further Exam.s	City & Guilds	1		
	Secretarial	2		
Life at school	Happy	3	Unhappy	14

EMPLOYMENT

Worker	Good/hard worker	7	Lost job due to drinking	11
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MARRIAGE

Husband (patient)	Left wife	2		
	Divorced	2		
	Remarried	1		
	Gets on with the children	1		
	In financial difficulty	12	Aggressive	1
Husband (patient's)	Left wife	4		
	Remarried	1	Used to hit wife	2
Wife (patient)	Divorced	4		
	Remarried	1		
Wife (patient's)	Left husband	10	Heavy drinker	2
	Threatens to leave	3		
Children	Well looked after	10	Killed in car crash	1
			Fostered	3
			In care	2

RELATIONSHIPS

Girlfriend	Gets on well with patient	1		
	Supportive	1		
Boyfriend	Gets on well	2	Aggressive	1

SOCIAL/FINANCIAL PROBLEMS

Category (frequency)

Homelessness (12)  
Debts (9)  
Social Isolation (16)

Of the 23 patients included in the Social Worker's letters, the majority (N=16) are described as having been unhappy in childhood, and four are reported as fostered, two in care and five separated from parents.

The family background includes dramatic events such as death of parents or siblings, violence and heavy drinking. Schooling is also described for most patients as an unhappy time (N=14). Again category modifiers help to justify the development of the drink problem.

This dramatic and unhappy background presented by the social worker is followed by more dramatic events in patients' marriages relating to relationship and financial problems. In addition, about half the patients are described as being homeless and 16 as socially isolated. The dramatic and eventful account of patients' circumstances helps the reader to understand and legitimise the emergence of patients' drink problem which appears to be an inevitable outcome.

It is interesting to note that when patients' children are mentioned in these letters, they are mostly described as well looked after (N=10). Patients are thus displayed as morally adequate and caring parents. The next tables 3B and 3C include long lists of positive attributes relating to patients' moral character, physical and mental state, alcohol/drug history and motives for drinking.

**TABLE 3B:**  
**COLLECTION: MORAL**

Category(frequency)	CBA	Frequency	CM	Frequency
Nice/likeable (N=18)				
Pleasant (N=9)				
Honest (N=8)				
Kind (N=12)				
Outgoing (N=4)				
Enthusiastic (N=3)				
Active participator (N=8)				
Good at sports (N=4)				
Enjoys playing music(N=6)				
Successful (N=4)				
Hard worker (N=5)				
Caring parent (N=12)	Looks after her children's needs		6	
	He/she would never hurt the children			4
Cooperative(N=4)				
Talented (N=6)				
Bright (N=7)				
Intelligent (N=6)				
Articulate (N=4)				
Was able to talk about difficulties (N=9)	Eg. Able to talk about loneliness, lack of confidence, relationships			
Benefited from the programme (N=21)	Increased confidence	2		
	Better self-image			
	Highly motivated to stop drinking	21		
	Shows ability to make changes	2		
	Plans to change his/her lifestyle	16		
	Wishes to get a job	5		
	Better able to relate to people	8		
	Better able to express feelings	10		
	Better able to cope with stress	13		
	Better able to control his impulses	1	needs further help	1

**TABLE 3C:**

<u>COLLECTION</u>					
<u>Category</u>	<u>Frequency</u>	<u>CBA</u>	<u>Frequency</u>	<u>CM</u>	<u>Frequency</u>
<b><u>PHYSIOLOGICAL</u></b>					
Respiratory problems	1				
Stomach problems	7	Ulcer/ gastritis		4	
Liver problems	4	Failure Enlarged		2 2	
Muscular cramps	3				
Peripheral neuritis	5				
Head injury	2				
Brain damage	2				
<b><u>MENTAL/PSYCHIATRIC</u></b>					
Paranoia	1				
Anxiety/panic attacks	6				
Guilt feelings	2				
Depression	4				
Suicide attempt	5	Overdose Cut/slashed wrist(s)		4 2	
<b><u>SOCIO-PSYCHOLOGICAL MOTIVES</u></b>					
Poor self-image	1				
Lacking in confidence	4				
To combat:loneliness	11				
boredom	9				
isolation	8				
frustration	3				
tension	2				
To cope with stress	2				
<b><u>DIAGNOSTIC</u></b>					
Chemical dependency on Alcohol	23	Shakes, sweating Relief drinking Fits, D.T.s, hallu- cinations Amnesia		22 9 12 9	
Drug dependency	7				
Heavy/addicted smoker	6				
<b><u>TREATMENT</u></b>					
Detox	23	No. previous detox		12	
programme	19	No. previous programmes Did well on the programme		4 18	Failed to benefit 1



## DRINKING HISTORY

Normal teenage drinker (22)	Used to drink at weekends	9	
	Drank socially	22	
	Drank in pubs with friends	6	
Became regular heavy drinker (23)	When the marriage broke down	10	Cry for help 2
	When mother died	1	
	When girlfriend left	1	
	Could not get a job	6	
	When he lived on his own	8	
	He had nowhere to stay	1	
Abstinence ( 12)	Has had long/signi- ficant periods of abstinence	15	
Control over drinking (8)	Able to control his/her use of alcohol	8	

## LEGAL

Drunkness offences (16)	Drunk & disorderly	10	
	Fines	6	
Drunken driving (1)	Fine	1	
Drug offences (1)	On probation	1	
Theft/shoplifting (6)	Cans of beer	2	
	Bottles of spirits	4	
Malicious/criminal damage (1)	Imprisonment	1	
Assault (1)			

Social reasons such as loneliness (N=11), boredom (N=9) and isolation (N=8) are frequently used by the Social Worker, hence patients' needs for social support and a place to live are emphasised. Patients' drinking history shows how various life events such as a marriage breakdown (N=10) and/or unemployment (N=6) have contributed to the drink problem. A social worker's training may relate more to sociology and psychology rather than to medicine; however, the rest of the professionals, included in this study, with medical training such as the Senior Registrar, General Practitioners and Hospital Registrars also offer one or more social reasons, e.g. loneliness, social isolation, homelessness, unemployment.

Thus, all professionals, whose letters have been analysed in this study, seem to rely on commonsense notions of reasons for personal troubles. Complications due to the drink problem such as drunkenness offences (N=16) are also included, thus reinforcing the need for social support.

These letters indicate the Social Worker's skilful ways of presenting patients' problems by legitimising them. Most letters are written to directors of 'dry houses' asking for a place for the patient. Thus homelessness and social isolation are emphasised by the social worker. The Social worker's as well as the Senior Registrar's letters follow the holistic approach, in Armstrong's terms (1983) looking beyond the body into undifferentiated spaces between bodies.

It is interesting to note that category modifiers describing an unhappy family background and an unhappy school life help the reader to form an image of the patient as a victim of a tragic and unhappy environment. They also give the account a lively character. Counting frequencies of membership categories, CBAs and category modifiers, used in the Social Worker's letters, has helped to increase the reliability of the qualitative analysis by emphasising consistency throughout the Social Worker's letters.

General Practitioners' letters of referral addressed to the director of the Alcohol Treatment Unit are brief and unlike the Senior Registrar's and the Social Worker's letters, they do not present case histories. The family background and childhood experiences feature in a small number of letters only. Details of past treatment are kept to a minimum. Usually the number of previous treatment for detoxification or a special programme is given.

Tables 4A and 4B, on the next pages, list frequencies of membership categories, CBAs and category modifiers used in General Practitioners' letters of referral. As in previous tables, categories and category-bound activities overlap, due to the fact that more than one category or activity is often associated with the same case.

**TABLE 4 - MEMBERSHIP CATEGORIES, CATEGORY-BOUND ACTIVITIES (CBA) AND CATEGORY MODIFIERS (CM) DESCRIBED IN GENERAL PRACTITIONERS' LETTERS OF REFERRAL. N=30**

**TABLE 4A:**

**COLLECTION**

<u>Category</u>	<u>CBA</u>	<u>Frequency</u>	<u>CM</u>	<u>Frequency</u>
Father	Died(before child)	2		
	Helpful attitude	1	Heavy drinker/ alcoholic	10
Mother	Died(before child)	7	Not in contact with patient	6
			Heavy drinker/ alcoholic	2
			seriously ill	1
			Not in contact with patient	3
Child (patient)	Normal/Happy	1	Unhappy	16
			In care	2
Brother	Cares for patient	1	Heavy drinker/ alcoholic	7
			Not in contact with patient	2
Sister	Looks after patient	1	Disabled	1
			Heavy drinker/ alcoholic	1

**SCHOOLING**

Life at school      Happy      0      Unhappy      14

**MARRIAGE**

Husband  
(patient's)      Threatening to  
leave patient      2

Wife  
(patient)      Unhappy      9

Wife  
(patient's)      Left husband      4

Threatens to  
leave      2

Divorced      5

Children      In care      4

**RELATIONSHIPS**

Girlfriend      Supportive      1      Threatens to leave      3

**SOCIAL/FINANCIAL PROBLEMS**

Homeless (8)

Housing problems: Rent arrears 10  
(16)      Threatened with  
eviction      6

May lose job  
due to drinking (3)

Lost job due  
to drinking (7)

Unemployed (21)

Debts (11)

Unable to cope (26)

**TABLE 4B:****COLLECTION**

CATEGORY (frequency)	CBA	FREQUENCY	CM	FREQUENCY
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**MORAL**

Friendly/pleasant (21)  
honest/polite (16)

Cooperative (19)

Highly motivated (28)  
to stop drinking

He/she will be  
grateful (8)

He/she will comply  
with attendance (16)

Anxious/cry for help (18)

Good insight into  
his/her problems (18)

Has managed long  
periods of abstinence (12)

He/she will benefit  
from detoxification (27)

**PHYSIOLOGICAL**

Stomach problems	7	Gastritis	3
		Ulcers	4

Liver problems (5):		Failure	1
		Fatty liver	2
		Hepatitis	2

Pancreatitis	2		
Peripheral neuropathy	8		
Epilepsy	1		

**MENTAL/PSYCHIATRIC**

Anxiety/panic attacks	14		
Distressed	17		
Depression	8		
Tension	2		
Suicide attempt	5	Overdose	3
		Slashed	
		wrist(s)	2

Korsakoff's psychosis	2		
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Confused/disorientated	4		
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**DIAGNOSTIC**

Chemical dependency on Alcohol	30	Shakes, sweating	30
		Relief drinking	5
		Fits, D.T.s, hallu- cinations	5
		Amnesia	6
Drug dependency	3	Tranquilisers	3
Compulsive gambler	1		

**TREATMENT**

Detox		Number of previous detoxification	9
Programme		Number of previous treatment programme	2

The emphasis in General Practitioners' letters is placed (table 4A) on patients' unhappy family circumstances with heavy drinking/alcoholic fathers (N=10) and accounts of an unhappy childhood. This, again, is consistent with other professionals' choice of commonsense grounds for personal troubles which could apply just as much to alcoholism as homelessness.

About 50% of patients referred by GPs are described as having been unhappy at school (N=14). Category modifiers again help to provide justifications for the drink problem. A large number of patients are described as either being homeless (N=8) or having housing problems (N=16), or having debts (N=11), and some patients as experiencing problems in their marriage. The majority of patients (N=21) are reported as being unemployed and in 26 cases patients are described as being unable to cope.

Table 4B highlights General Practitioners' displays of patients' moral adequacy, their mental state and the existence of withdrawal symptoms. Twenty-one patients are described as being friendly or pleasant, 19 as cooperative, 18 as having good insight into their problems, 27 as likely to benefit from detoxification, and 28 as highly motivated to stop drinking. Patients are shown as being distressed (N=17) or suffering from anxiety, panic attacks or depression, thus in need of help. Chemical dependency is emphasised in all 30 cases. This indicates patients' immediate needs for detoxification.

As in the SR's and the Social Worker's letters, the patient is displayed as a 'whole' person and as a morally adequate individual with an unhappy family background, numerous social/financial problems, marital difficulties, but highly motivated to stop drinking. This style of narrative is aimed at achieving practical results such as getting an appointment for the patient at the out-patient clinic of the Alcohol Treatment Unit.

The structure of hospital registrars' letters of referral (N=22) written to the director of the Alcohol Treatment Unit is similar to that of General Practitioners' letters and therefore tend to be brief. Tables 5A and 5B, on the next pages, list frequencies of membership categories, CBAs and category modifiers used in Hospital Registrars' letters.



TABLE 5 - MEMBERSHIP CATEGORIES, CATEGORY-BOUND ACTIVITIES (CBA) AND CATEGORY MODIFIERS (CM) DESCRIBED IN HOSPITAL REGISTRARS' LETTERS. N=22

TABLE 5A:

COLLECTION					
Category	CBA	Frequency	CM	Frequency	

FAMILY

Father	Died (before child)	5	Never got on	
			with father	5
			Heavy drinker/ alcoholic	6
Mother	Died (before child)	3	Unable to help	2
			Heavy drinker/ alcoholic	3
Brother(s)			Heavy drinker/ alcoholic	5
Sister	Supportive	1		
Child (patient)			Unhappy	13

MARRIAGE

Husband (patient)	Wants to save marriage	3	No communication with wife	2
Husband (patient's)	Left wife Divorced patient	1 4		
Wife (patient's)			Heavy drinker	1
			died of overdose	1
			Shares few interests with patient	2
Children			In care	3

RELATIONSHIPS

Boyfriend			Violent	1
			Irritable & tense	1

**TABLE 5B:**

<u>COLLECTION</u>					
<u>Category</u>	<u>Frequency</u>	<u>CBA</u>	<u>FREQUENCY</u>	<u>CM</u>	<u>Frequency</u>
<b><u>MORAL</u></b>					
Likeable	10				
Pleasant	16				
Successful businessman	1				
Intelligent	4				
Highly motivated to stop drinking	20				
<b><u>PHYSIOLOGICAL</u></b>					
Stomach problems	2	Gastritis		2	
Peripheral neuritis	7				
Recurrent tumour	1				
<b><u>MENTAL/PSYCHIATRIC</u></b>					
Anxiety	16				
Depression	7				
Tension	4				
Schizophrenia	2				
Suicide attempt	11	Overdose		6	
		Slashed wrist(s)		5	
Memory difficulty	5				
Sleep difficulty	11				
Loss of concentration	4				
<b><u>SOCIO-PSYCHOLOGICAL MOTIVES</u></b>					
Compulsive personality	1				
Personality disorder	6				
Inadequate personality	1				
Social isolation	7				
Loneliness	4				
Frustration	4				
Rejection	3				
Boredom	4				
Inability to cope with stress	14				
<b><u>DIAGNOSTIC</u></b>					
Chemical dependency on Alcohol	22	Shakes, sweating		22	
		Relief drinking		7	
		Fits, D.T.s, hallu- cinations		11	
		Amnesia		3	
<b><u>TREATMENT</u></b>					
Number of previous detox	6				

Hospital Registrars have included patients' family background only in some cases, however 13 of the 22 patients are described as having had an unhappy childhood. Marriage and relationship problems are mentioned in some cases. These again are commonsense notions for personal problems such as alcoholism.

The patient is again displayed as a morally adequate individual as in the other professionals' letters discussed previously. Hospital Registrars offer socio-psychological motives for patients' problems and manifest a 'holistic' approach as do the other three professionals mentioned earlier. Patients' family circumstances, relationships and mental state are included, thus providing justifications for their chemical dependency on alcohol (N=22). Patients' inability to cope also features in GPs' letters relating to social/financial problems.

Hospital Registrars, refer to patients' inability to cope with stress as the other three professionals do, as well as patients themselves. Inability to cope with stress is often given as a motive for drinking. As Young (1980) points out, inability to cope with stress is part of the modern medical discourse. The emphasis on patients' moral adequacy, social and mental problems, chemical dependency on alcohol, and their high motivation to stop drinking present skilful ways to achieve practical results in getting an appointment at the out-patient clinic.

## Conclusion

The analysis of membership categorisation devices in this section, by a simple counting method, used in patients' accounts and professionals' letters reveals common structural elements such as family background followed by accounts on schooling, marriage problems, housing/financial difficulties and current problem chemical dependency on alcohol.

The holistic modern medical approach is present in patients' and professionals' texts. In addition, displays of moral adequacy characterise both discourses. As mentioned earlier, Baruch (1981) has found that parents' stories of encounters with the health professions were displays of moral adequacy.

This analysis helps to provide support to the MCD analysis by highlighting the comparability, consistency and generality of membership categories and CBAs in patients' and professionals' texts, in terms of frequency levels. It also improves reliability of the MCD categories and category-bound activities described in individual patients' accounts and professionals' letters, through recurrent themes.

Patients' and professionals' skills in the display of patients' moral adequacy and in the dramatic accounts of family and marital problems, are illustrated further by this counting method. Patients emerge as victims of dramatic circumstances leading to the inevitable outcome, i.e. the drink problem, in patients' own accounts and in professionals'

letters. The benefits of the Treatment Programme to patients emphasised in the Senior Registrar's and the Social Worker's provides justification of such an expensive treatment for alcoholics, and indicates progress to satisfy funding agencies (Silverman, 1993).

Up to this point, I have described 'how' alcoholic patients and health professionals construct drinking problems and present them within total life experiences. In Part III, following this chapter, I shall attempt to explain the study findings and answer the 'why' question. I shall discuss the roles of context and gender in patients' and professionals' discourses. I shall also examine patients' and professionals' reconstructions of life experiences which are holistic and do not focus on the drink problem. These reconstructions refer to patients' entire life experiences and their total lifestyle.

The next three chapters (7, 8 & 9) are much shorter than the previous two chapters presenting the MCD analysis (Sacks, 1972) and the tabulations. The focus of my analysis, in this study, is the application of MCD to describe 'how' patients' and professionals' discourses are accomplished, and to examine the consistency of the use of certain categories, whilst the next three chapters are exploratory.

PART III. EXPLORING FOR POSSIBLE EXPLANATIONS OF THE FINDINGS

Chapter Seven: The role of 'context' in the organisation of  
'talk' in a clinical setting: the sociological  
debate and its relevance to this study

We have seen, in Part II, how the general threefold narrative structure of patients' accounts as well as patients' displays of moral adequacy, their competence and skills in the use of psycho-medical formulations of alcoholism are applicable to most patients in this study.

Part III presents attempts to explain the findings, and find some answers to the 'why' question. In this section, I shall discuss the role of context in the organisation of talk as it relates to alcoholic patients' discourses.

Some decades ago, Mills (1940) pointed out that descriptions of human behaviour appeal to motives which are imputed to the actors and hence are not subjective 'springs' of action. He defined motives as typical vocabularies having ascertainable functions in delimited societal situations. Rather than fixed elements in an individual, motives are described as terms with which interpretation of conduct by social actors proceeds, and as common grounds for mediated behaviours.

Consequently there is no need to invoke psychological terms like 'desire' or 'wish' as explanatory terms. Actors appeal to a vocabulary of motives associated with a norm with which both

members of the situation are in agreement, and are thus acceptable reasons. Often members are finding new reasons which will mediate action.

There is therefore 'diplomacy' in the choice of motives. Such diplomacy, Mills argues, does not necessarily imply intentional lies; it merely indicates that an appropriate vocabulary of motive will be utilised, that they are conditions for certain lines of conduct and that they integrate social actions. This view of motives shows that motives are of no value apart from the social situations for which they are appropriate vocabularies. Hence, they must be situated.

In this study, the social context seems appropriate when we consider patients' reasons given for their drinking. Patients' stated reasons are mostly in agreement with the accepted vocabulary of motives in the clinical context of the 'Treatment Programme' which has a psychological and medical orientation. We have seen, in Chapter Six, how psychological and medical reasons offered for drinking were predominant motives in patients' accounts. Thus, reasons such as coping with or relief of tension, anxiety, stress, to get courage, get over shyness or unhappiness, are common reasons offered by patients in the study.

The following extracts from patients' interviews are some examples which illustrate the situated motives offered for

drinking, and the part that context plays in the constitution of talk and social structure.

**Extract 46 - Patient no.4**

'I was very immature, naive and was very very nervous before I came here. Straightaway the first relationship I had I drank to cope with it.'

This patient is referring to his immaturity and inability to cope with a relationship. These are situated and acceptable motives for drinking in the clinical context where the treatment programme, which he is about to complete, has a psychological and medical orientation. Inability to cope is quite a common expression in patients' stated reasons for drinking and medically acceptable vocabulary, as we have seen in Chapter Six.

**Extract 47 - patient no.10**

'...I didn't get custody of my children which I hoped and access wasn't very frequent so I turned to drink again. I was drinking for extra courage to do something if I got annoyed with somebody. It got to an addiction.'

Patient no.10 is talking about the fact that she has lost custody of her children and her return to drinking is explained as a logical consequence of this unhappy situation. She also mentions getting courage, again an acceptable vocabulary of motives for drinking within the context of the 'Programme'. She is offering drinking as a way of dealing with a situation where she is annoyed with somebody, which is an acceptable psychological reason for drinking, and is locally available explanation within the clinical context. She



is also using medical vocabulary for alcoholism, i.e. 'addiction', an appropriate term for a medical setting.

**Extract 48 - patient no.15**

'One was born with Cerebral Palsy, it was a great strain on our marriage. He took up a lot of our time, I mean our social life was absolutely nil...It went on years and years and years, and crying every night, every day you know. It was a very big strain on us...I continued drinking...I think that this is an illness that will never leave me.'

In this extract, the patient is referring to his child with Cerebral Palsy, and emphasises the strain that this has caused and hence provides an acceptable psychological reason for his continued drinking. He is also offering the medically acceptable explanation for alcoholism i.e. the 'illness' concept, which is also a situated reason in the clinical context of the 'Programme'. He also points out that he will always have this illness, thus implying the absence of treatment, in its orthodox sense, and referring to it as a chronic illness.

**Extract 49 - patient no.12**

'... became my third husband...He became violent. We got married because we thought that would straighten everything. I couldn't cope with him. To get me cope with the day, I was drinking, and then it was really just to drink to stop all the shakes, the sweats, and everything.'

This extract is part of a longer extract used in the MCD analysis in Chapter Five. The patient is describing her drinking in terms of her inability to cope with her marital relationship and the husband's violence. This also

illustrates the medical and psychological vocabulary, i.e. 'inability to cope' which is again a situated reason. She further uses an appropriate vocabulary in a medical context, i.e. reference to 'withdrawal symptoms' such as 'shakes' and 'sweats'.

**Extract 50 - patient no.3**

'I don't think it's been time wasted. I think that it's been four weeks very well spent. It certainly brought home a lot of things to me. I had already done quite a lot of thinking about this as to why I drank, trying to come to terms or overcome some of the feelings that I had. A lot of the time, you know, mentally what it is, it's the feeling thing within you.'

This patient is clearly emphasising drinking as a way to overcome feelings without being specific. Again, in Part II.6, we have seen how psychological reasons associated with emotional states or feelings such as frustration, anger are given as reasons for drinking. The cultural emphasis on the 'feeling' patient will be discussed in Chapter Nine.

This emphasis on feelings are in agreement with the psychological orientation of the Unit. Following Mills, this study shows that the social situation or context within which the talk takes place, is relevant to the vocabulary of motives, as it is evident in patients' stated reasons for their drinking.

As we have seen, in Chapter Six, patients' expressed reasons for drinking were mostly in agreement with the psychological

and medical orientation, with 35 patients mentioning inability to cope with stress, 13 inability to cope with anger, frustration or hatred, 24 anxiety/tension, 12 depression, 25 lack of confidence, 13 boredom, and 33 alcoholism or problem drinking defined as an illness or disease.

Professionals' letters too often refer to patients' social and mostly psychological reasons for drinking. For instance, as we have seen in extract 30 in the MCD analysis in Chapter Five, patient no.2 talks about her hip fracture and explains her drinking in terms of her inability to sleep. The SR in extract 31, also refers to this patient's hip fracture and explains her drinking as a way to relieve her pain. Also in the MCD analysis, extract 38, patient no.13 states that he drinks because he is very anxious, and the Social Worker in extract 39, describes this patient's reaction to being homeless as 'distressed'. Another example refers to extract 40 where patient no.19 mentions also 'anxiety' in relation to his drinking, and the SR, in extract 41, refers to this patient's drinking as being useful 'to settle his anxiety'.

In recent years, the sociological debate on issues centring on the social organisation of talk and the social context (the relation between 'how' and 'why' questions of social order) has been discussed by Silverman and Gubrium (1994). They have distinguished three positions taken up by ethnomethodologically informed researchers focusing on social interaction.

The first position considers only the 'how' questions, and all 'why' questions are reducible to 'how'. The second position emphasises that 'how' questions are most important but that context can be referred to, in the analysis only if it is invoked in the talk. Thus, if context is not invoked, then there are no grounds for appealing to it ourselves. Schegloff (1991) defines this as the 'paradox of proximateness' referring to two separate approaches, i.e. talk-in-interaction and the traditional studies of social structure.

Schegloff offers three fundamental points for interpreting data: the problem of relevance, the issue of procedural consequentiality and the balance between social structure and conversational structure. The problem of relevance refers to descriptions made in the talk to be shown to be relevant to the participants. We cannot rely on our intuition for instance that gender is relevant to the talk unless it is invoked and is relevant to the participants. This point will be taken up in the section on 'gender differences' (Chapter Eight).

In addition, the local production of context needs to be also procedurally consequential, giving the talk its specific institutional character. Self-repair or same-turn repair by speakers in the organisation of talk highlighted in relation to procedural consequentiality, indicates CA's argument that there may be processes which go across contexts or cultures. It is the context-free structure that defines where and when

context-sensitivity can be relevant. Hence, we need not assume that descriptions made in the talk are relevant to the institutional context, they may be applicable to a range of contexts; hence we need a balance between social structure and conversational structure.

The third position on 'how' and 'why' questions discussed by Silverman and Gubrium (1994) refers to a combination of structural and interactional approaches recognising the merits of both. One of the examples they give is a study (1991) by Maynard; it illustrates how paediatricians providing diagnostic information may use a 'perspective-display sequence' in which they first invite the parents' views before they deliver bad news. Maynard, after asking how, proceeds to ask why. He offers an explanation to why doctors proceed in this way. He explains that this minimises social conflict and maintains social harmony by allowing different perspectives to be integrated.

My own approach, in this study, regarding the debate on answering the 'how' and 'why' questions, is close to the third position discussed by Silverman and Gubrium. My data analysis focuses on how patients and professionals present problem drinking and accomplish their discourses skilfully. This has been covered in Chapter Five in the MCD analysis (Sacks, 1972) applied to some extracts from interview transcripts.

In this chapter, however, I am attempting to answer why

patients are offering psycho-medical reasons for their drink problem and using medical terminology to describe their drinking experiences. In doing so, the context becomes relevant as patients themselves, following Schegloff, often invoke the context of the 'Treatment Programme' by talking about their increased knowledge on the harmful effects of alcohol, and increased self-awareness and their ability to talk about their feelings, acquired through the 'Programme' (see Chapter Four).

But I am also trying to explain that, when the context is not directly invoked by the respondents, one can find a meaning to explain why the talk is organised in a particular way. I am referring to psychological and medical explanations offered by patients (Mills, 1940) discussed earlier, without necessarily invoking and associating these reasons with the 'Treatment Programme'. As we have seen, these are situated reasons, appropriate in the context of a psychologically and medically oriented treatment unit.

Concerning reference to life experiences and life events, in this study, Martin Kohli's (1981) arguments are of relevance here. In relation to the reconstructive element in autobiographies, Kohli suggests that the reference to past events occurs in the context of the present situation, and under the criterion of their significance to it. Thus, following Kohli, patients' reconstructions of their life experiences, in this study, make sense in the context of the

clinical setting of the 'Treatment Programme' with a medical/psychological orientation. This agrees with the situated reasons for drinking discussed earlier in relation to Mills' arguments.

In this chapter, we have therefore seen how the social context, i.e. a treatment unit with medical and psychological orientation, is relevant to patients' 'talk' in this study. Patients' vocabulary of motives are situated and agree with the medical and psychological orientation of the 'Treatment programme' and professionals' letters. In the next chapter, I shall explore the role of 'gender' in patients' talk.

## Chapter Eight: Gender differences

In this chapter, I shall examine reasons for drinking offered by men and women in this study, and attempt to answer in what ways gender may be relevant to alcoholic patients' accounts. The 'talk' produced by males and females can be examined by applying a feminist perspective, Zimmerman and West's (1975) and Schegloff's (1991) arguments on gender. The question which is relevant here is the following: are stated reasons for developing a drink problem gender-specific?

The following two extracts (51 and 52) are examples which show some differences in male and female discourses.

### **Extract 51 - patient no.29 (male)**

'It started when I was in the Air Force. I got drunk once but I was drinking Saturday nights only. When I came ~~out~~, I went on drinking Saturday nights, but I started drinking more. It never occurred to me that I was drinking more than anyone else. I was drinking several pints a day in pubs. Steadily I suppose I was drinking more but I wasn't aware at the time.'

### **Extract 52 - patient no.24 (female)**

'...It's not about drinking, it's about living. I've lost the right to drink. My marriage has ruined my life; I can't even drink, being a social drinker. I became nostalgic, crying, and very depressed. I've been in and out of psychiatric hospitals, and tried to commit suicide many times. I want some kind of stability...I've learned to be assertive; I've got more insight into myself. There are things about myself that I don't like but I know myself now. I'd like to help others not to go through hell as I've been...to have less pain.'

Patient no.29 is describing his drinking behaviour as an activity that had started in the Air Force. He then states



that it became heavier, on leaving the Air Force, but that he was not aware of it. He does not attribute his drinking to a relationship; instead, he associates his drinking with a particular situation, i.e. the Air Force, and then to himself as he continues with the habit. He does not refer to relationships concerning his drinking, however, he appears to be morally adequate as he states that he was not aware that he was drinking more than anyone else.

Knowledge and insight gained from the 'treatment programme' feature in the extract from the interview with patient no.24. She blames her marriage for her drink problem. She describes her drink problem in the context of her marital relationship, and states that marriage has ruined her life<sup>1</sup>. However, this account does remove from the patient the responsibility for drinking, and thus can be interpreted as a display of moral adequacy.

These two accounts show some differences as they attribute the drink problem to different circumstances. The male patient does not appear to blame his relationships for his drinking, whilst the female patient describes her drinking in terms of her marital relationship. We shall see how these accounts can

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<sup>1</sup> Durkheim (1952), discussing suicide rates in men and women, stated that marriage offered no protection to women against suicidal pressures. He also suggested that bachelors had a higher rate of suicide than married men. It has also been suggested by Cochrane (1983) that women are more vulnerable to mental illness than men when they are married, and that hospital admission rates for psychiatric problems are subsequently lower for single women.

be interpreted through a feminist perspective, or through approaches to gender in Conversation Analysis (CA); I shall discuss these approaches and then apply to some data from interviews with male and female patients:

A) The feminist approach to gender

Feminist theorists such as Nancy Chodorow (1974) and Carol Gilligan (1982) discuss women's development of 'identity' and interpretation of life experiences in a context of relationships. Gilligan (1982) refers to Freud's analysis of male and female differences suggesting that women show less sense of justice than men, that they are less ready to submit to the great exigencies of life, that they are more often influenced in their judgements by feelings of affection and hostility. Freud saw this as a problem in women's development in their anatomical difference from men.

Gilligan (1988) however suggests that a variety of studies have found that two voices can be distinguished by listening to the ways people speak about moral problems. These voices refer to different ways of experiencing oneself in relation to others. The suggestion here is that there is an association between moral voice and gender. She had found that a 'care approach' in solving moral problems, although not characteristic of all women, was almost exclusively a female phenomenon in three groups of educationally advantaged North Americans, whilst a 'justice approach' was predominantly a male perspective.

Another feminist writer, Nancy Chodorow (1974), mentioned earlier, suggests that gender is socially constructed. She argues that the traditional female role being centred around rearing children and looking after parents, prepares women for their caring role and places the emphasis on their relationships with their children, parents and husband. Hence, feminine personality comes to define itself in relation and connection to other people more than masculine personality does, and female identity formation takes place in a context of ongoing relationships.

Gilligan (1988), when discussing images of relationships which women develop, suggests that the reinterpretation of women's experience in terms of their own imagery of relationships clarifies that experience and also provides a non-hierarchical vision of human connection, a structure of interconnection replacing the order of inequality. Women not only define themselves in a context of relationships but they also judge themselves in terms of their ability to care. Gilligan further suggests that while women have taken care of men, men have tended to assume or devalue that care. She argues that men and women have different ways of imagining the human condition, different notions of what is of value in life.

When we consider gender differences in the way that people talk about their families and marriages, feminist theories could show some relevance to these accounts. From a feminist perspective, differences can be found between males and

females in the choice of reasons for drinking. For instance, females show a tendency to talk about their heavy drinking emerging through stress due to 'looking after' a sick parent or due to a violent husband. The females in this study show a tendency to reconstruct their life experiences relating to their heavy drinking in the context of relationships and emerge as victims of stressful relationships. The males on the other hand, tend to situate their heavy drinking within a context of specific dramatic events such as loss of a job, separation, divorce, death of a parent or a child, financial problems, and emerge as victims of circumstances.

B) The debate on 'gender' in CA

Zimmerman and West (1975) have shown that structural factors can have a relevance to the interactional contexts. Their concern was the analysis of conversational structure in relation to sex roles. They argue that power and dominance constitute significant aspects of many recurring interactions, such as those between men and women, between whites and blacks, adults and children. They suggest that various features of language and speech furnish the resources for male dominance and female submissiveness in pervasive and often subtle ways.

In their analysis of conversations, women exhibited the most silence in cross-sex conversations, compared with equal distribution of silence in same-sex conversations.

They have also indicated how men are more likely to interrupt

women than vice versa, thus referring to a power structure.

Schegloff (1991) has argued against this, questioning the assumption that when women give way to men in conversation, that this necessarily shows a power structure. As discussed previously in the previous chapter, he suggests that when interpreting data, we must not jump to conclusions, but rather ensure that our descriptions are relevant to the participants. Thus, gender, for instance, must be shown to be relevant to the 'talk'. Sacks (1992) too did not consider gender to be a structural factor which could provide context for talk. For instance, he argued that it was not a feature of male conversation, or female or female-male conversation that one party talks at a time and speaker change recurs.

My data, in this study, are based on unstructured interviews, whilst CA deals with conversational data. However, arguments on gender can be applied to patients' accounts of their reconstructed life experiences.

Therefore, extracts 51 and 52 discussed earlier, in this chapter, can be interpreted through a feminist perspective, as the female patient is describing her drinking in terms of her marriage, whilst the male patient is not referring to relationships. Gender is, thus, invoked (Schegloff, 1991) by the female patient, as it is her marriage that she appears to blame. She is redressing the balance of power by stating that she has learned to be assertive. Both patients, however are

displaying their moral adequacy. The male patient is referring to a habit that has started in the Air Force, and he was not aware that he was drinking more than anyone else, thus not held responsible for his drinking, and the female patient is referring to her marriage, again she is not held responsible for her drinking.

I shall discuss further extracts from interviews with male and female patients which illustrate the problems in analysing talk in terms of gender. Most of the examples, in this chapter, are taken from extracts used in the 'narrative' and MCD analysis, in Part II, except for those from interviews with patient nos. 3, 24 (discussed earlier) and 31.

**Extract 53 - patient no.4 (male)**

'I don't blame other people or really situations for why I drink. It's my ability to cope with them, that's the reason, and for me alcohol has always represented short periods of oblivion if you like, when I really can just put everything to one side, when I don't have to deal with it today...I was very immature, naive and was very very nervous before I came here.'

**Extract 54 - patient no.18 (male)**

'...My wife left me once before through my drinking, by this time we had a baby of two and we went back together. Well, I didn't really seek help and my drinking habits got worse, worse and worse. Then my mother died, that sort of made things double worse. Well, I hit the bottle, heavier.'

**Extract 55 - patient no.32 (male)**

'I was drinking normally I suppose from the age of 19 when I was in the Royal Air Force. I got married and stayed in the Force for 12 years, and looking back now, I can see everybody drank a lot in the Force. It was stressful being in the Force. Drink was part of the social system as it were that was going at the time. I continued until the age of 40, when I realised that I was drinking to relax, for social reasons as well as when I got bored.'

**Extract 56 - patient no.1 (male)**

'...I got drunk a few times, it was just a question of growing up as most young lads do. There was never a question of women involved, it was just a good laugh and sometimes it ended up being drunk.'

**Extract 57 - patient no.2 (female)**

'...we just went out to see some friends and he said: "Would you like a drink?". I just turned and said: "What drink?". He said: "I'll mix you something, half an inch of Dubonnet with some bitter lemon"...I had a bad accident when I was arguing with my husband. He gets violent sometimes when he drinks; I had my hip broken, and had my hip replaced. My husband said: "Why don't you have a couple of glasses of whisky to get some sleep", because I couldn't sleep at all...I can't go back and live with him if he's gonna carry on drinking because I'm just gonna go back to square one again and I can't have that'.

**Extract 58 - patient no.3 (female)**

'...My thinking at that time was: oh, it's always been caused when my husband's around, when he's not around, it's not gonna be so much of a problem. My husband and I got back together again, we thought we'd try again which was a great mistake...all the old stresses and pressures were still there.'

**Extract 59 - patient no.12 (female)**

'I used to scare him because he just had no power or anything over me when I was drinking... I think I have been the one that's kept the family going...with my mother and it was always "... will cope". I looked as though I was coping, rushing around like a maniac and doing this and that and the other.'

**Extract 60 - patient no.31 (female)**

'...he was a compulsive gambler...he used to beat me up. About three years ago, I started drinking more ...Something my husband would say and that would trigger me off. As he continued getting rough on me, I decided a few months ago to get help.'

The male patient no.4 is offering psychological reasons for his drinking and is locating these reasons in himself. He does

not search for external sources such as relationships for these psychological states. This may agree with the feminist perspective on gender as this patient is blaming himself for his drinking, not his relationships, but he is also reflecting the medico-psychological explanations for alcoholism, predominant in the 'Treatment Programme', and shows insight into his problem and ability for self-analysis.

Patient no.18, as the previous male patient, does not blame his relationships; he does not link it to marital problems. Instead, he talks about his drinking habits without implicating anyone else, and also mentions a dramatic event such as his mother's death to which he attributes his escalation to heavier drinking. This too seems in agreement with the feminist position, but he is also implying that his drinking escalated to heavier drinking as he did not seek help and when his mother died. He is, thus providing justification for his heavy drinking and displaying himself as a morally adequate individual.

Patient no.32 is describing his drinking experiences, associating them to life in the Air Force. He mentions his marriage without relating it to his drinking. He then offers social and psychological reasons for drinking which are acceptable reasons in the context of the 'Treatment Programme'. He too emerges as a morally adequate individual, as he offers legitimate reasons for his drinking.



Gender is invoked in extract 56, when patient no.1 talks about drinking and getting drunk as a male activity as he says that most young 'lads' do. This patient is not talking about relationships in relation to his drinking, but, following Schegloff, he is invoking gender. This can be interpreted as a display of moral adequacy.

In contrast, the female patient no.2 is referring to her marital relationship. She is assuming a passive role and shows that most of the talk is done by her husband, thus emphasising her submissiveness. Following Zimmerman and West (1975), this could be interpreted as an example of power structure and male dominance. On the other hand, gender seems to be invoked (Schegloff, 1991) to show the husband's part in encouraging her to drink, thus highlighting her moral adequacy. Following Schegloff, patient no.2 is therefore invoking the husband's male role in inviting and encouraging her to drink, as well as her female submissive role in the organisation of her talk. However, as I have emphasised patients' skills in displaying their moral adequacy, this patient emerges as 'morally adequate', thus, not responsible for her drinking, when she invokes the male and female roles.

Following the feminist perspective, patient no.3 interprets her drink problem in terms of her relationship with her husband. She states that her drink problem is caused when the husband is around. She does also mention stresses and pressures which are acceptable reasons for drinking in the

context of the 'treatment programme'. She too emerges as 'morally adequate', not responsible for her drinking.

Patient no.12 first interprets her drinking in relation to her mother, the family and her husband, i.e. in terms of relationships. Following Zimmerman and West, one can also interpret gender here in terms of power structure. This patient is stating that when she drank, her husband had then no power over her, thus neutralising the male dominance and redressing the balance. She also shows insight in her relationships with her family and husband, thus, indicating that she has learned from the Treatment Programme to look into her behaviour and to analyse her feelings. She is invoking gender and by doing so she appears to be 'morally adequate'.

Patient no.31 describes her problem drinking in terms of her marital relationship, more specifically in terms of her husband's violence. She now feels independent and self-confident and capable of 'standing up to him', redressing the balance of power. As in previous extracts, this reconstruction of drinking experiences in the context of the marital relationship can be interpreted as a display of moral adequacy.

Female patients, in this study, showed a tendency to emphasise their husbands' part in encouraging them to drink, thus reflecting male dominance drinking behaviour and at the same time displaying their moral adequacy. Male patients too

tended to invoke gender, particularly when reconstructing their adolescent drinking experiences, as we have seen in extract 56 and this was discussed in chapter four ('The narrative'). There was a tendency in male patients to associate drinking with young males' behaviour in general, with a common expression 'as most young lads do'. Here gender is invoked, again for the purpose of displaying moral adequacy, describing drinking as a 'normal' activity.

In conclusion, the feminist perspective and arguments on gender in CA may offer explanations for some male and female patients' organisation of their talk. In terms of the feminist theories, when a female plans to return to her husband, she expresses her increased self-confidence and ability to stand up to him hence attempting to redress the balance of power and to eliminate the inequality which Gilligan (1988) talks about in relation to women's images of relationships. Feminist theories, however, fail to recognise people's or women's skills in describing themselves in a particular way for accomplishing their moral adequacy.

However, my own position is closer to that of Schegloff and Sacks. Gender, when invoked by males and females, in this study, is used skilfully for the purpose of display of moral adequacy, and is made relevant to the participants. When females talk about their marital relationship, their husbands' violence (patient nos. 2 & 31), in relation to their drink problem, they are offering legitimate reasons for their heavy

drinking, and emerge as morally adequate individuals. Again, when males invoke gender, they usually refer to drinking as a 'normal' male activity, in the beginning of their account, and thus appear to be 'morally adequate'. Therefore, when gender is invoked in patients' talk, it is constructed to accomplish 'moral adequacy'. In the next chapter, I shall examine patients' ambiguous explanations of the nature of alcoholism.

### PART III. EXPLORING FOR POSSIBLE EXPLANATIONS OF THE FINDINGS

#### Chapter Nine: Ambiguity between 'medical' and 'moral' versions of alcoholism in Western cultures.

In the literature review in Part I.b, it can be seen that there is a certain ambiguity between 'medical' and 'moral' versions of alcoholism. Attempts are made in this section to find some explanations for the way that patients' and professionals' 'talk' presents ambiguous conceptualisations of alcoholism by examining cultural concepts particularly in the West. I shall therefore try to provide answers to the 'why' question concerning the cultural resources implicit in participants' moves between 'medical' and 'moral' explanations of alcoholism in this study.

I am not suggesting that this is an unusual phenomenon in the social organisation of talk. It is treated as a normal aspect of accounts of life experiences. As I have mentioned in chapter four, Whyte (1980) has suggested that ambivalence is a fairly common condition of people. I am, however, attempting to explain why patients' and professionals' formulations of alcoholism show ambiguity.

This ambiguity appears in the quantitative literature on alcoholism including the modern medical discourse on alcoholism, the teachings of Alcoholics Anonymous and in statements made in the media. As discussed in Part I.b, Jellinek (1960) presented a classification of different types

of alcoholism, ranging from physical addiction to psychological addiction, and, he and others such as Mark Keller (1972) emphasised the concepts of 'loss of control' and 'compulsion to drink'. Subsequently, these concepts have appeared in the World Health Organisation's definitions of alcohol and drug dependence. Jellinek reformulated the disease concept of alcoholism which had originated at the end of the 18th century. This formulation was by no means clear as Jellinek himself found it difficult to define 'disease'. After exploring the lack of definition of disease in medical dictionaries and handbooks, he concluded that it was what the medical profession recognised as such.

Alcoholics Anonymous has redefined this disease model more specifically as 'allergy to alcohol'. AA, however, conveys ambiguous notions, by this definition. The ambivalence arises by its claim that alcoholism is an inherent medical problem, thus removing responsibility from the individual, and at the same time, emphasising the alcoholic's need to 'repent'.

Ambivalence can also be found in debates around alcoholism explained as a single or multi-dimensional phenomenon. It was implied in Jellinek's writings that alcoholism was a unitary phenomenon. Quantitative sociological work (Mulford and Miller, 1964; Sargent, 1968; Room, 1972), however, by the late 1960s, was questioning and criticising this disease concept formulated by Jellinek, and debating whether alcoholism constitutes a disease in its own right. Sargent (1968)

pointed out that to view alcoholism as a single entity, as implied in the disease concept, was misleading, and that there could be no set of symptoms and signs of a single disease type.

The notion of 'problem drinking' as a better term than alcoholism emerged in the literature (Cahalan, 1970). In the same period, public controversy focused on the issue of whether alcoholics could ever return to controlled drinking.

In addition, the disease concept implies that the disease 'alcoholism' occurs by the will of the affected individual. The notion of *involuntariness* of alcoholism was the main issue in deciding whether the alcoholic should be punished or treated (Room, 1972). Thus, the disease model has not removed moral responsibility from the alcoholic for his/her disease.

Room suggests that the disease model presented a better deal for the alcoholic (Room, 1972). Surveys by public opinion polls carried out by sociologists highlighted the ambiguity of the disease concept. They indicated that whilst alcoholism was widely defined as an illness, a considerable portion of this public acceptance seemed to be little more than 'lip service' (Mulford and Miller, 1964; Haberman and Sheinberg, 1969).

In the patient sample, in this study, data analysis in chapter six, showed that the majority of patients defined their

drinking as an illness or disease (N=36), and 34 described it as an illness as well as personal responsibility. Patients also reported experiencing loss of control (N=35). Equally, most patients stated that they drank alcohol to cope with stress (N=35), and 24 patients also gave anxiety as a reason for drinking and 25 mentioned lack of confidence as a reason.

The following extract from an interview with a study patient illustrates the ambiguity of patients' versions of alcoholism:

**Extract 61 - patient no.5 (male)**

'I'm an alcoholic, and I have come to realise that I am an incurable alcoholic. I now consider it an illness or a disease, not one that's hereditary but one that's brought on by self motivation basically, in selfishness and fear. Five weeks ago I took a drink, and it was because of the domestic situation with my ex-wife and the family. I could not cope with all the stresses, and the evil of alcohol took over from me...The drinking started in North Devon. I had an argument and I was evicted from the family house in North Devon at my ex-wife's request. At this stage, I know I wasn't completely and utterly responsible for my body and my mind, I can hardly remember the journey back to London.'

This patient starts with an acceptance of his alcoholism as an illness and as being 'incurable' . But this patient also talks about his motivation, his inability to cope with stress followed by the situation with his ex-wife. His acceptance of the disease concept seems to be rather insufficient as he searches for social and psychological reasons for his drinking.

He is expressing ambivalent statements regarding his responsibility, blaming himself and yet stating that he has not always been completely responsible for his 'body' and



'mind' as his drinking progresses. This is explained in the context of a 'blackout', in medical terms, which he has experienced, whereby he is unable to remember travelling back to London.

The next patient (female) describes her drinking also with ambiguous notions:

**Extract 62 - patient no.10 (female)**

'I was drinking for extra courage to do something if I got annoyed with somebody. It got to an addiction, but not really an addiction that people think. I made the addiction. I would call it a disease because although you mess about with alcohol, I've come to know that it's a drug and it's a very powerful drug, and you think you're winning, although you're drinking defiantly, it gets a grip of you in the end. It's up to me to put it right, in as much as I can do it at home, but I get very lonely at night.'

This patient expresses confusing notions about her drinking. She defines it as an addiction, a disease but does not seem to be certain about it, and, in the end, she states that it is up to her to help herself. Patients often express their need to treat themselves, to help themselves, and search for reasons located within themselves, i.e. in psychological terms, and in their relationships. This reflects the cultural emphasis on the thinking, feeling patient. Silverman and Bloor (1989) have described patient-centred medicine, preoccupied with patients' subjectivity, as part of a wider cultural movement in which truth or authenticity is associated with 'inner experience'. The medical query 'How do you feel?' has become 'the central concern of our age'.

As Armstrong suggests (1983), there has been a shift in location of the medical problem. This shift was from a concept of the body as an objective and passive entity, to a view that was subjective, derived from new ways of medical examination focusing on the realms of the social.

For modern medicine, the whole person is thus a multi-dimensional rather than unitary being, and the medical gaze extended into the community giving rise to epidemiological surveys, hence the emergence of the 'community gaze'. A medicine of the social emerged. GPs' preventive role was stressed, including the provision of advice on improving conditions of life.

Armstrong pointed out the influence of psychology in the new medical discourse. The medical gaze had shifted from body to mind which became medicalised. He further suggests that sociology and psychology have helped psychiatry in extending the medical gaze; thus, basic concepts such as *stress* and *coping* became<sup>part</sup> of medical and psychiatric discourse <sup>1</sup>.

The medical sociology literature indicates that medical reforms towards a patient-centred medicine, and a social rather than biomedical perspective inspired by Balint (1964), Byrne and Long (1976) and Mishler (1984) are already part of current medical practice. Silverman (1987) argues that the

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<sup>1</sup> Allan Young (1980) has suggested that discourse on stress is embedded in modern thinking on illness and disease.

centrality of patient's view can clearly be observed in paediatrics, psychiatry and chronic illness, and not easily observed in some areas such as fracture clinics. The intrusion of patient-centred medicine in a range of medical settings such as cleft-palate, diabetic, paediatric cardiology and ENT clinics is discussed by Silverman and Bloor (1989). They also point out that there are some 'sites' where the 'thinking, feeling patient' is absent and that in other kinds of conditions the patient is more likely to be constituted in terms of this new discourse.

For instance, Silverman (1981) has shown that Down's Syndrome children did not get the investigations and cardiac surgery usually performed on other children with similar cardiac problems. Parental consent for non-intervention was sought in an atypical manner, from a blunt statement on the child's clinical condition to an emphasis on the child's 'enjoyment of life' at home. Bloor (1976) observed a similar situation in a study of the assessment of children for adeno-tonsillectomy in ENT clinics. Parents found the surgeons discussing symptoms, not disposals, with the exception of one surgeon *who* would, on occasions, leave the disposal decision to the parents. This occurred when an operation was not immediately necessary.

The management of normality in the new medical discourse is discussed by Swann (1990). He argues that 'maintaining normality' is hard work. He explains that society enables its

members to pursue their business as usual, and the preconditions of achieving normality are fulfilled as everyone behaves more or less as expected. Deviance then is attributed to personal failure, to an individual handicap that should be corrected by the proper specialist. What was once the province of priests, has now become the task of policemen, teachers, doctors, psychotherapists and other *normalisers*; this also applies to the differing concepts of alcoholism from being considered as a sin before the end of the 18th century to the modern disease model.

Arney and Bergen (1984) too suggest that the new discourse of medicine invites the patient to talk about his/her experiences, and, they argue that it also incites them to speak. Encouragement of speech is as much a mechanism for power as repression of it (Foucault, 1979). In the *History of Sexuality*, Foucault has observed that there has been an institutional incitement to speak about it through explicit articulation and detail.

Arney and Bergen offer the example of alcoholism which, by the 1980s, had become a behaviour disorder characterised by psychological and physiological dependence on alcohol<sup>2</sup>. They also suggest that patient psychology has become a complementary part of total medical care, and that patient's lifestyle is blamed for his/her illness.

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<sup>2</sup> This was discussed in the literature review, in Part I, in relation to Jellinek's formulations of different forms of dependence on alcohol.

The discovery of mental and psychosomatic illness meant that doctors had to recognise the importance of the emotions, and studies on epidemiology encouraged considerations of the influence of family life and social class on morbidity. The new medicine searched for social pathology. It expects to find a reason for patient's illness by studying his/her life as a whole and the key to the restoration of his/her health. The clinical method started monitoring the social spaces between bodies and this required an incitement of the patient to speak.

Young notes that this 'humane' approach, concerned with patients' psychological and social problems, exists along with implicit forms of social control. Disease is located in the social body, and this individualised form of social control offers the potential for total surveillance.

In an editorial in the British Medical Journal, Edwards (1988), a psychiatrist well-known for his writings on the concept and treatment of alcoholism, has opened a debate by his novel medical approach suggesting the treatment of alcoholism as a problem of 'faulty lifestyle', thus drawing attention towards the individual's entire way of life.

In this 'humane' approach in modern medicine, the patient is incited to speak, to 'confess' (Foucault, 1979). He/she is also invited to self-survey. Arney and Bergen (1984) suggest that Foucault has more to offer than medical sociology with

reference to modern medical discourse. They argue that, contrary to the view of medical sociology, the person does not dissolve the activity of power as he or she begins to speak about what is important.

They stress that invoking knowledge about what is important to the person is the activity of power, and that we may have to treat this modern phenomena as a different form of play of power. They explain, in Foucauldian terms, that power is productive: the individual and the knowledge that may be gained of him belong to this production. Thus, we must cease describing the effects of power in negative terms such as 'excludes', 'masks', 'conceals'.

The following extract from the Senior Registrar's letters, is a particularly interesting one with an extended medical gaze, i.e. the community gaze centring around the person's actions, behaviour.

**Extract 63 - SR's letter no.1**

'He is a disturbed young man who has abused alcohol since the age of 14, has a history of self-injury and overdoses and who presents as a silent uncommunicative adolescent. He certainly looked better for a period off alcohol but remained a silent if approachable non-contributor in most of the sessions. at the end of the third week of the programme a sudden and rather dramatic change happened when, for the first time, he saw himself on the video screen. What is obvious to other people had not been obvious to him, that is, that what he says and feels is certainly not what he puts over in his non verbal communication. He seemed all at once to get the message that it is not what you say that counts but what you do and in the last week he was a different young man: altogether more pleasant, he got up in the mornings voluntarily, carried out his tasks without being reminded and took an active part in the remaining sessions.

It is hoped that this change in him might be one of a sudden

gaining of maturity. He certainly has acted and voiced a sense of willingness to take a responsibility for his own life and behaviour.'

The SR is describing a sudden change in this patient's behaviour which he interprets, in psychological terms, as possibly due to 'gaining of maturity'. Again, alcohol abuse does not feature as the focal point here. This patient is described as having changed his behaviour suddenly, like an awakening, from being a silent, uncommunicative person to a pleasant young man who talks and now has a voice, in the SR's terms, has 'voiced his willingness to take a responsibility'.

The incitement to speak, and turning the medical gaze by looking beyond the body into the totality of one's behaviour, and others' perceptions of one's own image is clearly the emphasis in this man's transformation. The 'gaze' is particularly vivid and powerful when the patient is described as seeing himself 'on the video screen' for the first time. This is a very skilful description of this patient's change of behaviour from being silent to becoming an active member of the group. It is told in such a way that it emphasises both the patient's moral adequacy as well as the programme's ability to have made this happen.

The SR also states that the patient has got the message that it is not what one says that counts but what one does. Again as in the previous extract, it does not matter what one talks about as long as one talks and changes and corrects one's

behaviour. The emphasis is on change of behaviour.

This is very similar to the Unit's Director's response who also used the word 'message', when I showed him my chapter on the 'narrative', in the initial stages of the analysis. He seemed very pleased when he read the chapter. His response was: *'They got the message. They're looking at their behaviour, their relationships, and are learning to analyse their feelings. This is indeed excellent.'* Rather than treat this as participant-validation of my findings, we can treat it as further data (Bloor, 1978) which highlights the holistic approach in medicine and psychiatry.

Bloor's discussion of the 'holistic' view fits well with Armstrong's (1983) emphasis on the emergence of the 'patient's view' in English medical education. Methods of communication became a focal concern for the issue of non-compliance with treatment. Armstrong points out that in 'nosographic' medicine concerned mainly with diagnosing and classifying diseases, normality was not an ambiguous concept. However, with the rise of 'idiographic' medicine, the emphasis now was on the 'whole person' approach and in paediatrics, on growth and development rather than pathology.

Armstrong argues that idiographic medicine, in shifting the panoptic gaze (Foucault, 1979) from the group to the individual, offers a potential of total surveillance. Users became self-regulators. The medical gaze which had, over a



century, analysed the microscopic detail of the individual body, began, in the 20th century, to move to the undifferentiated space between bodies and there proceeded to forge a new political anatomy.

Armstrong (1983) suggests that, whilst the clinical gaze dichotomised in terms of the normal and pathological, the tactics of the survey uncovered continuity and focused on the borderline cases, between normality and abnormality. This can be observed in studies on alcoholism. The need for identification and classification of different types within alcoholism, and for differentiation of normal and abnormal drinking became a recognised need (Kessel and Walton, 1965).

Kessel and Walton argued that to classify a particular drinker may not be easy, yet it is essential if he is to be helped. They further state that clinicians cannot proceed until they know whether the person is a social drinker, an excessive drinker, an excessive drinker with problems, an alcoholic, or has reached the further stage of chronic alcoholism.

As discussed earlier, the 'humane' approach in medicine has introduced a form of total surveillance, blaming the individual's lifestyle, i.e. the totality of his behaviour. Thus, the debate in recent medical alcoholism literature has focused on alcoholism as a behavioural problem and Edwards (1988), has suggested that excessive drinking ought to be conceived as dietary indiscretion or a fault in lifestyle than

a disease or neurosis. He has stated that when treating the milder manifestations of excessive drinking, what is needed is common-sense, destigmatisation and demystification. For the treatment of a high degree of dependence, he argued that the debate is open as to what treatment works for this group. Edwards has therefore offered a way of resolving the current tension between the disease concept of alcoholism, the predominant concept from the end of the 18th century through to the 1960s (as discussed in the literature review), and psychology's behavioural explanations.

A recent attempt to replace the disease concept of alcoholism was made by two psychologists (Heather and Robertson, 1985). They claimed that the 'problem drinking' concept, defined by them as faulty learning processes, represented a shift from a 'pre-scientific' to a 'scientific' paradigm. 'Pre-scientific' referred to the disease concept of alcoholism.

Dennis Gorman (1989), a sociologist at the University of Essex, has challenged this psychological explanation by Heather and Robertson. Gorman argues that the problem drinking concept is no more scientific than the disease concept as it is based on built-in assumptions, thus it cannot be considered as a change in paradigm. Rather than in Kuhnian terms (1970), whereby one tradition of normal science replaces or supersedes another through a form of revolution within a science, Gorman argues that this new 'problem drinking' concept presents a perspective that focuses on the conflict

between professions. The professions in this case are medicine and psychology competing for dominance in a particular field of knowledge.

Alongside these recent arguments about the scientific status of problem drinking, a multi-dimensional, multi-factorial approach co-existed. Chris Cook (1990), lecturer in Psychiatry at University College and Middlesex School of Medicine, argues that social, psychological, moral and other models for alcoholism, when viewed in isolation, prove to be inadequate.

He then suggests that in 'reality' a much more complex model adequately describes alcoholism. He puts forward the following definition which represents an all-inclusive, rather vague, approach consistent with the 'whole person' approach: *'Social, psychological and physical factors each contribute, to differing degrees in different individuals, to produce the heterogeneous condition which we refer to as "alcoholism".'* (October 26, 4).

He clearly expresses an ambiguous approach and ends the article by the following statement: *'Prevention and treatment both require a healthy combination of responsibility placed back upon the individual, combined with sympathy for the plight in which he unwillingly finds himself.'* He seems to accept that no medical treatment can be offered, hence the individual needs to treat himself.

In the 1940s and 1950s, many infectious diseases were acknowledged as having 'multiple causes', and 'multiple factors' were particularly recognised in understanding chronic illness (Armstrong, 1983). A sociologist (Chafetz, 1966) suggested that alcoholism is produced by so many factors that one may conclude that there is no such thing as an alcoholic.

In relation to alcohol problems in General Practice, Strong (1980) refers to doctors' reluctance to deal with alcoholics; one of the reasons lies in medicine's inability to offer any treatment, and also relapse is common and the success rate is estimated by the medical profession as being low. Thus, the Senior Registrar's 'discharge letters' addressed to patients' GPs, in this study, emphasise patients' moral adequacy and motivation to maintain sobriety. They also indicate the 'whole person' approach.

As we have seen in Chapter Six, in the tabulations of categories, all professionals tend to use the 'whole person' approach, rather than focus on the drink problem of the patient. The examples given below will include extracts from only Senior Registrar's letters, as they constitute the majority of professionals' letters.

Of the 80 letters written by the SR, included in this study, four were found to deviate to some extent from this type of letter. The difference was towards the end of the letter in the description of patients' involvement in the 'treatment

programme'. These cases will be discussed later in this chapter.

The following extracts from the SR's letters (N=80) highlight the shift towards the multi-dimensional and holistic approach to the treatment of alcoholism, presented as a complex problem with one's drinking behaviour and as the result of psychological problems and difficulties in relationships.

**Extract 64 - SR's letter no.7 (re: patient no.40)**

'His wife is fed up with his drinking...She had gone off to Somerset with her father and taken the three children. However, she later visited here and brought the children while he was on the programme.

... made good use of his time on the programme, and it was quite impressive to see how much he improved in ways of dealing with things which made him angry, as his pattern in the past had been to drink on such occasions and then try to deal with or ignore the issue later. These freed him from the anxieties of choice and helped him to focus on whatever needed to be dealt with or talked about.

He has been a popular and involved member of the group and our hope is that he would be able to maintain his improvement and progress.'

The Senior Registrar is talking about this patient's wife and the marital relationship. He is explaining the patient's drinking in psychological terms, as a way of dealing with his anger and childhood experiences. This is consistent with the holistic approach and the psychological orientation in medical discourse. The holistic approach is indeed predominant in all the SR's letters, sometimes in a formal history-taking format, mentioned earlier in Chapter Five.

The patient's moral adequacy is skilfully emphasised when he is described as being popular and an involved member of the

group. We hear that the patient was able to talk. This encouragement to talk is again part of the new medical discourse, as discussed earlier.

The next three extracts also illustrate the holistic approach and psychological/analytical explanations, and contain statements about the patient gaining insight whilst on the programme.

**Extract 65 - SR's letter no.2**

'His childhood was unhappy and there were a lot of arguments and violence. ... was often in the position of trying to keep the peace. He was a very nervous child... ... was a very active member of the treatment programme, and was ready to look at some of the problems which in the past he has preferred to suppress. He has been in the habit of keeping the peace and then, when he can no longer do so, using alcohol to dampen down his natural reactions. He gained in insight, in the course of the programme, and was able to talk more easily about his problems. He is a likeable person, sensitive and intelligent and has high ideals. He is well motivated to stay off alcohol and will continue to look at any unresolved pains of his earlier life in the hope of avoiding a relapse to the initial comfort which alcohol offers.'

This patient is described as a nervous person who was suppressing his reactions and problems. However, we are told that he now has insight and can talk about his problems and 'look' at them; this reflects the community gaze (Armstrong, 1983), looking inwards at feelings and relationships. He is described as a morally adequate individual, as a likeable, intelligent person who is also motivated to stay abstinent. This again is a skilful description of the patient aimed at persuading the General Practitioner to help him on discharge from the hospital. The next extract is another example where

the focus is not on alcohol but on patient's childhood experiences and relationships.

**Extract 66 - SR's letter no.53**

'...her father was at first in the Irish Army and later was a salesman. He died in a Road Traffic Accident when he was 41. Her mother was a publican. She is now 66 and lives in Ireland. Mrs ... is not on very good terms with her and still resents several childhood experiences... She and her husband separated in 1979... Mrs ... and ... have now parted, but remain in close contact.

She has had binges of excessive drinking, especially when relationships with her boyfriends are not going well. She finds she can express herself when drunk in a way which her shyness prevents when abstinent.

She was an active member of the group. As time went on, she gained in insight and was ready to question her reactions in a deeper way. She was popular and helpful to others in the group, and has a good sense of humour. She has an extremely complicated set of relationships, many of which are very confusing. She has a lively personality and presents herself in an attractive way.'

It is interesting how the emphasis in this extract is on the patient's confusing relationships. The focus is clearly not on alcohol; it is on her behaviour, her reactions and she now has insight and can analyse her reactions in a deeper way. The whole person is discussed and the drink problem has been reconstructed as a behavioural problem. The patient again is described as a morally adequate person with a lively personality and who is popular and helpful to others.

The patient's awareness of her difficulties is also stressed. She is said to be aware that she needs to resolve her difficulties without alcohol. Thus, the drink problem is presented as a secondary problem. The next extract also emphasises the patient's relationship difficulties and

stresses his moral adequacy.

**Extract 67 - SR's letter no.5 (re: patient no.20)**

'At first he found the alcohol rehabilitation programme very difficult, but he certainly gained in confidence and insight during the course of his time here. He was well accepted by other members of the group and as time went on he gained in insight and was able to express much better how he felt about things. In many ways he has been the youngest child at home and has had a good deal of attention from his parents. He is looking quite seriously at other ways of handling his difficulties than through alcohol, especially as he intends to continue to live at home. He is intelligent and good humoured and was perceptive, both of his own difficulties and of difficulties of other people. He is intending to stay off alcohol altogether and we hope he will be successful in this.'

Again the patient is described as morally adequate, as intelligent, perceptive, insightful. This letter stresses the patient's difficulties without describing what these are. The emphasis is on patient's insight into the difficulties and his ability to express himself and talk about things.

Therefore what seems important to the SR is the patient's ability to express how he feels about 'things', indicating that it does not matter what he talks about as long as he can express his feelings. The focus is on the whole person with his difficulties rather than the drink problem, as we have seen in previous extracts<sup>3</sup>.

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<sup>3</sup> As mentioned earlier, four letters written by the SR deviate slightly from the usual type of SR's letters. These letters follow the usual accounts of dramatic events, of difficulties in relationships, psychological explanations offered for heavy drinking and displays of patients' moral adequacy. The only deviation refers to how patients participated in the 'treatment programme'.



As illustrated in the extracts above, patients are described as being able to talk about their problems, their relationships and feelings in the 'treatment programme'. Some patients are described as being reluctant to talk about their problems and their feelings in the beginning of the programme, but learn to talk by the end of the course. Patients are also routinely given an out-patient appointment on discharge which is an accepted policy of the Unit.

In the four deviant letters, however, patients are described as unable or unwilling to participate by talking about themselves. What seems interesting here is that as the programme has failed to reach its objective in these patients, i.e. failed to incite them to talk, no out-patient appointment is given, thus no routine follow-up is offered to these patients.

These four letters illustrate, *first*, that the SR is not describing all patients in the same way, supporting the notion that we are not 'cultural dopes'. In some ways, this accounts for his own moral adequacy as it shows that he is not simply praising all patients in order to persuade GPs to help them. Nevertheless he is describing all patients, including these four, as morally adequate individuals to obtain a positive response in GPs to help patients. *Second*, having failed to enable these patients to talk about their feelings, to incite them to talk, the SR is unwilling to follow them up in the out-patient clinic, thus accepting the Unit's failure to reach

its objective in these patients.

In conclusion, patients and professionals in this study present alcoholism with ambivalent and ambiguous statements. We have seen the skills involved in patients' accounts through the MCD analysis when talking about their life experiences. They emerge, as morally adequate individuals and attempt to redress the balance between failure to control drinking viewed as an illness, and moral responsibility for it, thus restoring the moral order.

The ambiguity therefore between 'medical' and 'moral' versions of alcoholism, i.e. the disease model assigning a 'sick' role to the alcoholic and the moral responsibility of the alcoholic for his/her illness, is also reflected in patients' and alcohol professionals' versions of alcoholism. This ambiguity is by no means an unusual phenomenon, as I have commented on earlier; it is part of reconstructed life experiences.

Nevertheless, patients' and professionals' ambiguous explanations of alcoholism, are embedded in current views of alcoholism as a moral matter, in most Western cultures (Alasuutari, 1990). Furthermore, the emphasis on the alcoholic patient's lifestyle, relationships, emotional problems and the ability to talk about them, illustrated in the data analysis, in this section, whilst defining the problem as an illness, is a reflection of the modern holistic

approach in medicine to chronic illness. The only orthodox treatment offered to the alcoholic is detoxification which is not expected to cure his/her alcoholism.

Thus, medical and moral versions of alcoholism continue to co-exist, whereby alcoholism is formulated as a legitimate illness, and the moral responsibility for it, and for its treatment assigned to the alcoholic patient.

The modern medical discourse on alcoholism, with its ambiguous explanations, is thus invoked clearly in patients' and professionals' discourses, in this study. Gender, however, as we have seen in the previous chapter, is invoked by some patients, and functions to display their moral adequacy. In some cases, this is done in subtle ways as in the case of patient no.2, extract 57, where the violence of the husband is not clearly described. In Part IV, I shall present the conclusions of the analysis applied to the data, in this study, the limitations and implications of this type of qualitative analysis.

PART IV. CONCLUSIONS, LIMITATIONS OF THE ANALYSIS AND ITS  
IMPLICATIONS

Chapter Ten: Conclusions drawn from the analysis, limitations  
of the analysis and its implications

In this chapter, I shall summarise the conclusions of the analysis applied to the data, in this study, examine the limitations of the analysis and consider its implications.

a) Summary of conclusions

The unstructured interview, in this study, has been treated as an occasion where meanings are produced, thus, subjects have been actively involved in the meaning-making process (Holstein and Gubrium, 1995). Following Holstein and Gubrium, study respondents have not been viewed as repositories of knowledge, unfolding the 'truth' about details of life experiences. Patients' and professionals' discourses are not treated as simply versions of events (Cuff, 1980), but skilful presentations of events emphasising the pervasiveness of moral forms (Silverman, 1985).

The analysis of unstructured interviews with 40 alcoholic patients has shown that the narrative structure of patients' accounts indicates a threefold plot structure with three identifiable levels, i.e. Past, Present and Future. These levels are distinct in most accounts, except in deviant cases (Chapter Four).

Following Saussure (1974), I have explained first, in Chapter Four, by adopting a syntagmatic approach, the logical and chronological sequence between different levels of structure in patients' accounts. I have also applied a paradigmatic approach (Lévi-Strauss, 1968) to examine the meanings produced in these levels.

We have seen how 'normality', i.e. normal activities of young people including drinking in pubs and at weekends, is emphasised in the beginning of an account. This normal life-course is, however, ruptured by dramatic life events which help to legitimise the drink problem which appears to be the inevitable consequence of these life experiences.

Patients have shown competence as respondents and skill in using a locally appropriate vocabulary of motives, acceptable in a psychologically and medically oriented treatment unit, when talking about their reasons for heavy drinking.

Patients also show their knowledgeability of harmful effects of alcohol on the body and brain, and show determination to maintain abstinence, and make plans for the future such as 'getting a job', 'finding a place to live', 'getting back with the spouse and children', thus expressing their intent to return to normality. Throughout these accounts, patients appeal to moral forms, and display their moral adequacy.

A detailed MCD analysis (Sacks, 1972) has shown, in Chapter

Five, that patients and professionals describe problem drinking, and formulate problems skilfully by engaging in 'moral talk'. Patients have shown their competence in describing their problems and life experiences in terms of membership categories and activities, commonsensically bound to categories (Sacks, 1972), and achieve an intelligible account which displays them as morally adequate individuals and legitimises their drink problem.

The MCD analysis of professionals' letters shows that professionals too appeal to moral forms and display patients as morally adequate persons, but using often a passive institutional voice, in contrast with the 'emotional' account given by patients. Both, patients' and professionals' discourses do not focus on the drink problem; instead, they emphasise the totality of the alcoholic patient's lifestyle and problems, i.e. a holistic approach.

The tabulations of MCDs, membership categories and category-bound activities, in Chapter Six, have shown that descriptions are consistent throughout patients' and professionals' talk. In addition, deviant cases have highlighted that we are not 'cultural dopes' (Garfinkel, 1967). However, it is worthwhile to note that all patients, including deviant cases, are engaged in displays of moral adequacy. Silverman (1993) has pointed out that interviews share with any account an involvement in moral realities.

Displays of moral adequacy, as discussed in Part I.3, are also relevant to the study of different groups of respondents such as parents of handicapped children (Baruch, 1981). This is also relevant in confessional, self-help groups, such as 'Alcoholics Anonymous' (Alasuutari, 1990).

After having described 'how' alcoholic patients and alcohol professionals formulate problems and accomplish their talk, I have attempted to explore some answers to the 'why' question. I have discussed, in Part III, the role of context and gender in this study. The relevance of the social context lies in patients' and professionals' use of vocabularies of motive (Mills, 1940). Patients describe their reasons for drinking mostly in medical and psychological terms, acceptable in the context of the 'treatment Programme'. Professionals too give mostly psychological reasons for patients' drinking.

Concerning the role of gender, female patients have invoked their gender skilfully in relation to their husband's violence, or to their devotion as daughters looking after their sick parents. This has helped them to emerge as morally adequate individuals.

We have also seen how ambiguity, viewed as part of reconstructed life experiences, can be found between 'medical' and 'moral' versions of alcoholism. The medical disease model of alcoholism and the responsibility for its treatment have produced ambiguous, confusing explanations in the literature.

This is also apparent in patients' and professionals' discourses in this study, as discussed in Chapter Nine.

The analysis of the data has highlighted the competence and skills of alcoholic patients and alcohol professionals in accomplishing their talk with an emphasis on moral adequacy. The ambiguity between medical and moral versions of alcoholism in the literature and in this study reflects the cultural emphasis on the 'feeling patient', and the holistic approach in modern medical discourse, particularly in relation to a chronic illness.

As we have seen in Chapter Nine, ambiguous medical explanations of alcoholism can be found in patients' and professionals' discourses in this study. This highlights Alasuutari's (1990) argument concerning cultural models and language. He states that cultural models can be seen on the level of the macrostructures of language. The structural features found in textual wholes may thus be understood as cultural products.



## **b) Limitations of the analysis**

As stated earlier in Chapter Six, there is no standard analytical approach in qualitative research. A flexible approach is desirable particularly when a researcher is on new ground. There is no known or published work around self-descriptions of alcoholic patients in a clinical setting, where patients are admitted to an intensive treatment programme. Thus, this study is an exploration into new ground.

The analysis has basically been qualitative. Some simple tabulations of MCDs and membership categories have been carried out to complement the qualitative analysis. The following points summarise the limitations of this kind of the analysis, and attempts to overcome these shortcomings.

### **i) Reproducibility/reliability:**

The reliability of the data in quantitative research is ensured by means of standardised questionnaires. However, as Pope and Mays (1995) point out in a series of papers in the British Medical Journal, there is no way that any researcher can capture the literal truth of events. They argue that, in survey research, it is difficult to ensure that replies returned have the same meanings for all respondents.

In relation to qualitative research, Mays and Pope (1995) suggest that to ensure rigour researchers should seek first, to produce a plausible and coherent explanation of the

phenomenon under scrutiny, and second, to create an account of method and data which can stand independently so that another trained researcher could reproduce the analysis of the same data in the same way and come basically to the same conclusions.

I think that my method of data analysis by means of the Membership Categorisation Device (Sacks, 1972), using transcripts of interviews with alcoholic patients and letters written by alcohol professionals, would enable another researcher to come to similar findings. Furthermore, the analysis of 'displays of moral adequacy', which is the main focus in this study is similar to other researchers' analysis such as Baruch (1981), Voysey (1975) and Cuff (1980), as discussed earlier in Chapter Three.

The deviant cases, in this study, have helped to account for other possible ways of producing narratives by alcoholic patients. This assists to increase the reliability of the analysis. Through the tabulations in Chapter Six, I have shown the consistency of themes and structural units of narratives, thus increasing reliability of the analysis.

ii) Validity:

Validity in quantitative studies centres around scales used; the question is whether they are measuring the right concept. As we have seen in Chapter Six, a method of ensuring validity in qualitative research is offered by Denzin (1970), i.e. the

triangulation method. However, by using different methodologies to increase the validity of the data, one would ignore the role of context in the production of accounts or narratives, and would assume members to be 'cultural dopes' (Garfinkel, 1967). The skilful character of social interaction would also be ignored (Silverman, 1993).

Therefore, it is important to recognize that data collected in different situations or by several methodologies produce different data. Again, in relation to respondent validation (Bloor, 1978), as discussed in Chapter Six, data collected by going back to respondents with preliminary results simply generates further data.

iii) Generalisability:

The representativeness of the sample is an important consideration in quantitative studies. But, as Pope and Mays argue, it is not a prime requirement in qualitative methodology, when the purpose is to understand the process of meanings produced in the interview situation.

My aim, in this study, was not to select a random or representative sample from a population, but rather to identify a specific group of people, i.e. alcoholic patients, who are all going through an alcohol treatment programme, in the same setting. These patients live in circumstances relevant to the focus in this study which centres around meanings, reinterpretations of life experiences produced by

alcoholic patients in a clinical setting.

iv) Minimising researcher bias in the presentation of results

In quantitative studies, tables of data showing the statistical relations between variables help to minimise researcher bias in presentation of results. However, qualitative research depends, to a large extent, on producing a convincing account (Silverman, 1989). Mays and Pope (1995) suggest that one option for presenting qualitative analyses objectively, is to combine a qualitative analysis with a quantitative summary of the results. The analytical approach remains qualitative since events, themes or categories emerging from naturally occurring settings or unstructured interviews are being counted. I have adopted this option in my analysis by counting MCDs (Sacks, 1972), membership categories and category-bound activities, thus highlighting the consistency of respondents' categories throughout the interviews as well as categories used in professionals' letters.

By this method of combining qualitative analysis with some quantification, Silverman (1981) has shown that a simple counting method was needed to contrast two sorts of interview, i.e. the format of the doctor's initial questions to parents in a paediatric cardiology clinic when the child was not handicapped, with a smaller number of cases when the child had Down's syndrome.

v) The problem of being a member of the Alcohol Treatment Unit

As mentioned in the Methodology section, despite my efforts to describe my role in the Treatment Unit, to patients at interviews, I was addressed by patients as 'doctor'. Patients therefore identified <sup>me</sup> with the Treatment staff.

On the other hand, without participating in patients' treatment, I was a member of staff and attended weekly Unit meetings regularly with the rest of the staff.

Being a member of the setting, can present a problem in studying patients in that same setting. However, as a researcher, I had to try to treat the setting as 'anthropologically strange', to avoid taking for granted my commonsense knowledge of the Treatment Programme and what it meant. I leave the reader to judge how successful I was in this attempt.

### c) Implications for theory, method and practice

I shall consider, in this section, the usefulness of this study to theory in alcoholism and individuals labelled as alcoholics, methodology in social science research and to practice. I shall also discuss the version of interview used in this study and the relevance of the findings in relation to the modern medical discourse.

In quantitative studies, theory often evolves through deduction, i.e. starting with a hypothesis or a theory, whilst in qualitative research, theory is generally derived through induction, based on the data. This study presents a shift from surveys and ethnographies to analysing cultural products by means of a structural analysis of the macrostructures of narratives. It is primarily qualitative, and its implication for social theory in alcoholism can be understood by 'appeals to moral forms' in alcoholic patients' and alcohol professionals' discourses, derived from data analysis. The analysis shows how patients' and professionals' versions of alcoholism are constituted in the production of meanings.

The concept of 'grounded theory' (Glaser and Strauss, 1967) applies here as theory is based, in this study, on respondents' own categories, vocabularies of reasons for drinking. As mentioned earlier, displays of moral adequacy constitute a focal point in my analysis and agrees with discourses reported in areas other than alcoholism such as the case of parents with handicapped children (Baruch, 1981).

The usefulness of this study to methods in social science research, lies in its qualitative methodology as an alternative to quantitative methods which, to date, have been predominant in research in the Health Service, particularly in alcoholism.

I have been involved in quantitative studies measuring treatment outcome in alcoholism, for more than ten years, in the British National Health Service. To some extent, the methodology in this study can be complementary to the methodology used in the quantitative studies which I have carried out. Although it does not state whether age, social class or social complications of drinking are correlated with treatment outcome in alcoholic patients, it does, however, provide a better understanding of how and why certain complications or life events are reported by respondents.

Pope and Mays (1995) suggest that one of the ways in which qualitative research can complement quantitative work is by exploring complex phenomena or areas not amenable to quantitative research. I have explored in this study, for instance, the way that patients describe their drinking and the emergence of their drinking problem, and also provide explanations of alcoholism. These would not be possible by fixed-choice or open-ended questions through quantitative methodology, as an unstructured 'talk' is more appropriate for this type of inquiry.

Pope and Mays emphasise the need for qualitative research in studies in the Health Service, and suggest that qualitative methods can enrich our knowledge of health and health care. They point out that we need a range of methods at our fingertips if we are to understand the complexities of modern health care. They suggest that qualitative research is especially useful in times of reform or policy change. Likewise, Keen and Packwood (1995) argue that qualitative methods can be used to examine the consequences of changes in resource allocation and management practices at the micro level within NHS hospitals.

As the interview is treated here as a topic for study, the practical implications apply to a better understanding of meanings produced by alcoholic patients experiencing a treatment programme in a clinical setting. This may be informative and helpful in effective decision-making for professionals in the Treatment Programme designed for alcoholic patients.

By means of a qualitative analysis of the data, this study produces a better understanding of how and why alcoholic patients describe their problems in terms of certain events by appeals to the moral order. As mentioned earlier, this was not possible in quantitative studies measuring treatment outcome in alcoholic patients, which I have been involved in. For instance, no distinction was possible, in those studies, between patients in their enumeration of complications of



drinking, and subsequently complications may have had different meanings to each patient.

My version of the interview differs from standard interviewing which is appropriate for generating well-defined behavioural or demographic data. My approach is similar to that of Holstein and Gubrium (1995) which describes the interview as 'active' and the interviewer's questions as framing devices which respondents might follow in characterising experience. Holstein and Gubrium describe the active interview as a meaning-making occasion, loosely directed and constrained by the interviewer's topical agenda and objectives. Although I have conducted unstructured interviews without asking questions during the interview, nonetheless, my approach by the initiating phrase 'tell me about your drinking' unavoidably would influence the kind of responses being generated. My version, thus, offers a distinctive way of construing the interview, and is treated as an 'active interview' which is described by Holstein and Gubrium as a theoretical stance toward data collection and analysis.

I have treated the interview as an interactional event, as a means of producing meanings, and recognised its reflexive character. Thus the interviewer is regarded as being implicated in creating meanings. Holstein and Gubrium argue that active interviewing brings meaning and its construction to the foreground. This active view points to a greater range of interpretive activities of both parties. They suggest that

an active approach might be most appropriate in those instances when the researcher is interested in subjective interpretations, or more generally in the process of interpretation. My interest in this study has focused on the process of the production of meanings and linkages by alcoholic patients in a clinical setting.

Concerning data analysis in interpretive practice, Holstein and Gubrium suggest that it is less 'scientific' and somewhat more 'artful' than conventional interview data analysis. They point out, however, that this does not mean that it is any less rigorous as it requires attention and sensitivity to both process and substance, and, as mentioned in Part IV, respondents' talk is not viewed as a collection of reality reports, or social facts delivered from a fixed repository.

Holstein and Gubrium explain that writing and presenting findings from interview data is itself an analytically active enterprise. They suggest that rather than simply letting the data 'speak for themselves', the active analyst empirically documents the meaning-making process. My approach, therefore, to the 'interview' is similar to that of Holstein and Gubrium, which treats the interview as an occasion where interviewer and respondent are actively involved in producing meanings, and where the interviewer points respondents to a particular topic, inviting distinctive narrative treatments.

I would like to consider the substantive findings in this study relating to the modern medical discourse. As we have seen in Chapter Nine, the medical model of alcoholism emphasising the 'illness' or 'disease' concept is far from being a clear definition of alcoholism. Ambiguity surrounds medical and moral versions of alcoholism. The disease model which came about as a good deal for the alcoholic and legitimised the problem, has not removed his/her responsibility for the disease. Mulford and Miller (1964) showed that public acceptance seemed to be no more than 'lip service'. Most patients, in this study, have defined their drinking in terms of an illness or disease, but they also state that it is their fault. Therefore, this ambiguity in patients' discourses, which is not considered as an uncommon phenomenon (Whyte, 1980), reflects current ambiguous cultural explanations of alcoholism where the medical model is predominant.

Also in the modern medical discourse the patient is incited to speak, to confess (Foucault, 1979). This has been emphasised in qualitative research (Silverman, 1987; Armstrong, 1983). In my own study, the analysis of professionals' letters has highlighted the emphasis on patients' ability to talk about themselves, acquired through the Treatment Programme. The holistic approach in modern medicine is also reflected in patients' and professionals' discourses, as we have seen in Chapter Nine.

These findings seem to imply that research into individuals' descriptions of their problems reflect cultural trends of its time. Further research studying reconstructions of life experiences by patients admitted for treatment of a different problem such as drug addiction may provide data for comparison with data generated in this study. It would be of interest to see if the findings in this study by means of the MCD analysis could also apply to such a sample.

## PART V. APPENDICES

In Part V, I shall include a small number of transcripts of interviews with patients, just as illustrations of whole cases, and the Senior Registrar's letters written to these patients' General Practitioner.

### a) Samples of transcripts of interviews

#### Interview transcript - patient no.12 (female)

Interviewer: Tell me about your drinking.

Patient: Well, I never liked drinking because my father was always drunk. my mother hated drinking... I was living in Puerto Rico with my husband. We would go out most evenings and I started then drinking. I never really felt that it was a problem; I was just drinking with everybody else.

We used to have people coming to the house and we used to have a dart match. They used to drink; I never felt that I needed to drink; so obviously I was drinking because I was upset.

After a lot of violence, I finally left Puerto Rico after divorcing my husband. I stayed with my mother in England; I wasn't drinking then.

I managed to go to a furnished flat where I lived for three and a half years and I started again just having an occasional drink, sometimes it was sherry, sometimes it was Martini. Then things started to get very bad.

My mother, she was very ill, she had cancer. This was giving me a lot of stress, and I got also depressed. But in between, before she got totally ill, I met ..., my second husband who had a nervous breakdown and he committed suicide. We'd only been married for two months.

So my drinking began. At first it was just wine at dinner-time and then it gradually got more. I was trying to cope with my mother and my family; they didn't really want to see my mother in the state she was in.

So I used to go and then ring up everybody and have a drink afterwards. My mother got very very ill. She died in May 1980. I was then drinking a lot more.

The best man at my second wedding, ..., became my third husband. We moved from my flat to his flat. He became

violent. We got married because we thought that would straighten everything. I couldn't cope with him. To get me cope with the day, I was drinking, and then it was really just to drink to stop all the shakes, the sweats, and everything, but I never enjoyed drinking. I hated it.

I was shocked when I heard my father was alive because I thought he was dead and I hadn't seen him for twenty eight years and my mother left him when we were all small. There was five of us, four it was then. She left him because there was never any money. Dad used to drink everything up. My brother, next to me in the family, is very violent when he drinks but I have no contact with the family at all and he's been in trouble with the police with his drink.

My father is quite ill, he's seventy four now. I've seen him drink through, he says he doesn't drink any more but I mean he doesn't drink to the volume that he did years ago and then I think he was a beer drinker.

I just reached sort of rock bottom last year when I thought physically I couldn't really carry on the way I was going because either by the drink or by accident you know I was just going to virtually you know, kill myself and possibly that was...the overdose because of all the...the depression and everything that went with the drinking you know I took the tablets thinking, well that will solve the whole problem altogether; and I made my decision on detox. I realised then that I just had to do it.

I know four years ago when I was in here, I was only home four days after my detox and my husband upset me and I immediately went on the drink. He is still in contact with me and when I told him that I was going to be detoxed, he just said: "Oh well here we go again".

He is actually rather surprised about it all. He's very pleased for me and he's calmed down. He drinks but he will have maybe a few glasses and he becomes very very aggressive...and I think probably through me, I think it made it so obvious that he couldn't really drink and he sold his car.

He has his own business, he has to drive from here to Strood, he needs his car, I mean he is aware of so much I think because of what's happened to me, but I mean a lot of it was control with ..., and he knew there was no way that he could control me and the drink I mean he...well I mean I used to scare him because he just had no power or anything over me when I was drinking.

But I mean with my father I was totally honest with him that I had a drink problem and as I say my stepmother made this big arrangement for us to meet my father two years ago, and we did, and I was very very scared but unfortunately some time last year.

It was last Easter I had been staying with friends in Somerset and was going to spend the Easter with my father and I had been drinking on the train to get my Dutch courage up as I was to meet my father...and we were in the flat and he wanted me...he was pushing me into the bedroom because I said 'I was gonna' go out and get myself a drink', and I just left.

I've not seen him since and this was a very scary situation; it's like part of my childhood is gone. I can't remember, you see, there was just this fear there but whether that was just the drink or not I don't know. But I certainly feel much stronger this time.

Well, a lot of things have come out here in this course which I thought I would never talk about, or be able to talk about and immediately if things upset me at home, I'd go for the bottle so that I don't really have to talk about it or think about it. Here we've been able to talk about things. I mean I've obviously got upset about certain things and my anger I mean scares me, you know.

I know it's something that I have to control, I have to know situations that's going to upset me and I mean like now, we're going out tomorrow and if there's an upsetting situation I obviously cannot go for the bottle. I am very apprehensive. I know I've got more support this time and also from AA (Alcoholics Anonymous) of course. They've given me phone numbers as they say: "do not pick up the drink, pick up the phone".

Four years ago when I went to AA I mean you know I heard a lot of horror stories and I thought you know 'I'm in the wrong place, why am I here?'. You know I've never been in trouble with the police. At least I know that they'd reached that rock bottom that I had reached that anyway, you know.

I think most of the group will agree with me on this, it was this shock that we got when we saw...like the ones here what they call 'wet brains'. I think that with alcohol you say well, you know I mean 'I might get cirrhosis of the liver', or you know 'I might get killed'. But I think you don't really imagine that you could just be walking around like a zombie you know, and when they actually said that during one of my blackouts I could have come through like a 'wet brain' because that's what actually happens apparently.

I mean that did terrify me you know, but what I found also here is I mean obviously I don't trust anyone I think because of what has happened to me and I did have a bad time in the beginning of the group, because I couldn't really actually join in you know. I felt I was just somebody on my own I mean I still feel that very much I mean it's not because I'm never on my own.

I think I have been one that's kept the family going... with my mother and it was always "... will cope". I looked as

though I was coping, rushing around like a maniac and doing this that and the other. There was nothing for me at the end except depression and just feeling so lost and sad, so I used to think 'well I'll have a drink'.

There was no one there that I could really open up to. They were either too busy or they were coming home from work. There was always these excuses you know and then as it was expected of me to enjoy it. They didn't think I'm sure that whether they did it deliberately or whether it was there, I don't know. But they didn't realise the hurt that I was going through.

I need to just sit down and not panic. A lot of it is really sheer panic, fear. I have this, this crazy thing about supermarkets you know, I mean even last Saturday after sort of being on the programme for three weeks I actually got halfway around the supermarket and realised that I hadn't panicked, you see, I was normally panicking even before I got in the door.

In the group, I was shut up with myself, the first week of the course was a gradual thing for all of us to get to know each other. So really it's only at the end of the second week that you really are communicating, maybe really you need six weeks.

As a group we've been told that we have been a very good group and we were all chuffed when each Monday Dr.. would come in and she'd say: 'Oh you're all back, eight of you you're all back'. It was so hard to come back sometimes at the end of a weekend but it was also hard to leave on a Friday.

In my second week, I was so upset and I remember I had to go over to the pharmacy to get my tablets and ... (junior registrar) walked in and was having a 'go' at me but he wasn't I mean he was doing his job and he said to me: 'Will you be alright this weekend?'. I said: 'Of course I will be, I'll cope'. He said: 'You know you can come back anytime'. That was reassuring to know that I didn't have to go on Friday, that I didn't have to go if I didn't feel like it. I cannot believe that I just had an emotional problem, that's what Dr.. said.

I knew I had a very serious problem then, that was four years ago. At least this time my drink problem has been sorted out and some of the emotional problems that I had to deal with, I actually created. I've never had the feeling of enjoyment about drinking, so it was an illness within an illness because I was sick all the time you know. It was an absolute nightmare.

As far as I'm concerned I tell myself I'm never going to have a drink again, because to me I don't really have a choice, because I know that if I drink I will be dead. I am not very strong in myself. If I start to drink, I know that it won't



be just the one drink, it would be suicidal. I regard myself as two totally different people, a sober ... and a drunk ....

Interview transcript - patient no.5 (male)

**Interviewer:** Tell me about your drinking.

**Patient:** It all started at weekends, you know, I used to go out with the lads. I was drinking only beer. I didn't think then that I was an alcoholic. I know now; I'm an alcoholic, and I have come to realise that I am an incurable alcoholic. I now consider it an illness or a disease, not one that's hereditary but one that's brought on by self motivation basically, in selfishness and fear.

Five weeks ago I took a drink, and it was because of the domestic situation with my ex-wife and the family. I could not cope with all the stresses, and the evil of alcohol took over from me. It's a situation where two married couple do not understand that there's something else that's ill, i.e. myself that's an alcoholic, it's a non-workable situation.

I blame myself for going into that situation but at the time when I did go into it 15 months ago, I didn't realise how ill I was, how sick alcohol had made me and what happened was that I had lots of drink, and I only remember parts of it, because I was in semi-oblivion, semi-conscious. I was like this for maybe 10 days, I don't know, roughly 10 days.

The drinking started in North Devon. I had an argument and I was evicted from the family house in North Devon at my ex-wife's request.

At this stage, I know I wasn't completely and utterly responsible for my body and my mind, I can hardly remember the journey back to London. I woke up one morning in my flat in London not knowing how I got there. I knew I was there because it was my furniture, my surroundings, and around me there was a bucket of vomit, and no sign of food, just bottles, alcohol generally, cans of beer.

Several days after that I detoxed myself basically, I was ill for several days. I was sick all the time, then I blew up like a balloon, and did my liver some damage. I had malfunction, that's when I saw my GP and he prescribed me a drug. I attended the course in ... in September/October. I thought I could cope with my own drinking and I couldn't.

That slip in January made me realise that I needed some help. I consider that I had all the benefits that were given me in the treatment here, and that I had to do something for myself. I could help myself, you know.

The context of my drinking goes back to my childhood. It's still hard to believe now, my father was a heavy drinker. I believe he was an alcoholic now, but at that age group they're completely different drinkers. They had a lot more pain to suffer than we did, in the First World War.

He was in constant pain, physical and spiritually as well, and I could remember him as just being a person there. I never admired him and I couldn't really understand why my mother used to make sure none of us were around when he got back from work. He was never there.

I was one of nine children, we weren't a close family. My mother ran the family and protected my father, you know, perhaps he drank for his health, and when his health went he drank and he became violent, threw dinners at walls.

I kept myself clear of drinks except for beer up until the age of 23, 24. I had some Martinis once when I was 21, and I was violently ill then, that didn't put me off the drinking, it should have done when I come to think of it. When I was 34, I got a posting overseas in the Persian Gulf, there was no draught beer in those days, it was all canned beer and spirits.

Beer was very expensive, we tended to drink pink gins and whiskies and things like that, and drink was our social life; it was parties and that's all we had to do. There were no cinemas, no theatre and it was too hot to play sports.

I must have started to drink heavily on a regular basis because I was drinking everyday of the week as part of my job. We should talk to the ship's captains and officers and we ended up drinking.

When I came back to London, I tried to live the same life as in the Persian Gulf. Again, it was the signs that I was going onto the path of alcoholism. I had two jobs and in both I was asked to live.

Then I knew a person who was in the Police Force, he said: "Why don't you come into the Police Force?". Again, I tried the Police and it became the continuation of my old life.

After hours, we always knew a pub that was open and we had a few pints to relax before going home to wife and family, and this is what happened to me for 18 months and then this became a 9 to 10pm at night drinking spree. The Police Force terminated when I was injured. I had a couple of back operations and I was discharged as being medically unfit.

The lump sum I got when into an extension. I had good times, plenty of drinking, wandering around the streets, having drinks with my friends, and this became a habitual thing. I got a couple of small jobs and again I went my usual way.

Six years ago, my wife said: "I'm divorcing you", and she did. She divorced me and what she wrote, what the solicitor wrote about the circumstances of the divorce was such that I was horrified. I couldn't believe it. Is this person you married, you know, to love and cherish and she wrote all that rubbish about me, and yet she did and I didn't oppose the

divorce.

For years, I worked hard and pulled myself together, found myself a maisonette. I worked hard, rather a stressful job. I had a slight heart attack, hence I ended up in ..., doing the course.

I found the course was very good. It kept me dry; it identified me with other people to a certain degree. It also pointed out the seriousness of my illness, and of course my mental and physical illness.

It didn't sink in completely because as I said I've had those two slips. The course, I found was very good, but when I left it, going back to the domestic situation, I couldn't cope with the situation. There was no follow-up. Maybe it's my fault.

I'm here today, and I haven't had a drink since my last bout. I don't want to have a drink. I find that a lot of people are worse off than I am, and that's the story so far.

**Interviewer:** Is there anything else about your drinking?

**Patient:** To try and put my alcoholism into place, I don't believe it's hereditary, although my father, as I said, might have been an alcoholic. I have other binge situations, eating cakes, chocolate; I've been drawn to, at the present, peaches. I wonder if this stems from my childhood where I was one of a large family, although I was no more deprived than others, because I've always been very proud of my fitness.

I went to a Grammar school and I always felt under-deprived of all the things I had to have, sports equipment, new blazers each year, I've never had them. Shoes were handed down from my older brother or my father, and it was a hard life. It was a hard life for my mother as well, to keep us going.

This is probably the resentment that I've had in me of being an outsider. I probably was an extrovert and always wanting to be the ring leader, always the dare-devil, always a rebel.

In the Sixth Form, we were allowed to wear dark suit, black coat. I went and bought myself a black Cordroy coat, well out of date in the early fifties. I was hiding, I was hiding I think my fear of being not accounted for, and just being equal; always felt deprived.

I find this probably goes on into what happened in my current life, my recent life. It's the same situation through and through. I haven't grown up; I still have the child in me.

I still wanted that love and affection that maybe I never got from my father. I got it from my mother, but um, it's a situation where my mother loved all her children, and she showed it equally.

I understood that, but my father never came to any event at my Grammar school. He never attended any of my sports functions. He never saw me play in any of the sports.

He was just my father, he was nothing else. I probably have that resentment in me now, to the extent that my children have got the same to me. It's quite horrendous really. I've got all the badness in me from my father, and I've got to kill the pain of that badness, and this is probably when I turn to drink.

So now, I'm not numero uno in the sports clubs any more. But I've grown up, I'd have gin and scotch, this was the only thing I could excel at. I thought I could excel and that was outdrink everybody, little realising the damage it was doing to me and the damage it has done to me.

The physical side I know is reparable to a degree, if I stay off alcohol. This is something I have to come to terms with, through my own analysis and help from other people.

Whether I'll need further treatment from ..., I don't know. I think I probably do. Having said that, I was thinking of asking for help, but I've never really come to terms with going to hospitals for help.

Again, I don't want to be seen to fail, and yet, in the end, the biggest failure of all is when I take that drink, and put myself into oblivion. Having hallucinations, that is my biggest failure, because I can't come to terms with that I can't cope by myself and I need help. I'm trying to sort out on a daily basis, that's all I've got to say.

**b) Samples of professionals' letters**

The following pages contain copies of letters in their original form. Only page numbers are added. To observe confidentiality, all words enabling any identification of patients or professionals such as names, addresses and dates are erased.

The quality of the letter is unfortunately not very good. To allow 1.5 inch to the left margin, these letters had to be reduced to 90%.

The first letter (pages 287 and 288) is written by the Senior Registrar (SR's letter no.18) about patient no.12 to this patient's GP. The second letter (pages 289 and 290) is again written by the SR to the GP of patient no.5.

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Variable print quality

14th February, 89.

Dr.

Dear Dr.

re:

( )

Admitted: - Discharged:  
Unit No.

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was known to our unit in 19... and was referred back to us by Mr. ...  
..., C.P.N., in November 19... She was seen by Dr. ... at the Alcohol  
Clinic at ... Hospital and admitted dry to this unit for the four  
week rehabilitation programme.

Family History: She was born in Somerset, her father was a printer, who was a  
heavy drinker and left the family while ... was a child. He remained out of  
touch for twenty years but reappeared again last year. Her mother died in 19...  
at the age of 65. She has three brothers and one sister who lives in Australia.  
Betty was the second in the family.

Childhood: She had tuberculosis as a child and spent considerable periods in  
hospital up to the age of 16. She had an interrupted schooling, no examina-  
tions and was unhappy, mainly because her mother was also ill and she and her  
siblings were in the care of Dr. Barnado's for several periods of time. She  
describes childhood tantrums, for which she was seen by a Psychiatrist in 19...

Employment: She has worked as a Nurse; as a baby minder and has had jobs in  
Hong Kong and many other places around the world. Her last paid employment was  
in 19... She has no formal qualifications.

Marriage: Her first marriage was to ... and this marriage ended in divorce  
eighteen years later. There are two sons of the marriage now aged 29 and 27  
who live in the U.S.A. Her second marriage was to ..., but this only lasted  
a couple of months and ended when he gassed himself in the car. Her third  
marriage was to ..., who was divorced and had three children. This relationship  
ended in 19..., but since then they have been in touch with each other once a week.  
They seem to get on well, as long as they do not see too much of each other.

Treatment Programme: ... was an active member of the treatment programme. She  
recognised that she had always made great efforts to cope with difficult situations,  
especially concerning her siblings when she was only a child herself. Her own needs  
often remained unmet. When she comes to the end of her resources she has found  
comfort in alcohol and a gap from responsibility. She has attended A.A., and her  
plan is to continue with this. She will also keep follow-up appointments at the



re:

(2)

14th February, 1989.

~~Clina~~ with Dr.

She is planning to visit her sons in the States in the summer. is a kind hearted person, who has had long period off alcohol. I saw a great improvement in her general togetherness on this admission, which points to a good prognosis. She has our good wishes.

Yours sincerely,

Dr.

Alcoholic Treatment Unit.

17th October, 88.

Dr.

Dear Dr.

re: ( )

Date of Admission:  
Date of Discharge:  
Unit No.

---

Mr. was known to us in 19 when he kept some out-patient appointments at the Alcohol Clinic at Hospital. We were then not in touch with him until he was re-referred in July 1988. That referral came from Dr. Consultant Physician at the Hospital, who was looking after him because of his liver cirrhosis. He came in dry to Elmdene on the 7th September and discharged a month later on the 7th October, when he had completed the four week alcohol treatment programme. This was his first admission to our unit. Liver function tests on this occasion showed a raised gamma GT of 277 (normal 10 - 55), ALP 134 (normal 35 - 115). He was maintained on his customary dose of Mifedipine SR 20 mg. each morning and Allopurinol 100 mg. each morning while he was on our unit.

Family History: Mr. was brought up by his parents who are both now dead. He is the third in a family with one older brother and four sisters. Two of his siblings had epilepsy and one of his brothers died at the age of 4 from pneumonia. He was a war baby and describes people as being helpful to one another at that time. He felt particularly close to his mother, but describes his father as a sad character. His father died of emphysema at the age of 58. He believed that he had a serious problem with alcohol.

Schooling and Employment: enjoyed school, both the academic and the sporting side. He gained six GSE's and left at the age of 17½ to join the Police Force. He was a Police Officer for 15 years, until his retirement on medical grounds in 1980. During this time he was attached to Navy Intelligence for 10 years and gained the rank of Detective Sergeant by 1978.

Marriage: He married in 19 when he was 23. His wife is a District Nursing Sister and they were divorced in 19. He remains very unhappy about this, and they have had periods of being back together under the same roof. His drinking has been the cause of the problems in the marriage. He has two children

17th October, 1988.

aged 26 and 24, and he does not feel his relationship with them is very good. Both . . . and . . . live in their own flats in the East End of London and keep in touch with each other and with . . . by telephone.

Drinking History: He began drinking at the age of 18 and this became heavier over the years, largely associated with work pressures and his attempts to identify with the people he was working with. By 1978, when he had an injury to his back, he found that drinking spirits relieved his pain. Two years later he was retired and became bored and depressed and then drinking was a way of relieving himself. He has usually drunk cider and Vodka, most often alone and at home, consuming as much as 60 or 70 units on a heavy day's drinking. He has tended to drink in bouts of 3 or 4 days and has had periods of abstinence in between. As time went on he found that he could manage to stop drinking after one day of returning to it and reports that he has mostly been dry since the middle of last year. This should improve his prognosis, in view of the fact that he has cirrhosis of the liver. He has hypertension, for which he is being treated by the . . . Hospital Clinic. He is a non-smoker. Following the injury to his back in 1978, he had three vertebrae fused at operation, otherwise he is in good general health.

Treatment Programme: . . . successfully completed the four week treatment programme without resorting to alcohol. There were a few occasions when he and his wife had unhappy telephone calls. In the past this would have been enough to precipitate him into further drinking, so he was pleased that he had resisted this useless way of coping. With his background in the police and the security of firm discipline and clear directions, he found working in the treatment programme quite difficult. He remained somewhat apart from the rest of the group, though he was very eager to be popular and helpful. He recognises that he has always found it difficult to express his feelings, including within his marriage. We hope that he has gained from the time he spent in the Unit. He left us to return to his flat in London initially and then to explore the possibility of moving back with his wife, getting some local employment and living in the West Country. He is quite clear that he wants to be abstinent from alcohol. We wish him well.

Yours sincerely,

Dr.

Alcoholic Treatment Unit.

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## Census of a Reception Centre

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In the second half of the fourteenth century, the whole problem of poverty became in England for the first time a matter of government concern. The contractual relationship between landlord and villein which had prevailed during the Middle Ages, was breaking down, and the Black Death hastened this process. Statutes dealing with vagrancy and poverty were promulgated in 1349, 1351 and 1388: the able-bodied beggar was punished in the stocks and generally repression was the keynote, but despite harsh laws vagrancy increased. In a series of statutes from 1531-1601 the Tudor sovereigns initiated a system of local relief based on the Parish unit. In 1576, Houses of Correction were established:

"to the intent youth may be accustomed and brought up in labour and work, and then not likely to grow to be able rogues, and to the intent that such as be already grown up in idleness and so rogues at this present, may not have any just excuse in saying that they cannot get any service of work".

(De Schweinitz, 1943).

Thus was born the Workhouse, and with the lineal descendant of that institution the present paper is concerned.

To trace out adequately the history of the Workhouse during the ensuing four centuries would involve a very major essay in social history, but here only a bare outline need be sketched. The Poor Law Amendment Act of 1834 combined all but the larger parishes into Unions, so that the number of administrative units was reduced from some 15,000 to no more than 650, in order that larger workhouses, willingness to enter which was to serve as the "test" of destitution, could be built. The Metropolitan Houseless Poor Act of 1864 ordered the Unions to provide separate Casual Wards to segregate

the vagrant from the indigenous poor of the parishes, and in 1882 the two-day detention system was inaugurated, compelling the vagrant to give one day's labour for two nights' board. The aim in Victorian times seems to have been to make admission to the Casual Ward—or "the spike" as it came to be called colloquially—an even more humiliating experience than residence in the Workhouse (London, 1903). The first real change in official attitudes to the vagrant came when in 1909 the Royal Commission on the Poor Law accepted the principle that society's responsibility was to help (and treat) the vagrant rather than to punish or deter. In 1919 the overall supervision of the Poor Law administration came under the new Ministry of Health, but the individual institutions remained in the hands of the local Boards of Guardians, and Casual Wards were still rather grim places (Orwell, 1933). The Guardians were succeeded in 1929 by the Local Authorities (Counties and County Boroughs). In 1948 the National Assistance Board was set up and vested with responsibility for the welfare of "persons without a settled way of living", including the provision of "Reception Centres" where such people could be given temporary shelter; the Board, however, was empowered to arrange for the Centres to be administered on its behalf by the Local Authorities, and did so. Meanwhile, social changes made many of the former Casual Wards redundant, and in the year in which the present study was conducted (1965) there were in the place of about 370 such Wards only 19 Reception Centres in the whole of the United Kingdom with, in addition, two special hostels fulfilling similar responsibilities.

The biggest of these institutions is situated in Peckham, the Camberwell Reception Centre, administered until 1965 by the London County Council and now by the Ministry of Social

Security. It is a four-storey building largely erected in 1878, with two standards of accommodation. The Centre admits men for overnight shelter, and also for semi-permanent residence with the aim of rehabilitation. For vagrants the Centre provides large dormitories, 80 ft. from end to end, with 20 beds each, and 4 ft. space allowed per person, and 2 ft. space between the beds. Some semi-permanent residents also live in large dormitories, but the majority live in eight smaller dormitories about 35 ft. from end to end, with 14 to 15 beds each. The Centre is seldom if ever full, but on any one night—depending on weather and season—about 300 vagrants seek lodging within its walls. The work now being done by the staff of this Reception Centre deserves nothing but praise—every effort is made to help and to rehabilitate.

A number of recent studies have dealt with aspects of vagrancy in Great Britain, but our understanding of the roots of vagrancy in this country is still far from complete. Sargaison (1954) reported on Belfast lodging houses, Laidlaw (1956) described lodging houses in Glasgow, and Turner (1960) gave an account of a large London hostel. Whiteley (1955) discussed mental illness found among patients from the Camberwell Reception Centre admitted to a local observation ward, and Marsh (1957) reported the results of a mass X-ray survey carried out at the same Centre. Scott *et al.* (1966) studied patients seen in an Edinburgh general practice who were residents in nearby common lodging houses. Page (1965) has given a general account of the Camberwell Reception Centre. The special problems of the vagrant alcoholic have recently received some attention (Breed, 1966; Edwards *et al.*, 1966). There is also a mass of data on demographic features, etc. of Reception Centre residents which is accumulated in a series of National Assistance Board Annual Reports (1948–1965). Censuses of Reception Centres were carried out by the N.A.B. in 1950, 1955 and 1960.

A recent publication issued by the Board before its absorption in the Ministry of Social Security (1966) describes a survey on "Homeless Single Persons" carried out in March, 1966, and this was certainly the most ambitious attempt to date to build up a picture of the nature of

modern vagrancy. In that study, information from the 21 Reception Centres was pooled for purposes of analysis, and so the characteristics of the vagrant in any particular Centre would, if there were regional differences, be concealed by the averaging process. The fact that the census was conducted by N.A.B. officers might raise the question whether distrust of officials to any extent influenced the answers given to sensitive questions. The data in this recent N.A.B. publication are largely stated in terms of counts and distributions, and although some interesting cross-tabulations are presented few firm conclusions can be drawn as to correlation between variables. But despite these and several other minor criticisms, *Homeless Single Persons* constitutes an invaluable source of information.

The purpose of the investigation which will now be described was to conduct a census on one particular Centre, the Camberwell Reception Centre. The aim was to collect information which could be analysed in terms of counts and distributions and could then be submitted to statistical analysis which would show correlation between variables: we hoped, for instance, to be able to go beyond a simple statement as to what percentage of men had a drinking problem to an exploration of how demographic and social features, etc. distinguished these men from those who did not admit symptoms of alcoholism.

#### SURVEY PROCEDURE

A 100-item structured questionnaire was after preliminary piloting administered by a team of 22 interviewers to 279 men who were resident in the Reception Centre on the night of 28 April, 1965: interviewing started at 12.45 p.m. and continued until 2 a.m. when the last stragglers had booked in. Although the men were under no sort of duress, co-operation when the medical nature of the inquiry had been explained was generally excellent and only two men refused to be interviewed. Administrative difficulties led to a further 81 residents being excluded from the survey, but this is unlikely to have introduced any bias.

Data were analysed with the aid of a standard Survey Programme supplied by Mr. Alan Henrickson, using the IBM computer at the

Imperial College of Science and Technology, and a standard Correlation Programme was also provided by Mr. Michael Clarke using the Atlas computer of London University.

RESULTS

1. DEMOGRAPHIC

*Age.* Mean age was 46.1 (S.D. 12.2) years. Distribution was age 16-25 years, 5 per cent.; 26-35, 16 per cent.; 36-45, 27 per cent.; 46-55, 23 per cent.; 56-65, 27 per cent.

*Marital status.* 70 per cent. of men were single, 1 per cent. married with marriage considered intact, 16 per cent. separated, 8 per cent. divorced and 4 per cent. widowed (1 per cent. not known).

*Number of children.* Only 20 per cent. of men had any children, and the total number of offspring claimed by the 270 subjects totalled 133.

*Ethnic origin.* Country of birth was England 51 per cent., Ireland 20 per cent. (16 per cent. Irish Republic and 4 per cent. Northern Ireland), Scotland 14 per cent., Wales 5 per cent., other white culture 6 per cent., non-white culture 4 per cent. (including 1 per cent. West Indian).

*City versus rural origin.* Birthplace was London 21 per cent., other city (population greater than 50,000) 37 per cent., town (population greater than 5,000) 28 per cent., rural area 11 per cent., unknown 3 per cent.

*Age on leaving school.* The mean school-leaving age was 14.5 years (S.D. 2.3); 17 per cent. had continued in full-time education beyond the age of 15, and 7 per cent. beyond 16.

*Age on leaving home.* The mean age on leaving home was 23.1 years, S.D. 10.2.

*Social class.* Distribution of social class of subjects and of fathers of subjects is given both as

"now" and "best" by reference to occupation (General Register Office, 1961) in Table I below. Men unemployed were categorized by reference to their last job. Class I implies professional occupation and Class V unskilled labouring, etc.

*Religion.* 44 per cent. were Church of England, 38 per cent. Roman Catholic, 6 per cent. Non-conformist, 1 per cent. Jewish, 4 per cent. other religions, 6 per cent. no religion, 1 per cent. not known.

*Service records.* 28 per cent. had served in the regular forces, and a further 30 per cent. had seen wartime or peacetime National Service. 12 per cent. had been in the Merchant Navy.

2. SOCIAL STABILITY

*Length of time in England.* Those who had not been born in England (49 per cent. of total) had first come to England on average 18.4 years (S.D. 12.5) ago: only 3 per cent. (of these 49 per cent.) had first come to England less than 1 year ago, and 68 per cent. first came more than 10 years ago. 11 per cent. had, however, *on this visit* been in England less than 1 year.

*Length of time in London.* Those who had not been born in London (76 per cent.) had on average first come to London 14 years ago (S.D. 11.6), and only 4 per cent. (of 76 per cent.) had been in London first less than 1 year ago. Of the total 279 men, 21 per cent. had *on this occasion* been in London less than 1 month, and 43 per cent. less than 1 year: men on average had first been to the Reception Centre 68.1 months ago, but there was a considerable scatter (S.D. 69.3): 9 per cent. had first come within the last month, 26 per cent. within the last year but 39 per cent. first more than 5 years ago, and 12 per cent. first more than 12 years ago.

TABLE I  
Class Distributions by Percentage

	I	II	III	IV	V	Unknown
Subjects "Now" ..	0.5	0.5	8.5	17.0	72.5	1.0
Subjects "Best" ..	0.5	3.0	22.0	27.5	45.0	2.0
Fathers .. ..	2.5	9.0	34.5	27.0	22.5	4.5



*Recent residential stability.* Within the previous six months men had on average spent at the longest 14.1 weeks (S.D. 8.7) in one place of residence, only 3 per cent. giving "less than 1 week" as the answer to this question. The *place* of longest recent residence was for 38 per cent. the Reception Centre and for 33 per cent. a hostel or lodging house. 37 per cent. had been resident outside London for some part of the last 6 months. Residence in more than two cities or towns during that period was reported by only 21 per cent.; 9 per cent. had been highly mobile with five or more towns or cities of residence during this period.

*Work stability.* 82 per cent. were unemployed, and of these (percentage of 82 per cent.) 11 per cent. had been unemployed less than 1 month, 38 per cent. 1-6 months, 12 per cent. 7-12 months and 39 per cent. more than 1 year; 9 per cent. had been unemployed more than 5 years. Average length of unemployment was 22 months, but with wide scatter (S.D. 38 months). In the last 6 months the longest time in one job was on average 5.6 weeks (S.D. 7.8) but 48 per cent. mentioned a period of less than 1 week. The longest period ever spent in one job averaged 65.5 months (S.D. 67.6), 1 per cent. giving less than 1 month, 17 per cent. 1-12 months but 12 per cent. more than 10 years.

### 3. PHYSICAL ILLNESS

Thirteen per cent. stated that they had suffered from a peptic ulcer, and 9 per cent. had been operated on for this complaint. 8 per cent. had been treated for tuberculosis. 6 per cent. had suffered from head injury of such severity as to result in more than one day's loss of consciousness. 11 per cent. had been in a general hospital during the previous six months.

### 4. MENTAL ILLNESS

The number of times men had been in a mental hospital (for reasons other than drinking) was 0, 76 per cent.; 1, 13.5 per cent.; 2, 5.0 per cent.; 3, 2.5 per cent.; 4, 1.5 per cent.; 5 or more 1.5 per cent. Those who stated that they had at some time attempted suicide amounted to 7.5 per cent. 7 per cent. had been in a mental hospital during the previous six months.

### 5. DRINKING

*Hospital treatment.* Eight per cent. had at some time received in-patient and 2 per cent. out-patient hospital treatment for drinking.

*Drink a problem.* Answers to the questions "Would you say drink is a problem to you now?" and "... ever?" are set out in Table II.

*Symptoms of pathological drinking.* The percentage of men reporting symptoms indicative of abnormal drinking is given in the first columns of Table III, and the age at which each symptom was first experienced in the last column.

*Drunkenness arrests.* Those who had been arrested for drink (45 per cent. of total) had on average been arrested 8.5 times, but there was a wide scatter (S.D. 14.5): 22 per cent. of those arrested had only been so once, but 21 per cent. had undergone arrest more than 20 times.

*Crude spirit drinking.* Eight per cent. had drunk surgical or methylated spirit "once or twice", and 3 per cent. answered "yes" to "regularly". Average consumption when drinking these spirits was 2.1 bottles (42 oz.) per day.

*Level of drinking and beverage choice during previous six months for "daily drinkers".* Table IV gives the percentage of "daily drinkers" choosing beer, cheap wine, and spirits during the previous six months and the average and "maximum daily intake" for those daily drinkers

TABLE II  
*Drink a Problem "Now" and "Ever", by Percentage*

	No	Yes	Unsure	Not Recorded
"Now"	73	19	7	1
"Ever"	65	30	4	1

TABLE III  
Occurrence Rate (Percentage) of Symptoms of Abnormal Drinking, and Mean Age at first Occurrence

Symptom	Percentage				Age in Years at first Occurrence	
	Never	"Once or Twice"	"Quite often"	"Unsure"	Mean	S.D.
Morning Amnesias .. .. .	62	12	24	2	30.8	9.5
Morning shakes .. .. .	61	10	25	4	31.8	10.8
"Morning livener" .. .. .	60	9	28	3	30.7	11.5
Arrest for drunkenness .. .. .	53	"Ever" 45		2	34.5	11.5

choosing each beverage. As can be seen, there was some overlap in beverage choice.

*Recent drinking frequency.* Twelve per cent. stated that their last drink was "today or yesterday", 29 per cent. within the previous week but 41 per cent. claimed to have had no drink for more than 1 month. 38 per cent. stated that their usual pattern was "daily", while 32 per cent. said they seldom or never drank.

6. DRUG TAKING

Only 2 of subjects had ever taken opiates, and 4 pethidine. Experimentation with barbiturates and amphetamines was more common. As regards Drinamyl, for instance, 9 (3 per cent.) subjects had taken this drug regularly and 7 (2.5 per cent.) on occasion.

7. IMPRISONMENT

Fifty-nine per cent. of men had at some time been in prison, and 18 per cent. had been in prison during the previous six months. Average age on first imprisonment was 32 years (S.D. 12.0 years): 31 per cent. experienced first

imprisonment aged 15-25, 31 per cent. aged 26-35, 21 per cent. aged 36-45, and 12 per cent. first at age 46+ (3 per cent. unknown). The longest prison sentence a man had served averaged 12.4 months (S.D. 20.3). 62 per cent. of those who had been in prison had never been sentenced to more than 6 months, 13 per cent. 7-12 months, 11 per cent. 13-24 months, 9 per cent. 25-36 months, and only 5 per cent. more than 3 years; for those who had been in prison the average number of sentences was 7.4 (S.D. 9.5), only 24 per cent. having served only one sentence and at the other extreme 10 per cent. having served more than 20 sentences.

8. CORRELATIONS

A correlation matrix was prepared relating each variable to all others. From the full matrix the information given below has been abstracted.

*Correlation Between Different Indicators of Drinking Pathology*

These correlations are set out in Table V: only those greater than .3 are shown, and these

TABLE IV  
*Beverage Choice Average and Maximum Daily Intake. A bottle of Whisky and a bottle of Wine contain Approx. 800 ml., and 1 pint equals approx. 540 ml.*

Beverage Choice	% partaking	Average daily intake	Maximum daily intake
Beer .. .. .	77	9 pints	12.5 pints
Wine .. .. .	22	2 bottles	2 bottles
Spirits .. .. .	25	.75 bottle	.75 bottle

are all significant beyond the .001 level. It can be seen that with these men the presence or absence of a history of hospital admission for treatment of alcoholism is not a satisfactory indicator of drinking pathology, while the level of wine drinking is a better indicator than the level of beer or spirit intake.

In the following paragraphs the notation +, ++, +++ will be used for positive correlations significant beyond the 5 per cent., 1 per cent. and 0.1 per cent. levels respectively, with similar notation for negative correlations. Significant correlations will be reported even when of relatively low magnitude, for it seems likely that any significant relationships demonstrated on data obtained from this relatively crude questioning may provide useful pointers for further research.

"Drink now a problem." Table V suggests that an affirmative answer to this one question is a confident indicator of a whole cluster of symptoms indicative of drinking pathology. The relationship of this item to a number of other groups of items was as follows.

(a) *Demographic factors.* "Drink now a problem" gave a negative correlation of .215 (-) with age, of .133 (-) with being London born, and of .162 (-) with being English born. There was no significant correlation with social class now or best social class, father's social class, ever being married, or having served in the Merchant Navy.

(b) *Social stability factors.* There was a negative correlation of .248 (-) with longest residence during the last six months, and of .113 (-) with being employed. A positive correlation of .265 (++) was found with being in prison

during the last six months. There was no significant correlation with longest employment during the last six months or ever, time now unemployed if unemployed, time now in London, number of towns or cities in which resident during the last six months, longest prison sentence or number of sentences.

(c) *Other.* There was a correlation of .127 (+) with having attempted suicide, and of .354 (+++) with having taken any of the drugs into which inquiry was made. No significant correlation was found with tuberculosis, peptic ulceration, or severe head injury.

*London versus Non-London Born*

Being London born showed a positive correlation of .125 (+) with present age, of .184 (++) with age on leaving home, and of .183 (++) with age on first using the Reception Centre. There was a negative correlation of .133 (-) with drink now a problem, of .205 (-) with age at first drunk arrest, and of .190 (-) with a score of drinking frequency.

*Age on First Coming to Reception Centre*

Age on first coming to the Reception Centre correlated at .248 (+++) with age on leaving home, .887 (+++) with age now, .291 (+++) with longest time in one job, .147 (+) with now unemployed, .128 (+) with London born, and .191 (++) with English born. There were negative correlations of .134 (-) with drink now being a problem, .168 (-) with drinking surgical spirit ever, .183 (-) with ever being in prison and .176 (-) with being in prison during the last six months.

TABLE V  
*Correlation between Different Indications of Drinking Pathology*

	"Drink a Problem Now"	I.P.	Morning Drink	Amnesias	Morning Shakes	Drunk Arrest	Usual Beer	Usual Wine	Usual Spirit
In-patient ever for drink									
Morning drinks ever ..	.524								
Amnesias due to drink ever .. .. .	.530		.528						
Morning shakes ever ..	.546		.651	.554					
Arrested for drunkenness	.423		.446	.438	.449				
Usual quantity of beer ..				.318		.321			
Usual quantity of wine ..	.433	.344	.452	.369	.367	.304			
Usual quantity of spirit								.498	
Surgical spirit ever ..	.338		.331	.318	.350			.337	

## DISCUSSION

*Heterogeneity*

What in essence is the picture of the Reception Centre population which emerges from this research? The really striking feature is the heterogeneity: rather than the data adding up to make one whole picture, it seems that pieces of several different puzzles have been thrown together. Under one roof are being performed the functions of an old people's home, lodging house for the itinerant labourer, alcoholism rehabilitation centre, mental after-care hostel, half-way house for the discharged prisoner, and perhaps a dozen other functions besides. Further study is required to delineate all these different sub-groups clearly, but the results so far obtained suggest certain leads to analysis.

1. *London-born and London-immigrant.* The division which can be made here is perhaps partly along the lines of the historical separation between "the poor of the parish" who were the inhabitants of the Workhouse proper and the vagrants of the Casual Ward. Their problems are not identical, and legislators may not have been so wrong in seeing these as fundamentally different groups. The correlation matrix suggests that the London-born were those who had held on to social stability longer, came first to the Reception Centre later in life, and were less likely to be pathological drinkers. One may suspect that from further work would emerge the identification of a London-born sub-group who were more often men of inadequate than positively abnormal personality, who as the result of advancing age and some imposed stress—bereavement, loss of job, or mental illness—had found themselves unable to maintain social integration. And perhaps the younger man who is the immigrant to London is more frequently in the Reception Centre because of a drinking problem or some sort of gross and positive psychopathology, but on the other hand he may sometimes be found simply to be an itinerant labourer temporarily out of a job, just a young man looking for free lodgings.

2. *The Late-comers.* In that the men coming late to the Reception Centre tend to be Londoners, examination of the influence of age *per se* on coming to the Reception Centre is obviously complicated by interreaction with this

other factor, but the correlation matrix shows certain significant associations with age at coming to Reception Centre which are not found with the man being London-born. The late-comers are people with previously better work record than those who come to the Reception Centre younger. Drink is not such a problem for them and their prison records not so considerable; but they are at present having greater difficulty than the younger arrivals in getting work. The data suggest that a sub-group could be made out consisting of elderly men who are socially inadequate rather than anti-social, and it seems likely that this group would largely but not entirely overlap with the London-born—"the Poor of the Parish"—and would in any case be largely English-born.

3. *Men with Drinking Problems.* The question whether there is among vagrants a high incidence of addictive drinkers, as opposed to simple non-addictive over-indulgers in alcohol, was discussed in a recent study of men found in a London soup-kitchen (Edwards *et al.*, 1966): that investigation showed that 49 out of 50 bomb-site drinkers were severely dependent chemically on alcohol, a finding at variance with American reports (Straus and McCarthy, 1951; Pittman and Gordon, 1958) which suggests that among vagrants most pathological drinkers are not addicted drinkers. In the Reception Centre the sum of evidence is that something like 25 per cent. of the men are chemically addicted, but in view of 45 per cent. having been arrested for drunkenness one must suppose that there is indeed in the Reception Centre an important segment whose drinking is excessive but not addictive—the fact that about half of this latter segment answer "once or twice" to questions on morning shakes, etc. suggests that they too may before long enter an addictive phase. However, the whole question of the natural history of pathological drinking among the socially rootless in this country needs much more study—we can at present only guess as to how often, and over what period of time, occasional drunkenness will progress to alcohol addiction. Again, it is not at all clear how often drinking is the *cause* of rootlessness, as opposed to its being no more than a symptom of the central personality disturbance which is the real and basic cause of

the drifting life. Drug addiction among British vagrants is still rare.

4. *Former Mental Hospital Patients.* The findings that 24 per cent. of subjects had at some time been in a mental hospital for reasons other than drinking suggests that the contribution which mental illness is making to Reception Centre admissions deserves further scrutiny. The seriousness of the gap in after-care is underlined by the finding that 7 per cent. had been out of hospital for six months or less.

5. *Ex-prisoners.* Fifty-nine per cent. of these men had been in prison, but the length of sentences show that the offences were usually trivial. The ex-prisoner in the Reception Centre is not the major criminal who has fallen on hard times, but the habitual petty offender. It is unlikely that for many of these men imprisonment any longer serves as a deterrent, and difficult to believe that prison is for them rehabilitative: Springhill, Wandsworth, Pentonville have become just further points in ceaseless circulation, part of the way of life, part of the muddle, aids to the process of desocialization.

*The 1966 N.A.B. Census.* As mentioned in the Introduction to this paper, the 1966 N.A.B. census pooled data from all over the country instead of giving separate information on different Reception Centres, and it is therefore interesting that distributions on ethnic variables, employment history, imprisonment, problem drinking, and mental hospital admissions are in many ways similar: one of the few discrepancies is the finding of 51 per cent. unemployed more than six months in the Camberwell Reception Centre, as opposed to the figure of 27.1 per cent. in the whole country survey. The conclusion must be that the vagrant population throughout the country has largely similar characteristics.

*Future Research.* A number of obvious questions for future research have already been mentioned—contribution of old age and social mishaps to homelessness, the question of how many "normal" men are using the Reception Centre as lodgings, the problem of whether drinking is cause or simply the accompaniment of vagrancy. Rather than further large scale census studies, what is immediately needed is research which concentrates on the problems of specific sub-groups. We need, for instance, to

study in detail the 24 per cent. of men who have been in mental hospitals so as to obtain diagnostic categories, and we need also to trace out how it is that these patients come to be in a Reception Centre.

*Future Policy.* That the Reception Centres are at present being asked to perform so many different functions is clearly no more than an accident of history. The whole mood of social reform and social conscience makes the inhumanity and negative policies of the old Casual Wards abhorrent, and much more has been done since 1948 than change the name. But the Reception Centre as it exists today is a vast anachronism. The move must be towards hostels where special needs can be met by special and trained staff.

Hostel care is indeed at the forefront of thinking in many different fields, and inevitably, the Government will some time soon have to consider the possibility of a Hostel Service (*British Medical Journal*, 1966); in particular the need is for central organization of staff training and recruitment, and a career structure which can attract people of imagination and ambition. Something as important as the nursing profession or the probation service is waiting to be brought into existence.

#### SUMMARY

1. The history of Reception Centres is briefly reviewed. A 100-item structured questionnaire was administered to 279 men entering the Camberwell Reception Centre, London, on the night in April 1965.

2. Demographic data are presented, information on incidences of some physical illnesses, on mental hospital admissions, and on criminal involvement.

3. Aspects of drinking behaviour are examined: about 25 per cent. of men are chemically dependent on alcohol.

4. A correlation analysis shows the considerable interrelatedness of different symptoms of pathological drinking, explores the relation of demographic and social facts, etc., to drink being a problem, and to some extent differentiates London-born from non-London-born and early from late comers to the Reception Centre.

5. The heterogeneity of the Centre's population is noted and an attempt made to delineate subgroups. Future planning should be for smaller hostels in which the special requirements of particular subgroups can be met. A Hostel Service is needed.

#### ACKNOWLEDGMENTS

We would like to thank the National Assistance Board (now Ministry of Social Security) for their generous co-operation which made this study possible, and in particular our thanks are due to Mr. D. V. Jones and the staff of the Camberwell Reception Centre. We wish to thank all the interviewers who assisted in the census, Miss Barbara Kinsley and Mr. Michael Clark for statistical advice, and our secretaries Mrs. J. Polglaze and Miss E. Cross. The work was supported by a grant from the Bethlem-Maudsley Research Fund.

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(Received 18 August, 1967)

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Drinking Behavior and Attitudes and Their  
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*I. Principal Components in the Drinking Domain.*  
*II. Personality and Social Influence. III. Sex Differences*

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REPRINT FROM

QUARTERLY JOURNAL OF STUDIES ON ALCOHOL

Vol. 35, No. 4, pp. 1316-1374, December 1974

*Editorial Office:* Rutgers University Center of Alcohol Studies

New Brunswick, NJ

*Printed in U.S.A.*



# Drinking Behavior and Attitudes and Their Correlates among University Students in England

I. Principal Components in the Drinking Domain.  
II. Personality and Social Influence. III. Sex Differences

Jim Orford, Seta Waller and Julian Peto<sup>1</sup>

*SUMMARY.* The responses of 1323 first-year students at an English university to a questionnaire concerning their drinking patterns and attitudes are examined in terms of the correlations between the drinking-related variables, the relationship of personality and social factors to drinking, and sex differences in the questionnaire responses.

THE DRINKING HABITS of adolescents and early adults and their attitudes toward the use of alcohol have been extensively studied in the U.S.A. Samples of high-school students (e.g., 1-7), college students (e.g., 8, 9, 10) and identified delinquents (e.g., 11, 12) have been examined. There have been rather fewer European reports of this kind (e.g., 13, 14, 15)<sup>2</sup> and at the time of writing only one major British study has been reported (16).

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*ACKNOWLEDGMENTS.*—This study was conducted while the authors were employed on a grant from the Nuffield Foundation and were working at the Addiction Research Unit, Institute of Psychiatry, under the direction of Dr. Griffith Edwards who was involved in the project in its early stages. Also involved at that stage was Dr. A. N. Oppenheim. We also thank Margaret Elliott and Carole Hewlett of the London School of Economics who processed the data through several stages of its analysis and Joyce Oliphant who typed the manuscript.

<sup>2</sup> Also, KLIMEK, O. and SKALA, J. Attitudes of male youth toward the consumption of alcoholic beverages. Presented at the 12th International Institute on the Prevention and Treatment of Alcoholism, Prague, 1966.

Received for publication: 15 May 1973. Revision: 20 March 1974.

Many of these studies have attempted no more than a description of drinking practices or attitudes while others have begun to try to explain individual differences within the drinking domain by searching for significant correlations between drinking and nondrinking variables. Most of the latter have tried to explain differences in drinking behaviors or attitudes in terms of social or demographic variables such as age, sex, socioeconomic status and religious affiliation (e.g., 9), others have sought differences in psychological variables such as anxiety (17, 18), lack of perceived opportunity for satisfaction (e.g., 6, 19), interest in sentient activities<sup>3</sup> and the need for power (20). Many of these authors, as well as others, have considered the influence of drink-specific factors such as parental and peer-group drinking behaviors and attitudes (e.g., 9, 21, 22, 23).

With notable exceptions (e.g., 19) these studies have examined no more than one or a few of these factors at a time and it has therefore not been possible to obtain an indication of their relative importance. The major purpose of the study reported herein was, therefore, to examine the correlations of a number of social and psychological variables, both individually and in combination, with variables in the drinking domain among a British sample of young adults.

## I. PRINCIPAL COMPONENTS IN THE DRINKING DOMAIN

This first paper is concerned with a logically prior question which in our view has received insufficient attention in the literature on young people and drinking. The question is that of the structure of the drinking domain and the choice of criterion drinking variables.

Agreement on the choice of criterion drinking variables for research in this area is far from perfect and the result is a proliferation of both concepts and procedures. A number of themes are nonetheless apparent. As Stacey and Davies (24) have noted in the course of an evaluative review, there are at least two major areas of concern. The first, informed perhaps by moral concerns as well as an awareness of alcoholism particularly among younger adults (25, 26), has to do with matters under the heading of "problem drinking." Much research in this area makes a major assumption

<sup>3</sup> ZUCKER, R. A. Social drinking and sentient behavior in adolescent boys. [Unpublished manuscript, Rutgers University, 1967.]

that some youthful drinking is more problematic than other youthful drinking and accordingly prominence is given to operational measures of problems, complications or symptoms associated with drinking (e.g., 9, 10, 27, 28).

The second broad area according to Stacey and Davies "concerns the general nature of the drinking experience. . . ." It seems that the simplest of conceptualizations of the nature of the drinking experience, contrasting "users" with "nonusers," is agreed to be of little value except where the age of the sample studied is particularly low or where study is made of a locality where a relatively large proportion of people place a high value upon abstinence (e.g., 29). Hence procedures for quantifying the nature of the drinking experience should reflect an appreciation of the complexity of this experience. Among behavioral parameters which investigators have felt the need to examine are age of first use, frequency of recent use, usual quantity consumed on one occasion, the location of drinking, and the age and sex composition of groups within which drinking takes place. Despite the fairly wide range of parameters which have been included, relatively little attention has been paid to some matters, such as the types of alcoholic beverage drunk and the nature of activities which accompany drinking. It might be supposed that these would modify the nature and meaning of the drinking experience for the individual concerned. Factors such as the concentration of alcohol in beverages consumed and the association of drinking with eating, for example, have an important place in prevailing theories of problem drinking or alcoholism (e.g., 30, 31).

Apart from overt drinking behavior there is a strong theme in the literature which supposes that the assessment of attitudes toward drinking is necessary both for an understanding of the nature of the drinking experience and also, particularly among relatively youthful samples, for the prediction of later drinking behavior. Many youth-drinking surveys have included attitude items or scales and some (e.g., 32) have relied more heavily on these than on self-reports of drinking behavior as criterion variables. An aspect of drinking experience which is prominent in the literature, but which procedurally lies uneasily in the important area between reported behavior and expressed attitude, is that of stated reasons, or motivations, for drinking. Several students of youthful drinking (e.g., 9, 19, 33), as well as others concerned with adult drinking

practices (e.g., 34), have asked their respondents questions about personal or psychological, as opposed to social, reasons for drinking.

Those who seek, as the present authors have done, for some social and psychological correlates of drinking experience among young people are therefore faced with a bewildering choice of criterion variables with the help of very little evidence on the relative reliability, stability or validity of the alternatives. The question to which this report is addressed concerns the structure of the drinking domain: whether alternative variables are to a large extent independent of one another or whether a single summary variable can suffice as a description of drinking experience in this age group. Quite opposing viewpoints would appear to be equally credible at the present state of knowledge. For example, from the psychiatric perspective (e.g., 35) the assumption is that motivation for drinking is to a considerable extent independent of the frequency parameter, young problem drinkers being distinguished from young normal drinkers more in terms of the former variable than the latter. A more parsimonious expectation might be that, owing to the unavoidable effect of alcohol on the central nervous system, "drinking for effect" is a fairly universal experience among drinkers and will covary with basic parameters such as frequency and quantity. This is a matter of considerable theoretical and practical importance in view of alternative prevailing conceptions of problem drinking or alcoholism. The prevalence of alcoholism might be proportional to total alcohol consumption in a population (36) or else proportional to the prevalence of particular "unhealthy" drinking attitudes (e.g., 30).

Park (28, 37) has focused on the same problem in reporting the results of a factor analysis of 28 drinking and attitude items employed in the Straus and Bacon (9) study of student drinking. Items included referred to frequency and quantity, complications, problems and stated reasons for drinking. Five factors were reported but it is important to realize that the factor solution employed was not an orthogonal one and there were a number of high interfactor correlations. In particular, the first "social drinking" factor was correlated with the second "problem drinking" factor and, furthermore, items indicative of "relief drinking" loaded more highly on the former dimension than on the latter. Park also reported that the problem-drinking dimension correlated with peer identification of "problem drinkers" and differentiated a group of

"referred" students from a random student group. Although this is interpreted as evidence for the validity of the problem-drinking dimension, it is clear that scores on the first social drinking factor, as well as other factors, correlate and differentiate criterion groups in the same way (37, p. 164).

This section reports the results of a component analysis of data on drinking behavior and attitudes obtained from three samples of college students at an English university. This may contribute to the literature on the structure of variables in the drinking domain in a young age group, and has also served to inform the present authors in the choice of criterion variables for a study of the social and psychological correlates of drinking behavior and attitudes which is reported in section II.

## METHOD

### Sample

Completed questionnaires were received from 1323 first-year students at 2 colleges of the same English university. The results from three samples will be reported separately: 259 female students at college A (representing a 77% return rate), 495 male students at college A (a 73% return rate), and 569 male students at college B (a 79% return rate). College B was predominantly male, the number of female first-year students being insufficient to constitute a separate sample.

All but a small minority of students in each sample were single and aged between 17 and 19. As is to be expected at an English university, the sample has a middle-class bias, half the sample giving a description of their father's occupation which could be categorized as professional, high administrative, managerial or executive, only about 5% being classifiable as semiskilled or routine manual workers. Over half reported the religion and denomination in which they were brought up to be Protestant and approximately 10% were in each of the three categories, Catholic, Methodist and "none," smaller percentages stating other denominations or religions. Less than 10% were of other than British nationality and all but 10 to 15% had spent most of their childhood living within the British Isles.

At college B all students were enrolled in the faculty of science or engineering, while at college A faculties of arts, law and medical sciences were also represented. There was a higher questionnaire return rate from science (plus medical science) than from other students in both the college A male sample (76% versus 68%) and in the college B male sample (83% versus 75%), the difference in return rate being statistically significant in the case of college B men only (chi square,  $p < .05$ ).

Some indication of the degree of selection bias resulting from a less than 100% return rate may be obtained by comparing the replies of

early and late returns if the assumption can be accepted that late returners are likely to be more similar as a group to nonreturners than are early returners. In view of the fact that late returns were not all obtained spontaneously without reminders there may be some truth in this assumption. College B men who returned questionnaires within 1 week of receiving them were compared with those who returned questionnaires in the second or subsequent weeks in terms of a combined drinking quantity-frequency (QF) score.

The students were divided into three roughly equal groups on the basis of QF scores and the association of QF and early vs late return was found to be statistically significant (chi square,  $p < .05$ ) with both low QF and high QF scorers, particularly the former, being overrepresented among late returners and middle-range QF scorers being overrepresented among early returners. This analysis, which has only been carried out for one sample, suggests that relatively light and heavy drinkers may possibly be underrepresented in the sample of completed questionnaires.

### The Questionnaire<sup>4</sup>

All students received a 44-page questionnaire through their internal college postal systems and were requested to return completed questionnaires to centrally placed collection points in their college. They were assured of confidentiality but each questionnaire bore an identity number which made it possible to identify nonreturners who were reminded by mail about returning the questionnaire, and if that failed were reminded again through personal contact.

Approximately half of the questions dealt with the student's own drinking behavior or his own attitudes toward the consumption of alcohol. Only data obtained from these sections of the questionnaire will be reported in this section.

### Variables in the Principal-Component Analysis

In nearly all cases the individual variables included in the analysis represent a condensed summary of answers to a number of questionnaire items. A number of scaling principles and procedures were employed in deriving these summary scores. In many cases a set of items relating to a common topic was factor analyzed and only those items with moderate or high loadings on a common factor summed to produce a single summary score (variables 3-5 and 7-12). In two cases (variables 15 and 16) procedures for identifying cumulative or reproducible scales (38, 39) were followed while in other cases (variables 6, 15 for women only, 17 and 18) less stringent methods of item analysis (40) were used

<sup>4</sup>For the Student Drinking Questionnaire, order NAPS Document No. 02476 from ASIS/NAPS, c/o Microfiche Publications, 440 Park Ave. South, New York, NY 10016; remit with order \$1.50 for microfiche copy or \$7.40 for full-size photocopy. Outside the U.S.A. and Canada, postage is \$2 for a photocopy or \$0.50 for a microfiche.

whereby the significance of individual-item-total-score relationships was examined by means of product-moment correlations (variable 6) or by contingency tests (other variables).

Item pools were in many instances derived from individual and group discussions with students (this particularly applies to variables 7-9 and 15-17) and the format was in several instances arrived at in light of pilot administrations (this particularly applies to the format adopted for variables 1 and 6).

Following are brief descriptions of the 18 variables:

*Variable 1—Drinking Quantity.* A grid format was used. Six grid rows represented different quantities of alcoholic beverage from "1 drink only" to "more than 20 drinks" and 13 columns were headed with numbers representing the percentage of "drinking days" on which these quantities had been consumed (none of the days; less than 10%; 10%; 20% . . . 90%; more than 90%; all of the days). The subjects were asked to place a cross in each row to indicate the approximate proportion of "drinking days" on which each quantity had been consumed. One drink was defined as either half a pint of beer or cider, or a "single" drink of "spirits" (containing approximately 8 g of absolute alcohol) or a single glass of wine, sherry or any other alcoholic drink.

The average quantity consumed per drinking day was computed from the completed grid and this was the variable included in the principal-component analysis.

*Variable 2—Drinking Frequency.* The following single question was presented in forced-answer format: "On approximately how many days in the last 12 months did you consume any drink(s) containing alcohol?" Alternative answers ranged from "Every day or nearly every day"; "5 or 6 days a week on average"; to "1, 2, or 3 days in the last 12 months"; "No day during the last 12 months."

*Variable 3—Drinking Style I.* The following items made up this scale: (1) Drinking beer or any drink containing beer; (2) Drinking with one friend of own sex; (3) Drinking with a small group of friends (2-4 people), all of own sex; (4) Drinking in a pub; (5) Drinking in any other licensed bar; (6) Drinking during the evening (up until 10 PM); (7) Drinking between 10 and 11 PM.

In each case the question asked for an approximate estimate of frequency during the previous 12 months and all questions were in forced-answer form.

*Variable 4—Drinking Style II.* The following items presented in the same way made up this scale: (1) Drinking wine; (2) Drinking with at least one parent (or guardian) present; (3) Drinking in a licensed restaurant; (4) Drinking in parents' (or guardians') home; (5) Drinking at or with lunch; (6) Drinking at or with the evening meal.

*Variable 5—Relief-of-Feelings Motivation.* The following are examples of the 8 yes-no items which were included in this scale following selection from a total of 11 items on the basis of principal-component analyses: "Do you sometimes drink alcohol when things have got you down?"; "Do you sometimes drink alcohol when you are bored?"; "Do you sometimes drink alcohol in order to face meeting people?"

*Variable 6—Expected "Tolerance."* This scale comprised the following questions which were asked separately for three different types of drink (beer, spirits, wine): "How many drinks ( $\frac{1}{2}$  pints, singles, glasses, depending on the type of drink) do you expect would make you (1) Have difficulty think-

ing as clearly or quickly as usual? (2) Feel dizzy? (3) Stand or move about less easily than usual? (4) Feel 'sick'? (5) Slur your speech or otherwise speak abnormally?" A grid format was again employed, columns being headed  $\frac{1}{2}$ , 1, 2 . . . 16, more. In each row respondents were asked to provide both a maximum and minimum estimate.

A single expected-tolerance score was computed by averaging these estimates for each row and summing the 15 row averages.

*Variable 7—Extraversion Effects.* The following are examples of the 9 items included in this scale: "More relaxed"; "More generous"; "Merrier"; "More interested in other people."

Each item included in this and the two other "effects" scales was prefaced by "When you drink alcohol how often does it make you . . .?" In each case three alternative replies were available: "on all or most occasions when you drink alcohol"; "on some occasions when you drink alcohol"; "hardly ever or never." (These responses were scored 2, 1 and 0, respectively, and summed across the 9 items.)

*Variable 8—Disinhibition Effects.* This scale consisted of the following four items: "Feel less in control of your own actions"; "Less aware of the effects of your own actions"; "Feel more inclined to be irresponsible"; "Less aware of differences between right and wrong."

*Variable 9—Intellectual Stimulation Effects.* The following three items were included in this scale: "Feel more intelligent"; "Feel that things seen or heard are more vivid or significant"; "More inventive."

*Variable 10—"Alcohol is for me"—Evaluative.* Respondents were required to rate the concept, "Alcohol is for me," on a number of scales presented in conventional, seven-point, end-labeled, semantic differential format (41) and the following scales selected from 16 scales on the basis of factor analyses comprised the evaluative dimension: Good-Bad; Clean-Dirty; Kind-Cruel; Pleasant-Unpleasant; Attractive-Unattractive.

*Variable 11—"My getting drunk would be"—Evaluative.* The following six semantic differential scales were included, again following factor analyses of a larger number of scales: Agreeable-Disagreeable; Good-Bad; Satisfactory-Unsatisfactory; Beautiful-Ugly; Wise-Foolish; Pleasant-Unpleasant.

*Variable 12—"My getting drunk would be"—Potency-Activity.* The following semantic differential scales represented the potency-activity dimension in ratings of this concept: Exciting-Dull; Hot-Cold; Important-Unimportant; Interesting-Uninteresting; Active-Passive; Dangerous-Safe.

*Variable 13—Ideal Frequency of Drinking.* Subjects were asked to indicate what they would consider to be "the ideal frequency of drinking alcohol for someone of your own age and sex?" by marking one point on a vertical single line graphic rating scale. The scale was marked at equal intervals with numbers representing frequencies which ranged from "7 days a week" to "1 day in 12 months" and finally "not at all." Equal-appearing intervals were treated as equal in converting responses into scores which ranged from 0 to 21.

*Variable 14—Ideal Frequency of Drunkenness.* The same graphic scale was used for the sake of convenience although in practice the majority of responses were placed at or near the lowest point on the scale. Again responses were converted to scores ranging from 0 to 21.

*Variable 15—Concern over Drinking.* For male samples 11 yes-no items each prefaced by the words, "Have you ever . . ." constituted a cumulative, or reproducible, scale (38, 39). For female subjects 9 of the same items constituted an internally consistent, but not reproducible, scale. Items with a relatively high frequency of endorsement included "Gone into a pub to drink

alone?"; "Felt that you had wasted too much money on drink?"; "Been aware of drinking more quickly than most other people you were with?" Items with a relatively low frequency of endorsement included "Felt guilty about your drinking?"; "Felt on at least one occasion that you were unable to control the amount you were drinking?"; "Deliberately decided not to drink alcohol anymore?"

*Variable 16—Experience of Intoxication.* Two 20-item reproducible scales, 1 for each sex, were derived from a pool of 25 items. The subsets of items are slightly different for the 2 sexes, 17 items appearing in both scales. Each item was prefaced by "How often has drinking alcohol made you . . .?" Five alternative replies were available ranging from "never" to "more than 25 times" but in computing total scale scores all replies other than "never" were assigned an equal weight. Items with a relatively high frequency of endorsement included "Feel dizzy"; "Less able than usual to think clearly"; "Noisier than usual." Items with a relatively low frequency of endorsement included "Speak incoherently"; "Unable to stand or move about without losing balance"; "Fall asleep in inappropriate circumstances."

*Variable 17—Complications of Drinking.* The following are examples of the 16 items included in this scale: "Failed or done badly in an examination?" "Been involved with the police in any way?" "Been evicted from a meeting, party or any other gathering?" "Been reprimanded about your drinking or advised to drink less by any person in authority such as a teacher or employer?" Items were prefaced by "How often as a result of drinking alcohol have you . . .?" and 4 alternative replies were available ("never"; "once"; "two or three times"; "more than three times") although in computing total scale scores all replies other than "never" were assigned equal weights.

*Variable 18—Morning-After Effects.* The following four items presented and scored in the same way were included in this scale: (1) "Suffered from uncontrollable shaking of hands or other part of your body?" (2) "Been unable to recall anything that happened to you over a lengthy period of time during the previous evening?" (3) "Had a patchy or unclear recollection of what happened to you the previous evening, not amounting to a total failure to recall a period of time?" (4) "Had what you would describe as a hangover?"

Some details of means or percentages in different response categories for several of these items are given in the Tables to section III of this report, which concerns sex differences.

### *Analysis*

Product-moment correlations between each possible pair of variables within this set of 18 variables were calculated for each sample separately after transforming the distributions of all variables so as to approximate normal distributions. Normalization was carried out to reduce the effects which could arise if a few subjects had extreme outlying scores on some variables. The effect of normalizing distributions was to increase slightly the size of correlations in most instances.

A principal-component analysis was carried out on each of the three resulting correlation matrices. Maximum Likelihood Factor analyses were also carried out and a number of alternative factor rotations were also tried. Although factor analysis followed by rotation produced more specific factors than were produced by principal-component analysis, the former procedures were unsuccessful in producing "pure" factors

which could be labeled "social drinking," "problem drinking," etc., and did not modify the conclusions to be drawn from the component analysis. As the latter provides a mathematically unique solution and as, in this case, it produced results which were more consistent between samples, it is these results which are presented.

## RESULTS

The correlations are shown in Table 1. With few exceptions, they are positive and significantly greater than zero.

Results for only two components are discussed as consistency between samples as well as interpretability breaks down beyond the second component. Although for each of the samples four components have latent roots above unity, components 3 and 4 appear to be of relatively little interest. Component 3 is largely specific to variables 10 to 14, all of which have moderate loadings in the same direction, and component 4, at least for the male samples, is on the whole specific to "effects" variables 7, 8 and 9. However, loadings for all the first four components are displayed in Table 2.<sup>5</sup>

When item loadings on component 1 are examined the similarity between samples is striking. Otherwise the main feature is the unipolar and general nature of this component, all 18 variables having positive loadings. The component appears to reflect a general involvement with, and appreciation of, alcoholic drinks. A diversity of variables, some concerning parameters of the extent of drinking experience, others reflecting concern and complications surrounding drinking, others concerned with stated relief motivation and the experience of psychological effects from drinking, all load in the same direction. Attitude variables also load in the same direction, adding weight to Straus and Bacon's (9) conclusion that consistency, or consonance, between drinking behavior and attitude is more apparent among students than is dissonance.

In terms of component 2, the similarity between the three samples is again striking. This component appears to represent a relatively great involvement in drinking (variables 2, 3, 4 and 6), a favorable attitude toward drinking (variables 10 for men, and

<sup>5</sup> The sum of squares of component loadings in Table 2 is the same for each component and is equal to unity. If an alternative presentation had been adopted, with sums of squares equal to eigen values, loadings on the first component would have appeared considerably larger.

TABLE 1.—*Intercorrelation Matrix of 18 Drinking Behavior and Attitude Variables in Three Student Samples\**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Drinking quantity		.50	.64	.33	.44	.54	.41	.25	.24	.14	.41	.11	.33	.34	.47	.54	.53	.47
		.51	.62	.37	.44	.49	.43	.33	.23	.28	.44	.18	.37	.39	.54	.58	.56	.46
2. Drinking frequency			.77	.58	.43	.40	.40	.27	.29	.24	.40	.09	.48	.28	.48	.53	.53	.42
	.60		.80	.61	.50	.41	.38	.23	.20	.31	.33	.09	.56	.32	.52	.55	.52	.43
3. Drinking style I				.46	.50	.45	.47	.28	.34	.25	.44	.11	.46	.31	.56	.61	.61	.48
	.66	.69		.55	.53	.45	.44	.31	.27	.31	.39	.12	.56	.38	.58	.62	.59	.50
4. Drinking style II					.30	.20	.31	.23	.25	.21	.21	.02	.35	.12	.22	.36	.26	.23
	.42	.67	.51		.33	.33	.32	.21	.14	.29	.23	.07	.43	.14	.35	.39	.36	.30
5. Relief of feelings motivation						.27	.43	.29	.37	.17	.36	.18	.26	.35	.51	.56	.58	.43
	.51	.52	.63	.47		.32	.42	.34	.36	.24	.35	.23	.35	.34	.61	.60	.58	.49
6. Expected tolerance							.27	.11	.17	.11	.26	.00	.23	.12	.35	.28	.39	.28
	.54	.42	.37	.30	.24		.30	.14	.15	.26	.31	.08	.29	.27	.35	.34	.38	.25
7. Extraversion effects								.54	.56	.19	.34	.22	.30	.29	.34	.55	.46	.39
	.43	.37	.46	.26	.45	.17		.59	.47	.28	.34	.22	.30	.34	.41	.52	.47	.36
8. Disinhibition effects									.32	.05	.15	.14	.20	.22	.36	.51	.40	.34
	.31	.33	.41	.22	.39	.04	.70		.35	.16	.27	.29	.19	.28	.34	.49	.36	.35
9. Intellectual stimulation effects										.13	.29	.20	.17	.24	.29	.43	.39	.33
	.33	.32	.41	.23	.42	.17	.58	.44		.18	.26	.22	.15	.23	.34	.40	.41	.28
10. Alcohol is for me—evaluative											.18	.07	.19	.12	.09	.13	.13	.10
	.15	.12	.17	.18	.12	.15	.16	.14	.15		.33	.10	.34	.21	.19	.27	.25	.13

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
11. My getting drunk would be—evaluative												.28	.32	.58	.27	.39	.38	.34
	.31	.21	.29	.11	.31	.18	.30	.27	.28	.18		.34	.32	.58	.38	.48	.46	.35
12. My getting drunk would be—potency—activity												.19	.22	.20	.17	.23	.13	
	.07	.07	.13	.00	.08	-.09	.31	.30	.36	-.02	.20	.17	.22	.23	.25	.25	.18	
13. Ideal frequency of drinking													.32	.25	.30	.30	.21	
	.37	.46	.42	.35	.36	.21	.23	.17	.18	.10	.14	.08	.35	.35	.40	.37	.27	
14. Ideal frequency of drunkenness														.26	.42	.37	.34	
	.25	.17	.24	.09	.25	.13	.26	.27	.25	.14	.36	.05	.36	.33	.44	.40	.37	
15. Concern over drinking															.62	.62	.52	
	.47	.42	.53	.30	.60	.29	.26	.24	.30	.02	.24	.05	.23	.16	.69	.67	.53	
16. Experience of intoxication																.70	.70	
	.57	.52	.64	.44	.59	.26	.53	.59	.50	.13	.37	.19	.32	.27	.58	.74	.70	
17. Complications of drinking																	.57	
	.51	.46	.55	.36	.59	.24	.44	.44	.47	.11	.26	.21	.25	.28	.55	.65	.61	
18. Morning-after effects																		
	.46	.44	.51	.36	.44	.26	.29	.40	.36	.10	.31	.08	.26	.24	.39	.62	.55	

\* Male sample correlations are shown above the diagonal, with Male A above Male B, and female correlations below the diagonal. Correlations are significant at  $p < .001$  at or above  $\pm .15$  for Male A and Male B and  $\pm .20$  for Female A; and are significant at  $p < .05$  at or above  $\pm .09$  for Male A and Male B and  $\pm .12$  for Female A.

TABLE 2.—Loadings of 18 Drinking Behavior and Attitude Variables on the First Four Principal Components for Each of Three Student Samples in Colleges A and B

	COMPONENT 1				COMPONENT 2				COMPONENT 3				COMPONENT 4				
	Male		Female		Male		Female		Male		Female		Male		Female		
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	
1. Drinking quantity	.27	.27	.29	.19	.09	.19	.02	.10	-.08	.02	.10	-.23	-.14	-.01			
2. Drinking frequency	.28	.27	.28	.33	.35	.26	-.00	-.09	-.00	-.08	-.09	.11	.07	.21			
3. Drinking style I	.31	.30	.31	.26	.26	.14	-.04	-.08	-.04	-.08	-.05	-.01	.01	.04			
4. Drinking style II	.19	.21	.23	.34	.37	.29	.03	-.07	.03	-.07	-.10	.43	.28	.29			
5. Relief of feelings motivation	.26	.26	.29	-.09	-.06	.06	-.05	-.18	-.05	-.18	-.11	-.06	-.06	-.15			
6. Expected tolerance	.19	.19	.17	.31	.23	.34	-.19	.14	-.19	.14	.29	-.27	-.06	.03			
7. Extraversion effects	.25	.24	.25	-.21	-.22	-.33	.01	.01	.01	.01	-.03	.35	.44	.24			
8. Disinhibition effects	.19	.19	.23	-.33	-.36	-.37	-.18	-.05	-.18	-.05	-.06	.35	.37	.13			
9. Intellectual stimulation effects	.20	.17	.23	-.28	-.35	-.31	.03	-.07	.03	-.07	-.04	.33	.35	.11			
10. Alcohol is for me—evaluative	.10	.15	.09	.23	.16	.01	.31	.45	.31	.45	.56	.30	.33	.43			
11. My getting drunk would be—evaluative	.22	.22	.17	-.02	-.13	-.20	.45	.46	.45	.46	.44	-.26	-.27	-.16			
12. My getting drunk would be—potency—activity	.10	.12	.09	-.33	-.36	-.44	.42	.31	.42	.31	-.24	-.07	-.03	.25			
13. Ideal frequency of drinking	.19	.21	.18	.25	.29	.20	.32	.23	.32	.23	-.11	.11	.10	.35			
14. Ideal frequency of drunkenness	.20	.21	.14	-.18	-.14	-.18	.42	.40	.42	.40	.50	-.28	-.32	-.25			
15. Concern over drinking	.26	.28	.24	-.07	-.04	.12	-.25	-.25	-.25	-.25	-.16	-.19	-.17	-.42			
16. Experience of intoxication	.31	.31	.32	-.17	-.12	-.08	-.17	-.18	-.17	-.18	-.08	-.01	-.11	-.14			
17. Complications of drinking	.30	.29	.29	-.11	-.09	-.07	-.15	-.17	-.15	-.17	-.13	-.15	-.15	-.23			
18. Morning-after effects	.26	.25	.26	-.16	-.12	.02	-.21	-.28	-.21	-.28	.00	-.14	-.27	-.23			
Percentage variance	39.1	41.8	38.6	8.1	8.9	10.0	7.2	6.5	7.2	6.5	6.6	6.5	5.8	5.8	6.0		

13), relatively unfavorable attitudes toward drunkenness (variables 11 and 14), denial of psychological effects from drinking (variables 7, 8 and 9), and particularly the holding of an “impotent-inactive” image of drunkenness (variable 12) at the positive pole and the opposites at the other pole. Unlike the first component, the second may be contrasting qualitatively different styles of involvement with alcohol.

The positive pole perhaps represents a more “mature” approach to drinking, greater experience of drinking being combined with an appreciation of drinking but not of drunkenness; the negative pole may in contrast represent a less “mature” approach which combines experience and appreciation of psychological effects from drinking and intoxication.

### DISCUSSION

A major aim of this part of the study was to develop criterion drinking variables for use in correlational analysis of social and psychological factors. This has been achieved and the second section of this report makes use of scores on the two components described above. In view of continuing interest in the structure of the drinking variable domain referred to in the introduction, however, the results of the component analysis are of interest in their own right.

Possibly the most important aspect concerning the first component is that it accounts for 40% of the variance. This percentage is large in absolute terms in view of the diversity of variables included and is certainly large in relation to the size of the next largest component. The implication would seem to be that drinking experience varies most strikingly between individuals in these samples in terms of individuals' relative positions on a general “involvement with and appreciation of alcohol” dimension. It follows that the most crucial descriptive statement which can be made about the drinking habits and attitudes of a student in one of these samples is a statement referring to his or her standing on such a dimension. In other words an answer to the question, “How much of a drinker is he or she?” will provide a more precise identification of that individual's drinking experience than will an answer to a question of the form, “What sort of drinker is he or she?”

A further consequence of the unipolar nature of this first major component is that no unambiguous interpretation of the meaning

of the component is possible from either a moral or an illness perspective. Neither high nor low positions on this dimension clearly constitute either an immoral or an unhealthy approach to drinking unless it be viewed from a position of adherence to total abstinence. The relative size of this first very general component will therefore give little comfort to those (e.g., 30, 42) who imagine that a contrast between healthy and unhealthy drinking practices and attitudes constitutes a major dimension in the drinking domain among young people.

It could be argued that the size of a general drinking component is inflated in a sample which includes very "heavy" and very "light" drinkers, especially in an age group characterized by rapid change and development of drinking behavior. At such a time the contrast between those who have developed adult drinking patterns and those who have not yet done so will be much larger than in either a younger or an older age group. In an older age group when the majority have developed adult drinking patterns qualitative differences in "style" may emerge as being more important. However, data on drinking frequency suggest that the drinking of these students is not particularly nonadult at least in terms of the frequency parameter. Among male students, 69.5% of those returning questionnaires reported drinking at least weekly and 5.0% reported drinking on 3 or fewer occasions in the previous 12 months. Among women students the equivalent numbers were 55.5% and 3.5%. As much weekly drinking and rather less abstinence or very infrequent drinking is therefore reported by these students as Edwards et al. (34) found among English middle-class urban adult householders.

A number of minor features of the pattern of component loadings support the interpretation that component 2 reflects relatively mature or immature styles of involvement. First, frequency of drinking (variable 2) has in each sample a higher loading on component 2 than does quantity of alcohol consumed (variable 1), showing that relatively large quantities consumed are less characteristic of the positive (mature) pole of this dimension than is a relatively high frequency of drinking. This is in contrast to component 1, where quantity and frequency have nearly identical loadings in all 3 samples. Second, whereas variable 3 (drinking style I) has the highest positive loading on component 1 and variable 4 (drinking style II) ranks only tenth in magnitude of loadings

on component 1, the relative position of these two variables is reversed in the case of component 2. The items included in these two "drinking styles" scales suggest that this feature of the results is consistent with the interpretation of the components given above. High scores on variable 3 indicate a relatively high frequency of drinking beer, in the evening, in single-sex company and in locations principally given over to the sale and consumption of alcohol. Contributing to variable 4 are items indicating, in contrast, a relatively high frequency of drinking wine (incidentally "sherry," "aperitifs" and "liqueurs" had a much closer association with this cluster of "style" items, "spirits" occupying a position intermediate between the two clusters), drinking with adults who have responsibility for the student, drinking with meals and drinking in locations where the consumption of alcohol is incidental to other activities. The latter features of drinking situations are just those often referred to as mature, healthy or safe, and reputed to characterize the predominant modes of consuming alcohol in countries with a high rate of consumption but a relatively low rate of alcoholism (30). Others (e.g., 13, 21) have discussed the role of integration of drinking into the family in preventing the development of drinking problems. Also relevant is the reference by Williams (43) to "the esthetic approach" to, or style of, drinking, in which drinking is slow and for the taste rather than for the effect.

A number of features of the pattern of the loadings on component 2, however, are rather less consistent with the interpretation offered above. First, although quantity has a lower loading than frequency, its loading is still positive where a negative loading might have been expected. However, it should be noted that "expected tolerance" or stated capacity for alcohol (variable 6) loads highly and positively. The positive loading of quantity might be due to a greater maturity or experience in drinking of individuals with relatively high scores on this dimension. A second difficulty lies in the near zero loadings of "relief of feelings motivation" (variable 5) which contrasts with the substantial positive loading of this variable on component 1. It is of some interest that this finding is in line with that of Park (37) who found a similar variable loading more highly on his "social drinking" factor than on his "problem drinking" factor. These findings either imply that "effect motivation" does not have the sinister significance often attributed to it or that scores on component 1 may be more predictive of future



problems than are scores on component 2. The third difficulty in making a clear interpretation of component 2 in maturity or health terms is the near zero or very small negative loadings on this component of "concern over drinking," "complications of drinking" and "morning-after effects" (variables 15, 17 and 18).

The absence here of an independent problem-drinking dimension and the positive loadings of "concern," "complications" and "morning-after effects" on the major general drinking dimension should be sufficient warning against assumptions about the possibility of predicting future problem drinking or alcoholism on the basis of the sort of information collected here. As Edwards (44) has pointed out, general adult population surveys have shown that problems connected with drinking are in many cases temporary and need not inevitably indicate an irreversible process of increasing alcohol dependence. The stability of the drinking patterns reported by these students shortly after entering college is quite unknown although a follow-up investigation carried out on the same samples 2 years later will enable us to comment on this in a subsequent report.

### *Limitations of the Study*

There are a number of cautions which should be kept in mind in interpreting the results presented here. First, there is the question of sampling. The present sample, in no way representative of the general population of this age group, is biased in terms of its predominantly middle-class background and its high level of educational advantage or achievement. Generalizations about drinking parameters such as frequency and quantity beyond the study population would be quite unwarranted. As these results are based on estimates of covariations, peculiarities of sampling may be thought to be less crucial. That the results are so consistent between sexes and in the men between two colleges which have very different images and offer different ranges of curricula is reassuring in this regard.

More serious is the fact that the response rate was substantially less than 100% and that there is an indication that the two extremes, heavy drinkers and lighter drinkers, may be underrepresented in the results. It could be argued that this has had the effect of restricting variance particularly on variables such as "concern" and "complications," thus preventing the emergence of a clear "problem-

drinking" dimension. This must remain an untested possibility but it seems to us unlikely. For one thing the extremity of a student's drinking behavior and attitudes must be only one among a number of reasons for reluctance to complete a questionnaire, and secondly we are unaware of any previous work suggesting that problem drinking exists as a dimension independent of general or social drinking among young people. In the only directly relevant piece of research known to us, Park (37) discussed the problem-drinking dimension which emerged from his analysis, but the factor solution which he adopted did not maintain the independence of factors and the correlation between his problem-drinking and social-drinking dimensions was positive. Even so, much room for independent variation of "problematic" and "nonproblematic" aspects of drinking experience remains, although, other things being equal, the two covary.

A further caution is that against too serious an interpretation of estimates of percentages of variance accounted for by components or of the precise component loadings of individual variables. These data are certain to vary depending upon the exact nature of the individual variables concerned and on the size and nature of the total pool of variables included in the analysis.

A final necessary caution concerns the inevitable weaknesses of data, including retrospective reports of behavior, obtained by means of a mail questionnaire.

## II. PERSONALITY AND SOCIAL INFLUENCE

Because of the wide variations in people's drinking habits and the apparent fact of drinking-related problems which affect some drinkers, much research has been directed toward discovering the causes of individual differences in drinking. The subjects for much of this research have been adolescents or young adults and, with the exception of a few studies which have used a longitudinal approach (45, 46, 47) and a relatively small number of experimental studies of drinking (e.g., 48, 49, 50), the majority have taken a cross-sectional survey approach similar to that adopted here.

Most of the possible causes, or correlates, of individual differences in young people's drinking which have been examined fall into one of three rough categories. Many investigators (e.g., 8, 9, 13, 15) have examined social and cultural factors such as race, country, religion and socioeconomic status while at a more mo-

lecular level are those who have investigated matters under the general headings of, first, social influence and, second, personality. Under social-influence factors there have been repeated demonstrations of the influence of parental example and friendship-group consensus (e.g., 9, 22, 51-56). Under personality may be grouped studies correlating drinking variables with alienation and self-esteem (6, 10), expectations for need satisfaction (15, 18), anxiety and depression (17, 18, 49) and dependency and sex-role conflict (57, 58). Also relevant are longitudinal studies which characterized prealcoholic men as unrestrained, aggressive, impulsive and rebellious (45, 46) and studies which refer to the antisocial symptoms of prealcoholic boys (47) or to the personality disorders of young alcoholics (26, 59). This is by no means a comprehensive list of personality concepts which have been used in this area of research, but it serves to demonstrate the variety, and arbitrariness, of the concepts chosen. Social attitudes, as distinct from personality, appear to have been relatively neglected although an inverse relationship between religiosity and extent of drinking or positiveness of attitude toward drinking (4, 60) has been demonstrated.

With rare exceptions (e.g., 19) the influence of variables from more than one of these broad areas of investigation has not been examined in the same study. A major purpose of the research reported here was to investigate both social influence and personality factors in the course of the same investigation in order to estimate roughly their relative importance. The sample employed, university students, could reasonably be expected to be heterogeneous with regard to variables under both these headings but is clearly far too homogeneous with regard to variables at the sociocultural level for any estimate of their relative importance to be made.

## METHOD

### Sample

The samples are those described in section I. The 1323 completed questionnaires, upon which the following results are based, represent a 76% return rate.

### *Variables Derived from Questionnaire Data*

#### 1. Personality.

(a) The Eysenck Personality Inventory (EPI)—Form A was used. From this 57 Yes-No item questionnaire can be derived scores for Extraversion and Neuroticism (anxiety) which the inventory manual claims

are "the two most important dimensions of personality" (61). Indeed if attention is limited to questionnaire measures of personality variables there would appear to be much evidence to substantiate this claim (62). A Lie Scale, designed to reveal the extent of lying or "faking good," can also be derived. Following are the mean scores ( $\pm$ SD) of the three samples of students: Extraversion—college A men,  $11.31 \pm 4.30$ ; college B men,  $10.84 \pm 4.29$ ; college A women,  $11.67 \pm 4.15$ ; Neuroticism—college A men,  $11.30 \pm 4.59$ ; college B men,  $11.00 \pm 4.17$ ; college A women,  $13.10 \pm 4.66$ .

(b) An Adventurous-Pleasure-Seeking Scale was designed for this study to assess an individual's involvement in activities other than drinking which might be styled as risky, pleasurable, mildly adventurous, sensation providing, against the "official morality" or marginally delinquent. The scale consisted of five multiple-choice items: recent frequency of dating; current frequency of smoking cigarettes; frequency of breaking the law "ever"; maximum speed traveled by car or motor-bike; recent frequency of attendance at religious services (scored in a direction opposite to that of the other items). Item analysis showed a satisfactory degree of internal consistency for this scale.

(c) Social attitude inventory (63, 64) from which scores on Radicalism-Conservatism and Tender-Tough-mindedness can be derived. These have been demonstrated to be two general dimensions of social attitude identifiable in a number of age, socioeconomic-status and sex groups in the United Kingdom (63, 65). Items are presented in 5-choice answer form and only 16 items which previous factor analytic studies (64) have shown load most highly on either of the factors were included.

#### 2. Social Influence

(a) *Fathers', Mothers' and Friends' QF Index.* The students were asked to provide estimates of the frequency and quantity of drinking during the last 12 months by their father (or male guardian), their mother (or female guardian) and by each of their two "closest" friends. The format used for these questions was identical to that used when asking the respondent for estimates of his own drinking and is described above in section I. Briefly, estimated frequency (F) was obtained by a single question with a choice of 8 answers ranging from "Every day or nearly every day" to "No day in the last 12 months" and estimated "Average quantity per drinking day" (Q) was obtained by a grid method which required respondents to estimate roughly the proportions of drinking days on which various quantities had been consumed. The QF index was simply the product of Q and F after converting answers to the frequency question into an approximate number of days out of a possible 365. The friends' QF index was obtained by averaging the two QF indices derived for the two nominated friends separately. It was stipulated that the friends should be of the same sex as the subject and should have been "closest" to him or her "over the longest periods of time during the previous 24 months." The fathers

of the college A men had a median QF score of 93 drinks per year (25% had 365 drinks or more); the mothers' QF score was 30 drinks per year (6% had 365 drinks or more). The scores of the other two samples were very similar.

(b) *Fathers'-Mothers' Approval.* The students were asked to indicate the likely extent of their parents' (or guardians') approval or disapproval if the respondent were to commit each of 11 drink-related behaviors which ranged from the innocuous (e.g., "Drink alcohol at home," "Drink 3 or 4 drinks on one occasion") to the relatively more serious (e.g., "Be drunk at home," "Drive a car after being affected by drink"). Each item was presented in 5-choice format with answers ranging from "Would strongly approve" to "Would strongly disapprove." The respective items were summed to provide a single "Father's approval" score and a single "Mother's approval" score. Item analyses showed satisfactory levels of internal consistency for these scales. Parents' disapproval of these four behaviors was reported by 13-20, 36-47, 91-94 and 97% of the men students. Among the women, 11-14, 56-64, 94 and 98% reported that their parents would disapprove. Mothers were reported to be slightly more disapproving than fathers.

### 3. Criterion Drinking Variables

The major criterion drinking variables with which personality and social-influence variables were correlated were scores on the first 2 principal components derived in the first section in this report: Scores on principal-component 1 reflect the general extent of, and favorableness of attitude toward, all aspects of drinking experience. High positive scores on principal-component 2 reflect a greater appreciation and experience of drinking per se than of intoxication, while low scores reflect the reverse, namely a greater appreciation and experience of intoxication than of drinking itself.

Correlations of personality and social-influence variables with two other drinking variables will also be reported. These are, first, reported frequency of drinking and, second, a cluster of intercorrelated variables suggesting problem drinking. Although both the frequency variable and each of the variables constituting the "drinking-related problems cluster" have positive loadings on the first major drinking component, the correlation between the two is .59 to .60 for each of the three samples. Although these correlations are highly significant for samples of this size, they are sufficiently small to leave open the possibility of finding that "frequency" and "problems" have somewhat different personality and social-influence correlates.

The two additional drinking variables are therefore: (c) Reported drinking frequency during the previous 12 months (a single question, with eight available answers ranging from "Every day or most days" to "No days in the last 12 months") and (d) Drinking-related problems cluster—the sum of scores on a cluster of five intercorrelated scales

("concern over drinking," "experience of intoxication," "complications of drinking," "morning-after effects" and "relief of feelings motivation").

### Hypotheses

On the basis of previous research in alcohol and related social fields, the expectation was that each of the personality and social-influence variables (with the exception of lie-scale scores and scores on the radicalism scale about which no particular expectations were held, and tender-mindedness where a negative correlation was expected) would be positively correlated with scores on drinking component 1. These predictions were made for all samples, except father's QF index (where the prediction was for men only) and mother's QF index (women only).

Owing to the sizable correlation between drinking frequency and drinking-related problems, expectations were on the whole the same again for each of these two drinking variables except that extraversion was expected to correlate more highly with the former and neuroticism (anxiety) with the latter.

The only prediction made regarding the correlates of component 2 was that neuroticism would correlate negatively.

### Analysis

Product-moment correlations were computed between each of the 11 personality and social-influence variables and each of the 4 criterion drinking variables after normalizing the distributions of all variables. Intercorrelations of the 11 personality and social-influence variables were also calculated and, in view of the many significant correlations in this  $11 \times 11$  matrix, partial correlations between each of these variables and criterion drinking variables were computed to estimate the independent contribution of each variable. Fifth-order partial correlations (i.e., partialling out the effects of 5 other personality variables) were obtained in the case of personality variables and 4th-order partials were obtained for each social-influence variable (i.e., partialling out the effects of 4 other social-influence variables).

## RESULTS

Table 3 shows the three  $11 \times 11$  correlation matrices of personality and social-influence variables.

Tables 4 to 7 show the zero-order and partial correlations with criterion drinking variables, those involving the two principal components in Tables 4 and 5 and those involving the "frequency" and "problem" criteria in Tables 6 and 7. Correlations of personality and social attitudes appear in Tables 4 and 6 and those concerning

TABLE 3.—Intercorrelation Matrix of Six Personality and Social-Attitude Variables and Five Social-Influence Variables for Each of Three Student Samples<sup>a</sup>

	1	2	3	4	5	6	7	8	9	10	11
1. Extraversion		-.19†	-.17†	.33†	.01	-.14†	.04	.05	.29†	.15†	.09
2. Lie scale	-.25†		-.17†	.32†	.03	-.15†	.03	.06	.23†	.00	-.01
3. Neuroticism	-.05	-.17†	-.29†	-.27†	-.14†	.19†	-.05	-.07	-.25†	-.13†	-.09
4. Adventurous pleasure-seeking	.32†	-.29†	.05	-.29†	-.09°	-.10°	-.07	-.06	-.23†	-.10°	-.08
5. Radicalism	.06	-.09	.01	-.04	.12†	.00	-.02	-.04	.01	-.10°	-.06
6. Tender-mindedness	-.09	.18†	-.05	.07	.10°	-.07	.03	.05	.06	.02	.04
7. Father's QF index	.16†	-.12°	.12°	.07	.21†	-.41†	.20†	.21†	.38†	.28†	.28†
8. Mother's QF index	.09	-.14°	.04	.36†	.19†	-.39†	.17†	.19†	.40†	.16†	.16†
9. Friends' QF index	.19†	-.05	.09	.01	-.18†	-.18†	-.02	.00	.18†	.03	.02
10. Father's approval	.18†	-.11	.04	-.45†	-.24†	-.18†	.06	.07	.17†	.06	.04
11. Mother's approval	.12°	-.11	.04	.33†	.06	-.15°	-.06	-.04	-.19†	-.13†	-.12†
				.26†	.11	.19†	-.08	-.09°	-.26†	-.09°	-.12†
				.28†	.04	.48†	.61†	.54†	.24†	.54†	.31†
				.45†	.19†	.19†	.29†	.61†	.34†	.53†	.27†
				.28†	.09	.61†	.31†	.29†	.28†	.32†	.45†
				.33†	.06	.25†	.54†	.31†	.31†	.36†	.47†
				.28†	.09	.24†	.29†	.31†	.28†	.28†	.25†
				.06	-.17†	.25†	.54†	.31†	.25†	.25†	.23†
				-.14°	.09	.61†	.31†	.31†	.24†	.25†	.70†
				-.17†	.06	.25†	.54†	.31†	.24†	.25†	.68†

<sup>a</sup> Male samples are shown above the diagonal with male A above male B and the female sample is below the diagonal.  
 °  $P < .05$ . †  $P < .01$ . ‡  $P < .001$ .

social influence appear in Tables 5 and 7. The main results from Tables 3-7 are as follows.

*Personality and Social Attitudes*

1. *Intercorrelations of Personality and Social-Attitude Variables* (Table 3, top left). There is considerable redundancy involved in the use of these six scales. Major positive correlations for all three samples ( $p < .001$ ) exist between extraversion and adventurous pleasure-seeking and between radicalism and adventurous pleasure-seeking. There are major negative correlations for all three samples between the lie scale and both extraversion and adventurous pleasure-seeking, as well as between tender-mindedness and each of the two scales, adventurous pleasure-seeking and radicalism. In addition there are less consistently significant correlations between a number of other variables.

2. *Correlations of Personality and Social-Attitude Variables with Drinking Component 1* (Table 4, top half). Multiple correlations between personality and social-attitude variables collectively and

TABLE 4.—Correlations between Principal-Component Drinking Variables and Six Personality and Social-Attitude Variables for Each of Three Student Samples in Colleges A and B<sup>a</sup>

	COMPONENT 1					
	Male A		Male B		Female A	
Extraversion	.37†	.27†	.37†	.26†	.36†	.24†
Lie scale	-.32†	-.16†	-.34†	-.16†	-.36†	-.15°
Neuroticism	.07	.11°	.15†	.13†	.28†	.31†
Adventurous pleasure-seeking	.52†	.35†	.48†	.28†	.62†	.44†
Radicalism	.28†	.20†	.19†	.10°	.28†	.08
Tender-mindedness	-.31†	-.09	-.32†	-.16†	-.39†	-.17†
Multiple correlation	.62†		.59†		.71†	
COMPONENT 2						
Extraversion	.06	-.04	.06	-.04	-.01	-.08
Lie scale	.00	-.02	.03	.04	.02	.00
Neuroticism	-.28†	-.26†	-.16†	-.16†	-.23†	-.24†
Adventurous pleasure-seeking	.15†	.17†	.22†	.25†	.12	.18†
Radicalism	-.14†	-.14†	-.06	-.09°	.02	-.03
Tender-mindedness	-.01	.04	-.04	.03	.04	.11
Multiple correlation	.34†		.30†		.29†	

<sup>a</sup> Zero-order correlation coefficients are shown in roman face and fifth-order partials in boldface type.  
 °  $P < .05$ . †  $P < .01$ . ‡  $P < .001$ .

TABLE 5.—Correlations between Principal-Component Drinking Variables and Five Social-Influence Variables for Each of Three Student Samples in Colleges A and B\*

	C O M P O N E N T 1					
	Male		Male		Female	
	A		B		A	
Father's QF index	.25†	.01	.32†	-.02	.33†	.05
Mother's QF index	.29†	.06	.35†	.11°	.41†	.17†
Friends' QF index	.58†	.52†	.62†	.56†	.53†	.45†
Father's approval	.33†	.06	.34†	.12†	.36†	.11
Mother's approval	.33†	.09	.31†	.03	.37†	.03
Multiple correlation	.62†		.66†		.62†	
	C O M P O N E N T 2					
Father's QF index	.18†	.05	.18†	.07	.23†	.11
Mother's QF index	.19†	.07	.20†	.03	.25†	.07
Friends' QF index	.20†	.14†	.26†	.20†	.14°	.05
Father's approval	.16†	.02	.12†	-.05	.19†	-.02
Mother's approval	.15†	.02	.16†	.08	.23†	.10
Multiple correlation	.26†		.30†		.31†	

\* Zero-order correlation coefficients are shown in roman face and fourth-order partials in boldface type.

°  $P < .05$ . †  $P < .01$ . ‡  $P < .001$ .

TABLE 6.—Correlations of Drinking Frequency and Problem Variables with Six Personality and Social-Attitude Variables for Each of Three Student Samples in Colleges A and B\*

	D R I N K I N G F R E Q U E N C Y					
	Male		Male		Female	
	A		B		A	
Extraversion	.31†	.18†	.29†	.17†	.33†	.21†
Lie scale	-.21†	-.08	-.26†	-.11°	-.27†	-.10
Neuroticism	-.06	-.03	.06	.03	.12	.11
Adventurous pleasure-seeking	.45†	.33†	.42†	.27†	.47†	.31†
Radicalism	.14†	.06	.12†	.03	.15°	-.02
Tender-mindedness	-.19†	.00	-.25†	-.10°	-.26†	-.07
Multiple correlation	.48†		.48†		.53†	
	D R I N K I N G P R O B L E M S					
Extraversion	.33†	.23†	.33†	.24†	.27†	.12
Lie scale	-.32†	-.15†	-.34†	-.15†	-.33†	-.12
Neuroticism	.15†	.19†	.21†	.20†	.33†	.37†
Adventurous pleasure-seeking	.49†	.34†	.44†	.26†	.63†	.50†
Radicalism	.28†	.20†	.20†	.11°	.29†	.10
Tender-mindedness	-.28†	-.07	-.27†	-.11°	-.36†	-.10
Multiple correlation	.61†		.57†		.72†	

\* Zero-order correlation coefficients are shown in roman face and fifth-order partials in boldface type.

°  $P < .05$ . †  $P < .01$ . ‡  $P < .001$ .

TABLE 7.—Correlations of Drinking Frequency and Problem Variables with Five Social-Influence Variables for Each of Three Student Samples in Colleges A and B\*

	D R I N K I N G F R E Q U E N C Y					
	Male		Male		Female	
	A		B		A	
Father's QF index	.30†	.08	.37†	.10°	.29†	.07
Mother's QF index	.34†	.09	.35†	.07	.39†	.20†
Friends' QF index	.51†	.43†	.57†	.49†	.42†	.34†
Father's approval	.30†	.00	.30†	.03	.25†	.03
Mother's approval	.32†	.11°	.28†	.05	.29†	.01
Multiple correlation	.57†		.61†		.52†	
	D R I N K I N G P R O B L E M S					
Father's QF index	.17†	.02	.24†	-.06	.29†	.07
Mother's QF index	.18†	-.01	.28†	.11°	.37†	.10
Friends' QF index	.48†	.43†	.54†	.49†	.51†	.43†
Father's approval	.23†	.02	.26†	.11°	.33†	.06
Mother's approval	.22†	.06	.23†	-.03	.38†	.10
Multiple correlation	.49†		.56†		.59†	

\* Zero-order correlation coefficients are shown in roman face and fourth-order partials in boldface type.

°  $P < .05$ . †  $P < .01$ . ‡  $P < .001$ .

component 1 as criterion range from .59 to .71 in the three samples. Major positive partial correlations with the criterion exist for adventurous pleasure-seeking and extraversion, the correlation with the former being the higher of the two in all three samples, especially among the women. Minor partial correlations ( $p$  at least  $< .05$  in all samples) with the criterion concern the lie scale (negative correlations) and neuroticism (positive). The positive correlation with neuroticism is considerably higher in the women.

3. *Correlations of Personality and Social-Attitude Variables with Drinking Frequency* (Table 6, top half). Multiple correlations with the drinking-frequency criterion are in the range .48 to .53. Although the pattern of partial correlations with this criterion is similar to that of correlations with the component 1 criterion, all correlations are reduced so that only those concerning adventurous pleasure-seeking and extraversion are significant in all samples, other variables producing significant partial correlations in, at most, one sample.

4. *Correlations of Personality and Social-Attitude Variables with the Drinking-Related Problems Cluster* (Table 6, lower half). Multiple correlations with this criterion range from .57 to .72. Again there are major positive partial correlations with adventurous pleas-

ure-seeking (considerably higher in the women) and extraversion (with the exception of the women for whom this correlation is not significant), but in addition there are major positive correlations with neuroticism (considerably higher in the women).

5. *Correlations of Personality and Social-Attitude Variables with Drinking Component 2* (Table 4, lower half). Multiple correlations with the component 2 criterion range from .29 to .34. Only two scales have consistently significant partial correlations: neuroticism (major negative correlations) and adventurous pleasure-seeking (positive correlations).

### *Social Influence*

1. *Intercorrelations of Social-Influence Variables* (Table 3, bottom right). Major correlations exist in all samples between students' reports of their fathers' and mothers' drinking behavior, also between perceived attitudes of fathers and mothers toward their child's drinking and also, for parents of each sex separately, between reported behavior and perceived attitude. Major, but lower, correlations also exist between the reported drinking behavior of closest friends and all four parental variables (father's QF index vs friends' QF index for women being the single intercorrelation which is only significant at a lower level,  $p < .01$ ).

2. *Correlations of Social-Influence Variables with Drinking Component 1* (Table 5, top half). Multiple correlations range from .62 to .66 and zero-order correlations of all five social-influence variables with the component 1 criterion are highly significant. However, when the intercorrelations among the social-influence variables are allowed for by calculating fourth-order partial correlations, only those involving friends' QF index remain highly significant.

3. *Correlations of Social-Influence Variables with Drinking Frequency* (Table 7, top half). Multiple correlations range from .52 to .61 and the pattern of individual variable correlations is similar to that for the component 1 criterion. Only partial correlations with friends' QF index are highly significant (somewhat lower in women).

4. *Correlations of Social-Influence Variables with the Drinking-Related Problems Cluster* (Table 7, lower half). Multiple correlations range from .49 to .59 and the pattern is again similar, the only noteworthy individual partial correlations being highly significant positive correlations with friends' QF index.

5. *Correlations of Social-Influence Variables with Drinking Component 2* (Table 5, lower half). Multiple correlations are in the range of .26 to .31. No individual partial correlation is significant in the women and only friends' QF index provides minor positive partial correlations for the two samples of men.

6. *Intercorrelations between Personality and Social-Influence Variables* (Table 3, top right and bottom left). There are a number of significant relationships between personality and social-attitude variables on the one hand and social-influence variables on the other. Parental drinking variables (reported behavior and perceived attitude of both mothers and fathers) correlate significantly and positively with adventurous pleasure-seeking in all samples but scarcely at all with other personality and social-attitude variables, with the possible exception of minor negative correlations with tender-mindedness. On the other hand, friends' QF index has more wide-ranging correlations, at least in the samples of men where there are major positive correlations with adventurous pleasure-seeking and correlations of lower magnitude with extraversion and radicalism (positive) and the lie scale and tender-mindedness (negative).

### DISCUSSION

#### *Extraversion*

The results support the prediction of a positive correlation between scores on the extraversion scale and scores on the first, general, principal component. It will be recalled that high scores on component 1 indicate reports of relatively great involvement in various aspects of drinking, as indicated by reports of greater frequency of drinking, quantity of alcohol consumed, greater experience of intoxication, more concern about the effects of drinking, as well as relatively favorable attitudes toward both drinking per se and drunkenness. The predictions regarding correlations with extraversion were made on the grounds that the latter scale combines elements of sociability and impulsiveness (66).

It might be expected that sociability would influence the extent of drinking experience and the favorableness of attitude toward drinking on the grounds that the more extraverted person would be more highly motivated to spend resources of time and money in the pursuit of social goals and that in the course of this pursuit such a person would have more opportunity for drinking. It might

also be expected that impulsiveness would influence drinking, following the findings of a number of longitudinal studies (45, 46, 47) which suggest that adolescent impulsiveness may predict future problem drinking. An analysis subsidiary to that reported above suggested that both aspects of extraversion contributed to the correlations but that sociability was the more influential of the two.

The over-all finding regarding extraversion is consistent with previous results regarding the relationship between sociability and late adolescent drinking which are summarized by Stacey and Davies (24), as well as with the findings of Edwards et al. (67), who report, in a normal adult sample, a regular increase in QF score with increase in extraversion. It is of some interest that extraversion has also been reported to relate positively to extent of smoking among preadult subjects (68) as well as to extent and variation of, and satisfaction with, sexual behavior among students (69).

The further prediction was made that extraversion would correlate more highly with nonproblematic aspects of drinking than with problematic aspects. This prediction gains no support whatever in the two male samples, both zero-order and partial correlations being somewhat higher for drinking-related problems than for frequency of drinking, but received some support from the female sample. The finding in men is similar to that reported by Lundin and Sawyer (17) that the number of extracurricular activities in which students took part was a better correlate of their "effects" measure (which appears to be a "self-report of drunkenness" measure) than was anxiety.

### *Neuroticism*

Individual predictions concerning the correlates of neuroticism received clearer support, correlations with drinking-related problems being significant while those with drinking frequency were not. However, only in the female sample do the correlations of neuroticism with component 1 and with problems rise above .30 and only in the female sample are the partial correlations higher than the parallel correlations with extraversion. Also as predicted, neuroticism is the only one among the 11 personality, social-attitude and social-influence variables to correlate (negatively, significantly and consistently across samples) with scores on component 2, indicating that the more anxious student is somewhat more likely to endorse pro-drunkenness attitudes, to report that drinking more

consistently makes him merry, disinhibited and intellectually stimulated, and to perceive the "potency" of drunkenness.

There is therefore some support for the widespread and long-standing notion that differences in anxiety levels are implicated in individual differences in drinking behavior and attitudes. Lundin and Sawyer (17) also report a correlation of .22 between scores on an anxiety scale and scores on their "effects" measure and Williams (49) reported a positive correlation between adjective check list anxiety scores and students' scores on a problem-drinking scale.

The use of product-moment correlations is of course based on the assumption of a linear relationship between two variables and in the case of anxiety Smart (18) predicted, and obtained some evidence for, a curvilinear relationship between student anxiety and drinking frequency, highest drinking frequencies being found at moderate anxiety levels. Using the present data, we examined bivariate distributions of neuroticism plotted against a combined QF index in all three samples, and no evidence of a curvilinear relationship was found. The only increase in average QF occurred in both sexes at the highest levels of neuroticism, 1 standard deviation or more above the sample mean.

It is possible to speculate on the somewhat different pattern of correlations found for the two sexes. At least in the case of drinking problems, extraversion is relatively more important for men, neuroticism for women. Combined with the fact that the experience of extreme intoxication, a relatively large number of social complications attributed to drinking, higher levels of concern over drinking and experience of morning-after effects are all considerably more common among male than female students, these findings may be interpreted as lending some support to a vulnerability-acceptance hypothesis (70, pp. 28-29). This cluster of drinking-related problems, being less common among the women, is more highly related to psychological vulnerability, while, being more common among the men, is more likely to be found among the more sociable. The relative importance of extraversion and neuroticism may therefore be seen as a reflection of the relative acceptance of behaviors among different groups. In a similar vein, Stacey and Davies (24), quoting research by Windham and Preston (71) which suggested that sociability was unrelated to drinking in early adolescence but was related after age 15, speculate that

this age difference is due to the greater deviance of drinking at the earlier age. It would be wrong, however, to equate female students in this study with early male adolescents in this regard, as it will be noted that drinking frequency is as strongly correlated with extraversion in women as it is in men. The sex difference lies in correlations with problems and it would be interesting to know how unique male late adolescents or early adults are in this culture in showing this pattern of correlations. An English drinking survey of adults (67) has shown drinking-related problems to be most frequent among young adult men and it is conceivable that it is among this age-sex group, and no other, that drinking-related problems are sufficiently frequent, and sufficiently acceptable, to be more strongly related to gregariousness and sociability than to any aspect of personality which has implications for psychological disturbance.

### *Lie Scale*

Although considerably reduced after partialling out the effect of other personality and social-attitude variables, the significant correlations between lie-scale scores and scores on component 1 in all samples, and with drinking-related problems in the men, suggest that there may be an influence, although not a great one, of reporting bias. Students who may be most motivated to "fake good" report relatively slight drinking experience and fewer problems. Although this may be the most likely explanation of these correlations, there is an alternative interpretation. It is conceivable that persons who endorse items included in the lie scale, such as, "Are all your habits good and desirable ones?" or refute items such as "Once in a while do you lose your temper and get angry?" are more inclined to obey the dictates of "official morality" on matters of social habit and behavior and are therefore relatively unlikely to drink in a way which incurs effects of drinking, complications and problems. On the face of it, it would seem likely that there is some truth in both interpretations and that such people are less likely to do such things, and less likely to admit to doing them if they do. The first interpretation, however, is in line with the suggestion, based on a comparison of survey research data and alcohol sales data, that survey questions on drinking produce a great deal of underreporting (72).

### *Social Attitudes*

In the case of tender-mindedness the predictions were supported by the existence of significant negative correlations in all three samples between this variable and scores on component 1, drinking frequency and problems. Partial correlations, however, were mostly insignificant owing mainly to the substantial negative correlations between tender-mindedness and adventurous pleasure-seeking. As is the case with many of the variables studied here, it could be argued that partial correlations are misleading. In this case, for example, the influence of tender-mindedness versus tough-mindedness as a social attitude may be unduly minimized by partialling out the effect of a variable such as adventurous pleasure-seeking. The latter might be construed as a relatively superficial variable reflecting individual differences in recent behavior in contrast to the more fundamental, and perhaps more stable, social attitudes of tough- or tender-mindedness. The importance of a tough self-image, combined with a more latent tenderness or femininity, in predicting future problem drinking was stressed by McCord et al. (45) and indeed there is some evidence for such "self-role strain" or "sex-role identity conflict" among the heaviest drinkers in high school (58) and college (73).

No predictions were made regarding radicalism but on the whole the correlations with component 1 and drinking problems are positive. Partial correlations are much reduced, mainly owing to the correlation of this variable with adventurous pleasure-seeking. Individual items of the radicalism scale show that high scores indicate, among other things, nonpunitive attitudes toward criminality, permissiveness regarding sexual matters and nonadherence to religious dogma on matters of morality. Although scores on this scale relate to political attitudes (63) it is probably the permissiveness versus restrictiveness element which is important in regard to drinking-related matters. That it is problems rather than drinking frequency which relates more strongly to radicalism may be seen as consistent with findings relating radicalism to illicit drug use (74, 75).

### *Adventurous Pleasure-Seeking*

This scale, designed especially for this study, provided the highest correlations, both zero-order and partial, among the personality



and social-attitudes set, with scores on component 1, drinking frequency and problems. High scorers on this scale are more likely to "date," smoke, drive fast and admit breaking the law and are less likely to go to church than others. That these behaviors correlate with each other and collectively with reports of drinking behavior was predicted. It is also consistent with evidence that smoking, drinking and the taking of other drugs tend to go together (76, 77),<sup>6</sup> evidence that drinking, smoking and premarital sexual behavior go together also (78), and that religious involvement covaries with restrictiveness regarding such issues as smoking and drinking where the moral issues involved are relatively ascetic in nature (60). It is also consistent with evidence reviewed by Stacey and Davies (24) that youth showing delinquent behavior are more likely to drink than others but that the link between drinking and delinquent behavior is not a simple causal one but rather reflects a general style of behavior.

It has already been noted that this variable, which we have somewhat arbitrarily called adventurous pleasure-seeking, is conceptually at a rather different level from the remainder of the personality and social-attitude variables. Its constituent items are phrased in the form of questions regarding recent behavior rather than in the form of questions about attitudes or questions of the form "what sort of person are you?" In a sense it is therefore conceptually somewhat closer to reported drinking variables with which it is correlated than are the other personality and social-attitude variables, and the greater magnitude of its correlations may be understandable in this way. It could be more appropriate to argue that students with radical and tough-minded social attitudes, or, alternatively, students who are more extraverted and less motivated to "fake good," are predisposed to greater involvement in a variety of adventurous pleasure-seeking behaviors of which drinking is but one, than to say that the influence of personality and social attitude is small beside the influence of behavioral style.

If an attempt were made to reconceptualize adventurous pleasure-seeking at a more traditional "personality" level, this might be done by linking it with radical tough-mindedness of attitude or a combination of extraversion and low motivation to "fake good."

<sup>6</sup> Also EWING, J. A., ROUSE, B. and BAKWELL, W. E. Alcohol use in a student population. Presented at the 29th Congress on Alcoholism and Drug Dependence, Sydney, Australia, February 1970.

However, there may be closer parallels with other personality constructs employed in other investigations of drinking and drug-taking, such as under-control (46, 47),<sup>6</sup> personal power or assertiveness (20), danger-seeking (79) or activity level (80).

### *Peer Influence*

Highly significant positive correlations exist in all samples between the measure of peer influence employed here and scores on component 1, drinking frequency and problems. This is consistent with similar findings relating drinking and friends' drinking in various countries and ethnic groups (e.g., 9, 22, 81, 82). Results regarding smoking are very similar (83).

The nature and direction of this influence are, however, unclear. Consensus in friendship groups may be attributed to the formation of groups on the basis of similarity in drinking behavior or attitude, or on the basis of similarity in interests, social attitudes or personality characteristics which predispose to alcohol use of a certain amount and type. Alternatively consensus may be attributed to processes occurring after the formation of friendship groups, such as attitude change on the part of "deviant" members under the influence of a majority, or self- or other-imposed exclusion of deviant members from the group. In all probability consensus may be attributed to all these mechanisms and possibly others. Alexander (55) reported a relationship between a high level of consensus in all-drinking groups and student "legitimation" of behavior when parental or societal permissiveness regarding the behavior is low. In the case of drinking among the students in this study, however, the need for legitimation of preexisting illicit drinking as a major motive for consensus among friendship groups seems unlikely. Rather than being formed with drinking in mind it would seem more likely that friendships are, for the most part, formed on the basis of accidental propinquity and similarity of social attitudes and interests. As some of these attitudes and interests, such as tough-mindedness or interest in adventurous pleasure-seeking activities, are related to drinking a certain degree of consensus in drinking behavior and attitude is likely to occur spontaneously in friendship groups. Further degrees of consensus may be brought about by a process of "behavioral contagion" during the life of a friendship group as a result of time spent together and the sharing of activities.

Correlations of both father's and mother's drinking, as reported by the student, and perceived parental approval of the student's own drinking with scores on component 1; drinking frequency and problems are significant and positive in all samples as predicted when zero-order correlations alone are considered. These results are consistent with previous findings (e.g., 9, 23) and with suggestions of a relationship between adult problem drinking or alcoholism and heavy parental drinking (24).

Four separate parental-influence variables were considered in order to estimate the relative influence of father's versus mother's influence and behavioral example versus perceived approval or disapproval, but the results strongly suggest that these influences are for the most part consistent and that no one of them appears to be more important than any of the others. What is most noticeable about this section of the results, however, is the relatively low magnitude of correlations involving parental-influence variables in comparison with those involving friends' drinking and the insignificant magnitude of most of the former once the contribution of friends' drinking is removed. Almost the only aspect of parental influence which appears to operate independently of peer influence is that of the example of mother's drinking on daughters' scores on component 1 and on daughters' drinking frequency. Even here the partial correlations are of only borderline significance. Once again, however, the use of partial correlations might misleadingly suggest the conclusion that parental example and approval has no influence on adolescent or early adult drinking. It seems reasonable to suppose that parental influence began to operate at an earlier age than did peer influence and operated over a longer period of time. Indeed parental characteristics associated with drinking may be among those factors influencing the level of drinking in their children's friendship groups.

Before leaving the issue of parental influence it is worth remarking on the pattern of correlations of social-influence variables with scores on drinking component 2. The pattern of correlations is similar to that for the first component although correlations are in all cases substantially lower. Nonetheless zero-order correlations are all positive and the multiple correlation of social-influence variables collectively with scores on component 2 range from .26 to .31 in the three samples. This seems to indicate that, quite apart

attitude toward aspects of drinking experience (reflected in scores on component 1), drinking experience and favorableness of attitude to drinking per se coupled with an unfavorable attitude to drunkenness (reflected in high scores on component 2) are correlated with a general positiveness of social influence. To put it another way, the latter combination is most likely to exist if the student has relatively drinking-involved parents and friends. The converse of this is that relatively favorable attitudes to drunkenness coupled with reports of more consistently experienced psychological effects from drinking are related to a relative absence of parental and peer drinking examples.

### *Personality versus Social Influence*

The size of the multiple correlations involving personality variables (Tables 4 and 6) are of much the same order as those involving social-influence variables (Tables 5 and 7). This provides an answer to one of the major questions posed in the introduction. Neither set of variables is more strongly associated than the other with aspects of student drinking. There is a slight suggestion that personality factors may provide marginally higher correlations in women, and with drinking problems as opposed to frequency, but the differences are small. It should also be noted (Table 3) that personality and social-influence variables are by no means independent of one another. In particular, adventurous pleasure-seeking and friends' drinking are correlated at a high level of significance in all samples. To some extent, therefore, to look at differences in personality is to look at differences in social influence from a different perspective and there seems little purpose to be served in speculating here upon questions of whether personality factors or social-influence factors are the more fundamental or the more amenable to modification.

### *Implications Concerning the Structure of Student Drinking*

There are implications reported in this section for the question of the structure of student drinking discussed in section I of this report. The major dimension of student drinking is a general one. Students with a high standing on it are likely to drink more and more often, are more likely to have been drunk and to have incurred problems and complications related to drinking. In addi-

tion, they are more likely to hold favorable attitudes toward both drinking and intoxication. Furthermore, these students, and their counterparts with a relatively low standing on this major dimension, are to an extent identified in other ways. The former have friends who drink and they themselves are more likely to take part in a range of activities which we have construed as adventurous and pleasure-seeking. They have parents who drink much and are relatively approving of their child drinking. They tend to be tough-minded, extraverted, radical and not particularly motivated to put over a good impression of themselves. If they are women, they may also be relatively anxious.

Independent of this general dimension but of much less importance in terms of accounting for individual variation is a second dimension which in summary may be described as contrasting a prodrinking and antidrunkness disposition with a prodrunkenness and antidrinking disposition. Not only is this dimension relatively unimportant in accounting for individual variation but also, in terms of the variables examined in this investigation, it is relatively difficult to identify individuals with one or other contrasting disposition. Those with a prodrunkenness and antidrinking disposition appear relatively anxious and are relatively unlikely to take part in adventurous pleasure-seeking. They are also likely to have friends and parents who drink relatively little and parents who tend to disapprove of their drinking. None of these correlations are at all substantial, however.

#### *Shortcomings of the Study and Suggestions for Future Research*

One major shortcoming of this study concerns the restrictions of its sampling. While this has made it possible to examine personality and social-influence factors unhindered by major variations in factors such as age, educational level, race and religion, it leaves very open the question of the generalizability of the findings. Although the comparability of results between colleges and between sexes, as well as the number of findings which confirm those of other investigators in other countries, is reassuring in this regard, there remains the possibility that a number of the findings are peculiar to the type of sample. For example, the negligible influence of parental example after partialling out the effect of peer drinking might be peculiar to an educationally advantaged middle-class sample.

tions employing survey methodology and a self-administered questionnaire. Correlations of lie-scale scores with drinking variables suggest that bias may have been operating, and many biases operating on the extent of covariation between variables may have remained undetected. For example, correlations of friends' drinking and self-report drinking variables may have been exaggerated by the operation of biases affecting the students' nominations of friends and the drinking which they attributed to those friends. It seems reasonable to suppose the existence of a general "consistency bias" whereby correlations between all drinking variables, whether they refer to the student's own drinking, to his parents' drinking or to his friends' drinking, would be artificially inflated.

Questionnaire survey investigations, with their peculiar weaknesses and strengths, should ideally be complemented by studies of quite another sort offering complementary weaknesses and strengths. In particular, we would advocate intensive studies of the natural history of adolescent or early adult friendship groups as well as studies focusing on drinking as one of a number of adventurous and pleasure-seeking activities.

### III. SEX DIFFERENCES

In Britain as elsewhere an excess of men over women has been noted among people identified in public records or by surveys as occasioning cause for concern by their drinking (84, 85, 86). Depending on the source of data, male to female ratios vary from 2 : 1 to as high as 8 : 1. The excess of men over women is therefore substantial and any explanation of the condition of alcoholism, or of problem drinking, must take these rather dramatic facts into account. We concur with the view (84) that a study of sex differences in drinking behavior and attitudes constitutes a potentially useful and relatively economical route to understanding the nature of these forms of behavior and the circumstances responsible for them.

Knupfer and Room (87) have written that surveys of drinking practices carried out in the United States agree that women drink less than men but that "much depends on the definition of 'less.'" From their own findings and those of others they conclude that there are bigger differences between the sexes in terms of quantity

or alcohol consumed on any one occasion than there are in terms of abstinence rates or frequency of consumption. Edwards et al. (67), reporting the results of a survey of drinking practices in England, show more than six times as many men as women in their "moderate" and "heavy" drinking categories. Although both quantity and frequency were taken into account in forming their categories, it is apparent that the sexes differed more dramatically in terms of quantity. There was little difference in the proportions of men and women in their "frequent light" drinking category. It appears that an answer to the question, "Why do there appear to be more male problem drinkers than female?" may require an answer to the question, "Why do women drink smaller quantities of alcohol than do men?"

In the course of the present investigation of the personality and social-influence correlates of drinking behavior and attitudes among English university students, data were collected from both men and women students attending the same university. Although it was not the original intention to compare sexes, we have taken the opportunity to do so.

## METHOD

### *Sample*

The sample is that described in the two previous sections, namely first-year students of two colleges of an English university. In these earlier reports data were presented for three samples: a male and a female sample at college A and a male sample only at college B. Results were so similar in the two male samples that the results from college B men are for the most part omitted.

Most of these results are based on replies to a questionnaire received by the students during the first week of their first term at college. A follow-up questionnaire was sent to the same students 2 years later, within the first week of the first term of their third year at college. Many of the same questions were again asked and as the results were similar in terms of sex differences they are not reported here. However, a few additional questions were asked which were not included in the initial questionnaire and some of these results are presented here (in Table 10 only). Because of the drop-out from college before the start of the third year and a much lower return rate for the follow-up questionnaire, the percentage of students starting out as first-year students 2 years earlier who returned a follow-up questionnaire is low (34% of college A men, 44% of college B men and 34% of college A women). Data reported in Table 8 are from replies to the initial ques-

tionnaire but pertain only to those students who in addition subsequently returned a follow-up questionnaire.

### *Variables and Method of Presentation of Results*

Table 8 concerns 12 scaled variables relating to the student's own reported drinking behavior and attitudes. Their content and the way in which they were derived from questionnaire replies have been described more fully in the earlier sections. The results are presented in the form of means and standard errors and the significance of the difference between sample means has been tested by computing the ratio of this difference to its standard error.

Table 9 concerns students' reports of quantities of alcohol consumed in any one day which were obtained by the grid method described earlier. A number of alternative measures of quantity could be extracted from these data. "Usual quantity" refers to that category reported to be consumed on the highest proportion of drinking days. "Maximum quantity" refers to the highest quantity reported for any drinking day and "Maximum-usual quantity" refers to the highest category reported consumed on at least 10% of drinking days. Replies all referred to a period of 12 months prior to completion of the questionnaire.

Table 10 concerns replies to single questions included in the follow-up questionnaire relating to the approximate recalled frequency with which different quantities of alcohol had been consumed at different rates within the previous 12-month period.

Tables 11, 12 and 13 concern replies to single questions included in the initial questionnaire relating to reported consequences, complications and concerns arising from the student's own drinking. The 9 items shown in Table 13 constitute an internally consistent scale for female subjects, and are 9 of 11 items which form a reproducible scale for male subjects only. Therefore for male subjects an affirmative reply to 1 of these items is very likely to be associated with affirmative replies to most or all of the preceding items.

Table 14 refers to replies to single questions included in the initial questionnaire regarding aspects of the drinking occasion which was most recent at the time a student completed the questionnaire.

In Tables 9-14 results are presented in the form of numbers and percentages of male and female replies in different answer categories. Approximate male:female (M:F) ratios have been calculated to the nearest half unit and the significance of differences between sexes calculated by computing the ratio of the difference in proportions to its standard error.

Because of the inflation of M:F ratios for a given difference in proportions, when the frequency of replies in the relevant category is low, moderate or low M:F ratios are frequently associated with a highly significant difference in proportions and extreme M:F ratios are sometimes associated with less significant, or even statistically insignificant, differences in proportions.

## Scaled Variables

Of the 12 variables in Table 8 only 4 show a consistent and significant difference between the female sample and both male samples. The men have significantly higher scores than the women on "average quantity consumed," "single-sex, beer, pub" style of drinking, "expected tolerance" and "positive evaluation of alcohol." Only in the case of "positive evaluation of alcohol," and then only in 1 male sample, is the difference highly significant. In the case of "positive evaluation of getting drunk" the female mean is lower than both male sample means, but the difference is statistically significant in 1 comparison only.

In other instances the direction of nonsignificant results is of interest. The female mean is lower than both male means in the case of "ideal frequency of getting drunk" and of "frequency of drinking." On the other hand the female mean is higher than both male means for reported frequency of drinking in a "with parents, wine, with meals" style of drinking, "relief of feelings motivation" for drinking, reported frequency of experiencing "increased extra-

TABLE 8.—Mean ( $\pm$ SE) Scores on 12 Alcohol-Related Variables of Three Student Samples in Colleges A and B

	Male A (N = 210)	Male B (N = 287)	Female A (N = 109)
Frequency of drinking <sup>1</sup>	86.7 $\pm$ 10.2	83.0 $\pm$ 8.7	74.4 $\pm$ 13.8
Average quantity consumed <sup>2</sup>	3.1 $\pm$ 0.3°	3.4 $\pm$ 0.3†	2.1 $\pm$ 0.3
Single-sex, beer, pub, style of drinking <sup>3</sup>	16.6 $\pm$ 1.0°	16.8 $\pm$ 1.0°	12.8 $\pm$ 1.2
With parents, wine, with meals, style of drinking <sup>4</sup>	11.5 $\pm$ 0.9	11.0 $\pm$ 0.8	13.4 $\pm$ 1.2
Expected tolerance <sup>5</sup>	5.45 $\pm$ 0.3†	5.30 $\pm$ 0.2†	4.33 $\pm$ 0.3
Relief of feelings motivation <sup>6</sup>	14.9 $\pm$ 1.9	16.1 $\pm$ 1.7	16.9 $\pm$ 2.8
Increased extraversion effects experienced <sup>7</sup>	9.8 $\pm$ 0.6	10.0 $\pm$ 0.6	10.3 $\pm$ 0.9
Disinhibition effects experienced <sup>7</sup>	3.3 $\pm$ 0.3	3.4 $\pm$ 0.2	3.8 $\pm$ 0.5
Positive evaluation of alcohol <sup>8</sup>	15.4 $\pm$ 0.3†	15.7 $\pm$ 0.3‡	13.7 $\pm$ 0.5
Ideal frequency of drinking <sup>9</sup>	13.9 $\pm$ 0.6	13.8 $\pm$ 0.6	14.5 $\pm$ 0.7
Positive evaluation of getting drunk <sup>9</sup>	10.9 $\pm$ 1.1	12.2 $\pm$ 0.9°	8.2 $\pm$ 1.4
Ideal frequency of getting drunk <sup>9</sup>	3.4 $\pm$ 0.6	3.3 $\pm$ 0.5	2.0 $\pm$ 0.7

<sup>1</sup> Roughly equivalent to number of days in 365. <sup>2</sup> Average number of drinks (each containing approximately 8 g of absolute alcohol) per drinking day. <sup>3</sup> Seven-item scale, range of scores 0 to 28. <sup>4</sup> Roughly equivalent to number of drinks before feeling intoxicated. <sup>5</sup> Weighted 8-item scale, range of scores 0 to 48. <sup>6</sup> Nine-item scale, range 0 to 18. <sup>7</sup> Four-item scale, range 0 to 8. <sup>8</sup> Semantic-differential factor score, high scores indicate favorable evaluation. <sup>9</sup> Ideal frequency for own age and sex: 2 = twice a year; 3 = three times; 14 = once every 10 days; 15 = once a week.

°  $P < .05$ , †  $p < .01$ , ‡  $p < .001$ , between male and female samples.

version effects and disinhibition effects from drinking, as well as "ideal frequency of drinking."

## Quantities

Table 9 shows that 5 of 6 comparisons between the sexes result in highly significant differences in proportions. The most extreme M:F ratios concern "usual quantity four drinks or more," "maximum quantity 11 drinks or more" and "maximum-usual quantity 11 drinks or more."

## Quantity and Rate of Drinking

All but one of the sex comparisons shown in Table 10 are significant. Only two comparisons, however, result in highly significant differences in proportions. These concern the proportions who report drinking a large quantity quickly at least once ("more than 10 drinks within 2½ hours, ever") and a moderate quantity quickly at least once ("6 drinks within 1 hour, ever"). In addition, M:F ratios of 6:1 are found in the proportions of male and female students reporting drinking a large quantity quickly more than 10 times, and the proportions reporting drinking a large quantity slowly more than 10 times.

TABLE 9.—Reported Consumption of Alcohol by College A Students in Terms of "Usual," "Maximum" and "Maximum-Usual" Quantities, in Per Cent

	Male (N = 484)	Female (N = 248)	M:F Ratio
<i>Usual Quantity</i>			
1-3 drinks	67.5	93.5	
4-10 drinks	31.6	6.1	2:1 } 5:1‡
11+ drinks	0.8	0.4	
<i>Maximum Quantity</i>			
1-3 drinks	17.2	43.2	
4-10 drinks	50.0	49.6	4.5:1‡ } 1.5:1‡
11+ drinks	32.8	7.3	
<i>Maximum-Usual Quantity</i>			
1-3 drinks	30.0	62.1	
4-10 drinks	59.6	36.7	8.5:1‡ } 2:1‡
11+ drinks	10.5	1.2	

‡  $P < .001$ .

TABLE 10.—Reported Quantity and Rate of Alcohol Consumption by College A Students, in Per Cent

	Male (N = 219)	Female (N = 115)	M : F Ratio
<i>More than 10 drinks within 2½ hours</i>			
Ever	38.8	11.3	3.5 : 1‡
More than 10 times	10.9	1.7	6.5 : 1†
<i>More than 10 drinks within 10 hours</i>			
Ever	32.4	20.9	1.5 : 1°
More than 10 times	10.5	1.7	6 : 1†
<i>6 drinks within 1 hour</i>			
Ever	34.2	5.2	6.5 : 1‡
More than 10 times	8.7	0.0	- †
<i>6 drinks within 4 hours</i>			
Ever	50.2	37.4	1.5 : 1°
More than 10 times	13.2	8.7	1.5 : 1

° P < .05. † P < .01. ‡ P < .001.

### Consequences

Table 11 shows that much higher proportions of male students report having been drunk ever or more than 10 times, having had a hangover ever, and having experienced "amnesia for the night before." In addition there are differences of a lesser degree in the case of a hangover more than 10 times, and "morning tremor." The

TABLE 11.—Four Drinking-Related Events Reported by College A Students, in Per Cent

	Male (N = 495)	Female (N = 259)	M : F Ratio
Been drunk ever	59.2	34.8	1.5 : 1‡
More than 10 times	12.1	3.9	3 : 1‡
Had a hangover ever	50.4	27.4	2 : 1‡
More than 10 times	8.3	3.5	2.5 : 1°
Had amnesia for the night before (ever) <sup>a</sup>	18.8	7.7	2.5 : 1‡
Had morning tremor (ever) <sup>b</sup>	7.7	3.9	2 : 1°

<sup>a</sup> The exact question asked was: "How often after drinking alcohol have you, the next morning, been unable to recall anything that happened to you over a lengthy period of time during the previous evening?"

<sup>b</sup> "How often after drinking alcohol have you, the next morning, suffered from uncontrollable shaking of hands or other parts of your body?"

° P < .05. ‡ P < .001.

more than 10 times.

### Complications

The frequency of reporting each of the 14 complications shown in Table 12 is higher in male than in female students and there are significant differences in proportions in 10 of the 14. Sex ratios, however, vary considerably from a complication such as "reprimanded or advised to drink less by a friend or acquaintance, more than once," where the female frequency is almost as high as the male, to a complication such as "been involved with the police more than once," where the M:F ratio reaches a high of 7.5 : 1. Items with low M:F ratios and without significant differences in proportions

TABLE 12.—Complications Attributed to Drinking Reported by College A Students, in Per Cent

	Male (N = 495)	Female (N = 259)	M : F Ratio
Worked poorly or inefficiently off and on for a period of some days or longer			
Ever	8.1	5.0	1.5 : 1
More than once	4.0	2.3	1.5 : 1
Worked poorly or inefficiently for a few hours			
Ever	48.5	33.2	1.5 : 1‡
More than once	29.1	16.6	2 : 1‡
Missed a day or half day at school or work or missed a lecture, seminar, tutorial or other meeting which should have been attended			
Ever	11.9	8.9	1.5 : 1
More than once	6.8	3.1	2 : 1°
Missed or had to cancel an appointment or date with a friend, acquaintance or colleague			
Ever	7.0	3.9	2 : 1
More than once	2.8	1.6	1.5-2 : 1
Felt ill or under the weather for a period of longer than one day			
Ever	14.7	8.2	2 : 1°
More than once	4.6	1.6	3 : 1°

[Continued on following page]

TABLE 12.—*continued*

	Male (N = 495)	Female (N = 259)	M : F Ratio
Been involved in an accident of any sort in which you or anyone else was hurt			
Ever	8.3	4.3	2 : 1 <sup>°</sup>
More than once	2.8	0.4	7 : 1 <sup>°</sup>
Been involved with the police in any way without subsequently being charged with an offense <sup>a</sup>			
Ever	9.9	1.9	5 : 1 <sup>†</sup>
More than once	3.0	0.4	7.5 : 1 <sup>°</sup>
Broken the law in any way without being involved with the police			
Ever	30.3	13.8	2 : 1 <sup>†</sup>
More than once	22.8	8.4	2.5 : 1 <sup>†</sup>
Been evicted or excluded from or threatened with eviction from a college, a club or any other institution, ever	7.1	1.5	4.5 : 1 <sup>†</sup>
Been evicted from a meeting, party or any other gathering, ever	3.0	0.8	3.5-4 : 1
Lost a friend or seriously damaged a friendship, ever	8.5	3.5	2.5 : 1 <sup>°</sup>
Been reprimanded about your drinking or advised to drink less by one or both of your parents or by another relative			
Ever	33.6	16.2	2 : 1 <sup>†</sup>
More than once	18.2	8.1	2 : 1 <sup>†</sup>
Been reprimanded about your drinking or advised to drink less by any other person in authority (e.g., teacher, employer)			
Ever	6.0	1.2	5 : 1 <sup>†</sup>
More than once	2.8	0.4	7 : 1 <sup>°</sup>
Been reprimanded about your drinking or advised to drink less by a friend or an acquaintance			
Ever	12.3	8.1	3 : 1
More than once	5.6	4.6	1 : 1

<sup>a</sup> A question was asked about being charged with an offense but the frequency of affirmatives was only 1% by the men and less by the women.

<sup>°</sup>  $P < .05$ .      <sup>†</sup>  $P < .01$ .      <sup>‡</sup>  $P < .001$ .

concern working poorly or infrequently or not on for a period of some days or longer," "missing or having to cancel an appointment or date with a friend, acquaintance or colleague" as well as the item concerning reprimands or advice by friends or acquaintances.

### Concern over Drinking

Of nine items shown in Table 13, six produce highly significant differences in proportions and one further item produces a smaller difference. The two remaining items which failed to produce a significant difference in proportions concern "feeling guilty about drinking," and "deliberately deciding not to drink alcohol anymore." Sex ratios vary from little more than 1 : 1 in the case of these two items to 6.5 : 1 in the case of "gone into a pub to drink alone."

TABLE 13.—*Elements of Concern about Drinking Reported by College A Students, in Per Cent*

	Male (N = 495)	Female (N = 259)	M : F Ratio
<i>Have you ever:</i>			
Gone into a pub to drink alone?	59.0	9.3	6.5 : 1 <sup>†</sup>
Felt that you had wasted too much money on drinking?	59.2	13.1	4.5 : 1 <sup>†</sup>
Been aware of drinking more quickly than most people you were with?	47.2	32.8	1.5 : 1 <sup>†</sup>
Made sure that you had alcoholic drinks before going to a party in case of not getting enough there?	31.5	12.8	2.5 : 1 <sup>†</sup>
Felt that you had wasted too much time drinking?	24.0	7.7	3 : 1 <sup>†</sup>
Concealed the amount you were drinking from anyone?	18.6	6.9	2.5 : 1 <sup>†</sup>
Felt guilty about your drinking?	19.6	16.2	1 : 1
Felt on at least one occasion that you were unable to control the amount you were drinking?	19.4	13.5	1.5 : 1 <sup>°</sup>
Deliberately decided not to drink alcohol anymore even if you later reversed this decision?	14.9	12.4	1 : 1

<sup>°</sup>  $P < .05$ .      <sup>†</sup>  $P < .001$ .

Table 14 shows a number of highly significant differences between the sexes. The men are significantly more likely to report drinking alcohol on the day of completing the questionnaire or on the previous day, are significantly more likely to report that alcohol was most recently drunk in the company of other people of the student's own sex only, in the company of between two and four other people, and are significantly more likely to report that the drinking occurred in a pub or a club bar. They are also much more likely to report that they bought or poured a drink containing

TABLE 14.—*Details of the Most Recent Drinking Occasion Reported by College A Students, in Per Cent*

	Male (N = 461-494)	Female (N = 245-257)	M : F Ratio
Last drink yesterday or today	58.4	42.5	1.5 : 1‡
<i>Number of drinks</i>			
5+	10.9	8.5	1.5 : 1
8+	3.8	1.6	2.5 : 1
<i>Company</i>			
Own sex	40.2	6.6	6 : 1‡
Opposite sex	10.1	27.0	1 : 2.5‡
Mixed	42.8	61.4	1 : 1.5‡
No other	6.3	2.3	2.5 : 1°
1 other	23.0	25.1	1 : 1
2-4 others	45.3	31.2	1.5 : 1‡
5+ others	24.6	39.8	1 : 1.5‡
<i>Place</i>			
Pub or club bar	53.3	35.5	1.5 : 1‡
Restaurant	3.7	10.2	1 : 3‡
Relative's home	5.1	8.6	1 : 1.5
<i>Decision to Drink</i>			
Not own or passive party	33.5	45.4	1 : 1.5‡
Own or active party	66.5	54.5	1 : 1
Bought or poured for self	60.0	12.0	5 : 1‡
Bought or poured for someone else	39.8	8.5	4.5 : 1‡
<i>Motivation</i>			
Very much wanted or wanted to drink	61.0	50.9	1 : 1‡
Neither wanted nor didn't want	30.5	35.9	1 : 1
Didn't really want or didn't want at all	7.1	10.0	1 : 1.5

°  $P < .05$ . †  $P < .01$ . ‡  $P < .001$ .

alcohol for themselves on that occasion, and also that they bought or poured a drink containing alcohol for someone else on the same occasion. On the other hand, the women are more likely to report drinking most recently in mixed company or in the company of a member of the opposite sex only, are more likely to report that the most recent occasion of drinking was in the company of five other people or more and are significantly more likely to report that they drank in a restaurant.

There are also a number of less significant differences. The men are more likely to report that they most recently drank alcohol on their own, that they took the decision to drink on that occasion or at least that they were a party to the decision, and that they wanted to drink alcohol on that occasion.

## DISCUSSION

### *Frequency, Quantity and Rate of Drinking*

Male students in this study are consistently higher than females on measures of frequency, quantity and rate of drinking, but in many instances the differences are unimpressive and they are not consistently significant. For example, average quantity drunk is significantly larger in the two male samples, but the differences are not highly significant and there are almost as many women drinking moderate to large quantities on the most recent drinking occasion. Average reports of frequency over a 12-month period show no significant sex differences yet significantly more men report drinking on the day of completing the questionnaire or on the previous day. There is the expected difference between the sexes in expected "tolerance," but even here the difference is not highly significant.

More dramatic differences are to be found, however, although they concern for the most part activities reported by only a minority of even male students. It seems to be relatively rare for girls to claim that they "usually" drink more than 3 drinks in a day, or to claim "ever" to have drunk more than 10 drinks in a day, and it is particularly rare for them to claim to drink more than 10 drinks on more than 10% of their drinking days. Questions on rate of drinking confirm these extreme sex ratios, women rarely reporting that they often drink a lot, whether quickly or slowly. However, the most extreme sex ratio in this section of the results shows that women are much less likely to report ever having consumed moderate amounts quickly which suggests that there are major sex



differences not only in drinking large quantities but also in knocking back relatively small quantities very fast. Indeed many colleges, and other institutions, have rituals centering around the rapid consumption of drinks and it is our impression that these rituals are largely indulged in by men.

In interpreting sex differences in quantity and rate the question arises of how to allow for average differences in male and female body weight. The formula worked out by Bruun (88) for calculating blood alcohol levels after a period of drinking does not make allowance for body weight in the numerator (grams of alcohol consumed minus 7 times the length of the drinking period in hours, 7 g per hour being the oxidation rate of alcohol in the body), but does allow for body weight in the denominator (0.68 times body weight in kilograms, 0.68 being the proportion of body weight accounted for by body water). Results of experiments by Forney and Hughes (89) suggest that this may be correct; when duration of drinking and grams of alcohol consumed per unit time per 150 lb of body weight were equated, no subsequent differences between the sexes were observed in blood alcohol curves. This suggests that estimates of quantities of alcohol consumed, as well as estimates of "tolerance," in the two sexes should be adjusted for differences in average body weight unless it can be shown that women drink more slowly. As we have presented some evidence to suggest that this may indeed be the case, it is impossible to judge to what extent survey estimates of quantities of alcohol consumed should be adjusted for body weight, or indeed whether they should be adjusted at all. Women may be as much affected by the smaller amounts they drink because of their lower body weight but this would not be the case if they drink more slowly.

For the moment, however, we shall assume that the evident sex differences in maximum quantities, maximum-usual quantities and rate are too large to be accounted for by differences in body weight alone.

### *Style of Drinking*

Two different styles of drinking were identified and described in section I of this report. Male students are more likely to drink in a "single-sex, beer, pub" style and female students are more likely to drink in a "with parents, wine, with meals" style, but only in the first style are the differences statistically significant and even then not highly so. Details of the most recent drinking occa-

sion suggest that the biggest sex differences in the style of drinking lie in the company in which they drink. On the most recent occasion the men are six times as likely to have drunk in the company of other members of their own sex only, whereas women are two to three times as likely as men to have drunk in the company of one or more members of the opposite sex only. In addition men are a little more likely to have drunk in a small group, consisting of themselves and between two and four others, women being more likely to drink in larger groups, consisting of themselves and at least five other people. Differences in location are far less dramatic. Although men are more likely to drink in a pub than are the women, this location is still the most frequent for both sexes.

There are also highly significant differences in the initiatives taken by men and women on drinking occasions, men being much more likely to either buy or pour drinks for themselves or for others. This may be a matter of etiquette and of little fundamental importance but it has an intriguing counterpart in the reports which students give of their parents' drinking habits. In one male sample, and the results are similar from other samples, 63% of students thought that their father drank more than their mother and a further 32.5% thought that their parents drank approximately the same, leaving only 4.5% who thought their mother drank more than their father. Although there were many mothers who drank more than many other fathers, it was rarely the case that a mother was reported to drink more than her own husband. If it is true that men for the most part take a leadership role in drinking occasions, leaving women to take a follower role, then it is to be expected that female drinking habits will be constrained by the drinking habits of the men with whom they are most closely associated.

So far we have established, for these samples at least, that young men and women differ most markedly in that a sizable minority of men drink fairly large quantities of alcohol occasionally or more often and that as a whole they are much more likely to drink in single-sex groups. In addition, in mixed company men are likely to lead in drinking. These facts are presumably linked but how they are linked is not apparent—whether some women have an inclination to drink large quantities but are restrained by having to drink largely in mixed company where they take a follower role or whether there is a factor inherent in maleness, whatever its origin, which leads to single-sex group heavy drinking and a leadership role in mixed-sex drinking.

In view of the sex differences in quantities, rates and styles of drinking it is not surprising that higher proportions of male students report each and every one of the complications, consequences and concerns to do with drinking. The sex ratios vary widely, however, and many of the differences are small or even insignificant. An inspection of individual items reveals a pattern. Many of the items producing a high M:F ratio, of 4 : 1 or greater, represent complications involving conflicts with other people who occupy positions of responsibility or authority. For example, 7 to 8 times as many male students report having been involved with the police more than once and 5 times as many men as women report having been reprimanded about their drinking or advised to drink less by a person in authority other than their parents. On the other hand, items with a very low sex ratio, of 1.5 : 1 or less, appear to involve harm or concern affecting the individual without having implications for relationships with people in authority although they may affect relationships with peers. Such items include getting drunk, work impairment, missing appointments, being reprimanded or advised to drink less by a friend or acquaintance, drinking more quickly than others, feeling guilty, feeling unable to control drinking and deciding to give up drinking. The surprisingly low sex ratio on these items may to some extent be the result of different thresholds for concern in the two sexes. Young women may feel guilty or decide to give up drinking in response to a much lower level of "damage" than do young men. However, this seems unlikely to be the total explanation in view of the evidence, presented in the first section, that male and female students define the expression "drunk" similarly and in view of the fact that low sex ratios are to be found on items involving reports of behavior (such as missing school, lecture or meeting) as well as on items reporting attitudes (such as feeling guilty about drinking).

### *Attitudes*

Do the attitudes which young men and women adopt toward drinking throw any light on the differences discussed so far? First, there are marked differences in their evaluation of drinking itself: men are much more likely to see it as "a good thing." Surprisingly, in view of the data on amount and rate, differences in the evaluation of drunkenness are less significant. The male mean is higher but

sexes showing that quite a lot of women think that getting drunk is quite as good a thing as many men do. However, when students are asked what they consider to be an ideal frequency of drinking and of drunkenness for people of their own age and sex, women advocate a higher frequency of drinking for their sex than do men for theirs (but not significantly so) while they advocate a lower frequency of drunkenness (again not significantly so).

That results concerning the concepts of "drunkenness" do not show greater sex differences is surprising and there are further surprises still. In view of quantity, rate and style differences, more "drinking for effect" might be expected among men. The opposite is if anything true although differences are not significant. Women are slightly more likely to admit to drinking "when things have got me down" or "when I am restless or tense" or "because it helps me to forget worries," etc., and are slightly more likely to admit that when they do drink they become "more relaxed," "more generous," "more enthusiastic," etc., as well as "less in control of my own actions," "less aware of the effects of my own actions" and "more inclined to be irresponsible."

### *An Attempted Integration*

In summary it would appear that the male students differ from their female counterparts in their greater appreciation of drinking itself, in the occasional indulgence of some of their number in heavy or fast drinking, in their far greater likelihood of drinking in single-sex groups and in their rate of antisocial consequences. Female students are in favor of drinking just as frequently as are men, in fact report drinking not very much less frequently, on average drink almost as much (particularly if allowance were made for average differences in body weight although the appropriateness of this correction is in doubt), and are not much less likely than are men to report consequences from their drinking as long as these are not antisocial. In addition, they appear to appreciate the psychological effects from drinking as much, if not more, than do men and are quite as ready to admit to drinking for these effects.

Speculating more widely, we would predict that if behavior associated with the use of a drug has harmful implications for the user's relationship with persons in positions of responsibility or authority, the male incidence of this behavior will be markedly

greater than the female incidence. In the same study, the associated behavior or consequence refers to mood modification, physical illness or complaints or concerns on the part of the drug user or his or her peers, male and female incidences will be more similar. Some recent data concerning the use and consequences of drugs other than alcohol in England and Wales are consistent with this view. Whereas the frequency of cannabis use among university students may be very similar in the two sexes (75, 90), cannabis convictions among men far exceed those among women (85). Differences between the licit and illicit are reflected in data showing that admissions to psychiatric hospitals of persons who have used amphetamines are similar in the two sexes whereas admissions of persons who have used lysergide (LSD) show a considerable excess of males (85). Certain historical changes in sex ratios and drug use might be incorporated into the same view. For example, in England and Wales, the M:F ratio of opiate users known to the authorities has increased since the early 1960s. It could be argued that from that time onward, when the total number of known opiate users increased dramatically and drug addiction came to public notice, opiate using took on an enhanced "antisocial" meaning. It is of course relevant here that almost all crimes, in England and Wales as in other western countries, show an excess of male convictions over female (91).

These findings seem to us compatible with notions of the sex-typing of behavior, the greater dominance and aggressiveness associated with the male role being consistent with a relative lack of restraint in drinking behavior, as in other social behaviors. The question of whether sex-typed behavior has a biological basis or whether it is entirely due to sociocultural conditioning is of course controversial and its discussion is far beyond the scope of this paper.

It is very relevant here to point out that the concepts of sex-role confusion and conflict over the expression of dependency (a female sex-typed set of behaviors) have been given a central place in accounts of the etiology of alcoholism in men (92) as well as in accounts of the dynamics of marriages in which the husband is diagnosed as suffering from alcoholism (93). Also relevant is the recent theorizing of McClelland et al. (20) concerning male motivation to drink in terms of increased "personalized power" thoughts and lack of restraint, a motivation which may be encouraged in cultures stressing the value of male strength and daring.

plications, including "drinking for effect" and non-antisocial complications, are not so clearly governed by ideas of appropriate sex-role behavior and it may therefore be wrong, certainly for the type of person studied here, to think of dependence on alcohol, or even certain types of problem drinking, as being much more acceptable for men.

Nonetheless it seems likely that rates of alcoholism and problem drinking will show a considerable excess of males over females on account of the likely definitions of the terms "alcoholism" and "problem drinking" prevailing among concerned professionals, members of the public responsible for referral to those professionals, and epidemiologists. This follows if, as seems likely, the definitions rest heavily on evidence of distorted relationships between the identified individual and people in positions of authority and responsibility, or people who make demands of appropriate role behavior from the individual, such as wives, employers and policemen. If on the other hand it were possible to assess the degree of dependence on alcohol, perhaps in terms of reluctance to give it up or regularity of alteration of mood, irrespective of the consequences of use for distortion of relationships, it might be found that rates in the two sexes were more nearly equal. There is some indication that this might be likely from cirrhosis death rates which are almost identical in the sexes in England and Wales (84) and from the relatively higher proportion of identified female alcoholics who consult general practitioners rather than any other source of help (86). Relevant here are the findings of Cooperstock (94) concerning the greater use of mood-modifying drugs in general among Canadian women, and those of Mitchell (95) concerning the higher rate of use of "decrement producing" drugs among a group of female students in the U.S.A.

One might further speculate that the natural history of alcohol dependence may be quite different in typical cases for the two sexes. Items reflecting "concern" over drinking (see Table 13) formed a reproducible scale for males but not for females. The latter were almost as likely to respond in the affirmative to items about feeling guilty about their drinking, feeling they were unable to control the amount they were drinking and deliberately deciding not to drink any more. However, unlike their male counterparts, women who did had not necessarily gone through a process involving

a party, concealing drinking or solitary pub drinking. We would therefore hypothesize that women who become dependent on alcohol do so for the most part in a restrained undramatic fashion within the constraints imposed by their domestic and social relationships. Women may cause other people relatively little bother by their drinking but they may just as often as men become mildly dependent on alcohol and make decisions to stop drinking for their own good.

These conclusions and speculations have been based on findings from a rather select group of young people in their late teens, who are unrepresentative of the population as a whole because of their relative youthfulness and predominant middle-classness. Previous studies in England (84, 86) have shown sex ratios in alcoholism to vary with socioeconomic class, lowest ratios existing among those of higher status. Changes in prevailing ideas of appropriate sex-typed behavior may mean that the age variable is relevant also. This comparison was made in an effort to throw light on extreme sex ratios in alcoholism and problem drinking, but it could be argued that we have, by accident, chosen for study a group which, on account of its age and social class, may later produce a relatively low male : female ratio of identified alcoholics or problem drinkers.

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A questionnaire on drinking behavior and attitudes was completed by 3 samples of first-year students at 2 colleges of an English university: 495 men and 259 women at 1 college and 569 men at another, most of them 17 to 19 years old. On the basis of their replies, the students were assigned scores on each of 18 variables, which included quantity and frequency of drinking, drinking styles, effects of drinking, attitudes toward drinking and drunkenness, and consequences of drinking. The variables were intercorrelated and 3 correlation matrices were subjected to principal-component analyses. Most of the intercorrelations were significant and positive and in the 3 samples there was a large 1st component to which nearly all variables contributed and which accounted for 40% of the total variance. This component indicates a general involvement with and appreciation of alcoholic beverages. The 2d ranking component, which accounted for 8-10% of the variance, appeared to contrast an interest in drinking per se versus drinking for psychological effects. No separate "problem-drinking" component emerged.

In the 2d part of the study, scores from Eysenck's Personality Inventory (measuring extraversion and neuroticism), a specially constructed Adventurous-Pleasure-Seeking (APS) Scale, Eysenck's Social Attitude Inventory (measuring Radicalism-Conservatism and Tender and Tough-mindedness) and measures of the quantity and frequency of drinking by parents and friends and approval of drinking by parents were correlated with the 2 components.

The 1st component had highest correlations with the personality variables of extraversion and APS. High scorers on the APS scale were more likely to report that they dated frequently, smoked a lot, drove fast and had broken the law, and were less likely than other students to report going to church. The 1st component was correlated significantly with the social-influence variables of fathers', mothers' and friends' drinking, and fathers' and mothers' approval of drinking, but when the effects of the other variables were partialled out, friends' drinking was the only one still significantly correlated. The 2d component was significantly negatively correlated with neuroticism and, among men, positively with APS. It is concluded that student drinking is largely under the control of peer-group influence. Personality is probably influential in the form of individual differences in sociability and involvement in a variety of adventurous pleasure-seeking activities.

In the 3d part of the study the questionnaire responses of the 495 men and 259 women were compared. The statistically significant differences included the following: A "usual" quantity of 4 or more drinks on a drinking occasion was reported by 32% of the men and 7% of the women; ‡ 34 and 5% had drunk 6 drinks within 1 hour; ‡ 59 and 35% had been drunk; ‡ 50 and 27% had experienced a hangover; ‡ as a result of drinking, 48 and 33% had worked inefficiently, ‡ 8 and 4% had been involved in an accident,\* 30 and 14% had broken the law, ‡ and 8 and 4% had lost a friend;\* 33 and 16% had been reprimanded about drinking by relatives; ‡ and 6 and 1% by other authority figures; ‡ 59 and 9% had gone to a pub to drink alone; ‡ 47 and 33% had been aware of drinking more quickly than others; ‡ 19 and 13% had felt on at least 1 occasion they had been unable to control the amount of drinking;\* 19 and 7% had concealed the amount of their drinking. ‡ On the most recent drinking occasion, 40% of the men and 7% of the women reported that they had drunk with others of their own sex, ‡ 10 and 27% with the opposite sex; ‡ 53 and 35% in a pub or club; ‡ and 4 and 10% in a restaurant; ‡ 33 and 45% reported that the

decision to drink had not been their own† and 60 and 12% had bought or poured their own drinks.‡ No significant differences were found in the percentages who had felt guilty about drinking, had made a decision to stop drinking or had been reprimanded by friends about drinking. The women advocated a higher ideal frequency of drinking for their age-sex group; more women reported drinking for effect and experienced psychological effects from drinking. It is suggested that as many women as men may be motivated to drink for the mood-modifying effects of alcohol and have experienced these effects. The different rates of alcoholism or problem drinking in the two sexes may be attributed to the prevailing norms of sex-appropriate behavior which expect women to drink in a relatively more restrained manner. [ \* $P < .05$ ; † $p < .01$ ; ‡ $p < .001$ .] [Bibliography of 95 items.]

## Tiapride in the Long-term Management of Alcoholics of Anxious or Depressive Temperament

G. K. SHAW, S. K. MAJUMDAR, S. WALLER, J. MacGARVIE and G. DUNN

Thirty-two chemically dependent alcoholics with significant levels of anxiety or depression were admitted to a double-blind randomised study in which the effect of the substituted benzamide tiapride was compared with that of placebo over a 6-month period. Twenty patients completed the study. Assessments included relevant biochemical and haematological tests, drinking levels and associated behaviour, expressed satisfaction with various areas of life, the Crown-Crisp Experiential Index of neurotic symptoms and questionnaires on self-esteem and alcohol dependence. The results indicated that in comparison with the placebo group, patients treated with tiapride drank less and had longer periods of abstinence. This was associated with improvements in laboratory tests, reduction in neurotic symptoms, gains in self-esteem and increased levels of expressed satisfaction with life situation. The drug was well tolerated and no deleterious effects were noted, suggesting its potential usefulness for this patient group.

This paper reports a study assessing the efficacy of tiapride as a treatment agent in chemically dependent alcoholics with significant symptoms of anxiety or depression.

Treatment of chemically dependent alcoholics is not universally successful and depressed or anxious alcoholics present special problems. The use of antidepressants carries the risk of facilitating suicide in a high-risk group, and the long-term use of minor tranquillisers not only increases the risk of suicide but also enhances dependency, both to alcohol and to the minor tranquilliser. Thus, those patients are frequently denied the benefit of drugs which might alleviate some of the symptoms likely to encourage further drinking on their part.

Tiapride (N-diethylaminoethyl 2-methoxy-5-methylsulphonyl benzamide) is a member of the substituted benzamide group of drugs which include metoclopramide (an antiemetic) and sulpiride (an anti-psychotic). It is a selective dopaminergic receptor blocking agent (Costall & Naylor, 1977), but differs from typical neuroleptics in that it is not sedative (Jenner & Marsden, 1979) and does not cause Parkinsonism (Jenner *et al.*, 1978). In common with typical neuroleptics, no anticonvulsant effect has been reported (Parent *et al.*, 1978). It is not a drug of addiction (La Barre, 1978).

The drug has attracted favourable attention in the literature on the management of alcoholism. It has been found to have beneficial effects on tremor, agitation, gastrointestinal disturbance, appetite

and craving for alcohol. Favourable results have been reported on the symptoms of anxiety (Marx, 1981; Bonnaffoux *et al.*, 1982; Peyramond, 1982) and on symptoms of depression (Bonnaffoux *et al.*, 1982; Stecchini & Corrias, 1982). In an earlier study from our own unit (Murphy *et al.*, 1983), tiapride was found to have beneficial effects on symptoms of anxiety and depression. It was observed that the drug did not affect vigilance and there was a suggestion that it alleviated craving for alcohol. Freour (1979) reported facilitation of abstinence with the drug and Bonnaffoux *et al.* (1982) reported an improvement in relationships within the work and family setting.

The non-addictive nature of the drug, its beneficial effects on symptoms of anxiety and depression and the possibility that it might lessen craving for alcohol suggested its usefulness in the long-term management of alcoholics of anxious or depressive temperament.

Treatment of alcoholism aims not only to promote abstinence but also to improve the alcoholic's ability to function in a social setting and to increase satisfaction, both with regard to relationships with significant others and with general life-style. Therefore, the study was designed to take account of those factors.

### Method

The study was double-blind and placebo-controlled with random allocation to groups. Consecutive male admissions to the detoxification section of an alcohol treatment unit



in 1983 and 1984 were admitted to the study, after routine detoxification procedures had been completed, if they fell in the age range 25-65 years, were assessed clinically chemically dependent on alcohol, gave current evidence of high levels of anxiety or depression, scored more than 30 on the Crown-Crisp Experiential Index (Crown & Crisp, 1979) towards the end of their period of detoxification and whose life history gave evidence of a tendency to react to adverse life situations with manifestations of anxiety or depression. Informed consent was obtained from all patients, who were then allocated randomly to an active group who received tiapride 100 mg *t.i.d.* for a period of 6 months or to a placebo group who received one identical dummy tablet *t.i.d.* for the same period.

At the time of admission to the study and at closure, a battery of laboratory investigations were carried out (haemoglobin, mean corpuscular volume, platelet count, total bilirubin, alkaline phosphatase, aspartate transaminase,  $\gamma$ -glutamyl transpeptidase and albumin).

At intake, each patient was interviewed by a sociologist and two schedules were completed. The first schedule collated demographic information about the patient and, taking as point of reference the six months prior to admission, data relating to employment, the use of medical, psychiatric or alcohol facilities, the use of social agencies and criminal involvement. The drinking history over the previous 6 months was examined in detail and data recorded in relation to the number of days drinking in the previous 6 months, the quantity drunk on drinking days, the complications and consequences of drinking and the social complications of drinking. The total years of heavy drinking and the number of years since excessive drinking had been regarded as a problem were also recorded.

The second schedule was completed by both the patient and the sociologist. Assessments were made of the quality of the relationships with spouses, relatives and friends, and of the degree of satisfaction with employment status, accommodation, use of leisure time and physical and mental health. At this time, the patient completed a questionnaire assessing self-esteem (Litman *et al.*, 1983), a questionnaire assessing dependence on alcohol, the Severity of Alcohol Dependence Questionnaire (SADQ) (Stockwell *et al.*, 1979) and the Crown-Crisp Experiential Index. Each patient was re-interviewed at monthly intervals throughout the trial, when compliance with treatment was assessed by estimating the number of tablets left and a further 1-month's supply of tablets was issued. Significant changes in social functioning were noted and details of drinking behaviour over the previous month were recorded.

At completion of the study, the schedules were completed — on this occasion with reference to the 6-month study period. The self-esteem index and the Crown-Crisp Experiential Index were also repeated.

Data collected at monthly follow-up interviews were not analysed separately but were used to improve the accuracy of the final rating schedules. The pre- and post-treatment scores of pathological investigations were analysed statistically using the Statistical Analysis System (SAS) and the data from the schedules using the SAS system backed up where appropriate by non-parametric Wilcoxon tests.

## Results

A total of 32 patients entered the study, of whom 13 received tiapride and 19 placebo. Seven of the latter failed to comply with follow-up; they were all of no fixed abode. Of the active group, two patients were lost as they removed from the area, 2 patients of no fixed abode did not comply with the protocol and one was withdrawn because of intercurrent physical illness (congestive cardiac failure) unrelated to trial treatment. Those who dropped out were similar to the others in age and in length of drinking history but appeared to be more disturbed. For instance, they were more neurotic, more dependent on alcohol and over the preceding 6 months had longer periods of unemployment, spent more time in hospital and had suffered more arrests. However, the main difference was that 75% of them were homeless, as opposed to 15% of those who completed.

A comparison of the active group (8 patients) with the placebo group (12 patients) found them to be well matched in respect of demographic data, drinking history, severity of dependence and on various biochemical parameters. None of the differences between the groups was statistically significant.

Conventional liver function tests and routine haematology were carried out before and after treatment in both the tiapride and placebo groups. Those patients treated with tiapride showed beneficial changes on all tests performed and in the case of mean corpuscular volume the change achieved statistical significance ( $94.75 \pm 7.76$  vs  $87.50 \pm 6.55$  fl). In contrast, the patients treated with placebo showed no change in mean corpuscular volume ( $96.75 \pm 6.63$  vs  $96.27 \pm 6.32$  fl), an increase in alkaline phosphatase ( $85.75 \pm 28.56$  vs  $101.30 \pm 102.62$  IU/litre), and a fall in albumin levels ( $42.42 \pm 7.22$  vs  $36.10 \pm 3.21$  g/litre), these adverse changes no doubt reflecting continued drinking.

Changes in various drinking parameters before and after treatment in the tiapride and placebo groups are listed in Table I. In the tiapride group there were significant improvements in the number of days abstinent, physical complications of drinking and average daily intake on a heavy drinking day. All other changes were in a beneficial direction. These improvements were not mirrored in the placebo group and in some instances changes have been adverse. It will be seen from a comparison of columns 1 and 3 that the groups were well matched prior to treatment and there was no significant difference between the groups on any variable.

Pre- and post-treatment scores obtained on the Crown-Crisp Experiential Index and Self-esteem Scale in the tiapride and placebo groups are listed in Table II. A comparison of pre-treatment scores in the tiapride and placebo group shows no significant differences between the groups. In the case of the tiapride group, there were significant beneficial changes in all measures, whilst no change was observed in the case of the placebo group.

Table III lists the percentage of patients expressing improvement in level of satisfaction with various social and health functions in both tiapride and placebo groups. It is clear that the patients in the active treatment group were markedly more satisfied with their level of functioning after

TABLE I  
Indices of drinking before and after treatment in the tiapride and placebo groups

Items (mean $\pm$ s.d.: range)	Tiapride		Placebo	
	Pre-treatment (n = 8)	Post-treatment (n = 8)	Pre-treatment (n = 12)	Post-treatment (n = 12)
Average daily intake of ethanol (units) on a heavy drinking day	44.38 $\pm$ 23.25 (16-86)	22.5 $\pm$ 16.69** (0-48)	41.92 $\pm$ 22.18 (14-92)	39.67 $\pm$ 29.27 (0-92)
Total days abstinent in preceding 6 months	36.13 $\pm$ 48.48 (0-126)	102.88 $\pm$ 70.34* (28-182)	40.33 $\pm$ 41.34 (0-133)	57.42 $\pm$ 66.99 (0-182)
Physical complications	3.38 $\pm$ 1.41 (1-5)	1.88 $\pm$ 1.64* (0-4)	4 $\pm$ 0.95 (3-6)	3.33 $\pm$ 1.99 (0-6)
Social complications	2.88 $\pm$ 5.06 (0-15)	1.25 $\pm$ 2.19 (0-6)	4.5 $\pm$ 7.05 (0-26)	8.08 $\pm$ 11.08 (0-32)
Use of medical and social facilities	28.13 $\pm$ 14.09 (1-46)	20.5 $\pm$ 14.83 (3-46)	18.5 $\pm$ 17.38 (3-66)	23.17 $\pm$ 17.34 (7-57)

\* $P < 0.02$ ; \*\* $P < 0.01$ .

treatment as compared to the situation prior to treatment. In the case of the placebo group, improvement in satisfaction was, at best, modest. In a number of instances, the differences in improved satisfaction between groups achieved statistical significance.

Additional statistical comparisons were made of score changes before and after treatment across the tiapride and placebo groups on all variables, with the following results. In the case of pathological parameters, the fall in mean

corpuscular volume was significantly greater in the tiapride group. In the case of drinking variables, the tiapride group fared better at a statistically significant level than the placebo group in respect of the average amount of alcohol consumed on a heavy drinking day, in respect of physical complications experienced and in the use made of medical and social facilities. In respect of the Crown-Crisp Experiential Index, the tiapride group fared better than the placebo group on all indices at highly statistically significant levels.

TABLE II  
Assessment of neuroticism and of self-esteem before and after treatment in the tiapride and placebo groups

Items (Mean $\pm$ s.d.: range)	Tiapride		Placebo	
	Pre-treatment (n = 8)	Post-treatment (n = 8)	Pre-treatment (n = 12)	Post-treatment (n = 12)
<i>Crown-Crisp Experiential Index</i>				
Neuroticism	51 $\pm$ 11.76 (34-66)	32.25 $\pm$ 14.15** (9-55)	51.83 $\pm$ 10.91 (34-70)	59.33 $\pm$ 18.38 (15-80)
Free-floating anxiety and phobic anxiety	15 $\pm$ 5.86 (8-26)	9 $\pm$ 4.63* (1-14)	16.33 $\pm$ 4.38 (11-23)	16.33 $\pm$ 6.47 (1-26)
Depression	10.5 $\pm$ 3.34 (7-15)	5.75 $\pm$ 3.92** (0-11)	9.75 $\pm$ 3.19 (2-14)	10 $\pm$ 3.74 (4-16)
<i>Self-esteem scale</i>				
	48.63 $\pm$ 8.57 (40-65)	40.88 $\pm$ 7.02** (30-54)	54.33 $\pm$ 7.95 (38-71)	51.42 $\pm$ 12.47 (34-73)

\* $P < 0.02$ ; \*\* $P < 0.01$ .

TABLE III  
Comparison of percentage of patients expressing improvement in level of satisfaction with various social and health functions following treatment in the tiapride and placebo groups

Pre-treatment (n = 12)		Tiapride (n = 8) %	Placebo (n = 12) %	Fisher's probability score
67 ± 29.27 (0-102)	Relationships			
	Patient-rating	62.5	25	0.11
	Interviewer-rating	75	16.6	0.01**
42 ± 66.99 (0-182)	Accommodation			
	Patient-rating	25	8.3	0.34
	Interviewer-rating	25	8.3	0.34
33 ± 1.99 (0-6)	Use of day			
	Patient-rating	50	16.6	0.13
	Interviewer-rating	50	16.6	0.13
38 ± 11.08 (0-32)	Use of leisure			
	Patient-rating	75	16.6	0.01**
	Interviewer-rating	75	16.6	0.01**
17 ± 17.34 (7-57)	Physical health			
	Patient-rating	37.5	8.3	0.15
	Interviewer-rating	50	8.3	0.05*
	Mental health			
	Patient-rating	87.5	25	0.009**
	Interviewer-rating	87.5	25	0.009**

\*P < 0.02; \*\*P < 0.01.

Discussion

This study was designed to assess the efficacy of tiapride as an aid in the longer-term management of chemically dependent alcoholics of anxious or depressive temperament. The severity of their symptoms of anxiety and/or depression is made evident from their pre-treatment scores on the Crown-Crisp Experiential Index (Table II), which all fall in the range of high pathology. Subjects scoring in this range would normally be treated either with conventional antidepressants or with minor tranquilisers. However, there is a reluctance on the part of clinicians to use these drugs in the alcoholic population, particularly since alcoholics are known to be a high-risk group in respect of suicide. Antidepressants are commonly used as suicidal agents and have peculiar dangers in that respect. The use of minor tranquilisers also increases the risk of suicide and carries the risk of substituting dependence on drugs for dependence on alcohol. There is also evidence (Smith & Wesson, 1983) that the use of alcohol increases the likelihood of developing

dependency to benzodiazepines and it is probable that the use of benzodiazepines increases the ease with which dependence on alcohol may develop. Thus, these patients are usually deprived of the benefit of drugs which might alleviate some of the symptoms likely to encourage further drinking on their part.

Tiapride is not a drug of addiction and is therefore unlikely to enhance the development of chemical dependence on alcohol. It is relatively safe even if taken in high dosage and there is no evidence of synergistic reactions if combined with alcohol. Thus, the danger of successful suicide with the drug is less pressing. Its known antianxiety and antidepressant effects, coupled with the facts that it does not affect vigilance and may alleviate craving for alcohol, suggest its usefulness in the management of this patient group.

That subjects in this group are difficult to treat is confirmed from a consideration of our placebo group. Both tiapride and placebo groups, in addition to medication, had the benefit of regular supportive follow-up interviews conducted by therapists specialising in the treatment of alcoholism. Despite this, the placebo group showed no significant improvement over a 6-month period in a battery of pathological tests, in ratings of neuroticism, depression and self-esteem or in various measures of drinking status. Furthermore, improvement in their level of satisfaction with various measures of social functioning was, at best, modest.

The results of this study indicate that the tiapride group fared considerably better than did the placebo group. A consideration of changes in a battery of pathological tests before and after treatment offered no evidence of any deleterious effect of the drug on any of the parameters measured. In the case of the mean corpuscular volume, there was indeed a significant post-treatment shift in a beneficial direction.

The tiapride-treated group showed highly significant improvements in ratings of neuroticism, anxiety and depression as assessed by the Crown-Crisp Experiential Index, improvements which were not seen in the placebo group. In both groups, there was an improvement in self-esteem over the trial period, but only in the case of the tiapride group was the change of statistical significance.

With regard to various measures of drinking status over the treatment period, the tiapride group showed a significant increase in total days abstinent over a 6-month period and showed significantly less in the way of physical complications over that period. Their use of medical and social facilities and the number of social complications which they suffered were also

reduced, although these did not achieve statistical significance. There was a highly statistically significant reduction in the amount of ethanol taken on a heavy drinking day. In contrast, the placebo group showed only modest improvement in respect of total days abstinent over the trial period, and their use of medical and social facilities increased, as did the number of social complications which they suffered.

Some indication that these improvements in drinking levels and in neurotic symptoms were accompanied by improved satisfaction with their life situation emerges from a consideration of Table III. In all instances, the tiapride group expressed much improved satisfaction in these areas whilst, at best, the placebo group made only modest gains.

This study is open to the criticism that the numbers are small, that the research questionnaires used by the sociologist have not been validated but rely on rather obvious face validity and that the research design did not allow complete confidence that patients were fully compliant with medication. Nonetheless, the results seem clear-cut. The tiapride group drank less, had longer spells of abstinence, improved significantly on measures of neuroticism and expressed greater satisfaction with their social situation and with their physical and mental health.

#### Acknowledgements

We would like to express our thanks to Delagrang International, who financially supported this study, to the Nursing Staff of Elmdene Ward, Bexley Hospital, and to Mrs Jean Johns for secretarial and administrative assistance.

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(Accepted 24 March 1986)

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## Alcoholism: A Follow-up Study of Participants in an Alcohol Treatment Programme

G. K. SHAW, SETA WALLER, SINE McDOUGALL, JENNIE MacGARVIE and GRAHAM DUNN

One hundred and twelve alcoholic patients treated by an intensive one-month residential programme were followed up for one year. As a group, they were socially disadvantaged and highly dependent on alcohol. Outcome of treatment was assessed at six months and one year following discharge by multiple measures which included assessments of drinking behaviour, measurements of social stability, neuroticism and self-esteem, and self-ratings of satisfaction with important aspects of day-to-day living. During the first six months following treatment, 37% were abstinent or drinking in controlled fashion; during the second six months, 53% achieved this status. Improvement in drinking status was positively related to improvements in all other outcome variables.

Over the past decade or so it has been increasingly recognised that the majority of people with alcohol-related problems neither require nor particularly benefit from relatively lengthy periods of in-patient treatment (Miller & Hester, 1986a,b; Edwards *et al*, 1987; Edwards, 1988). There are, therefore, legitimate doubts about the role of Alcohol Treatment Unit (ATU) programmes and the type of patients likely to benefit from them. Reports of outcome studies from British ATUs have been scanty and this report, in essence an audit of some of the work of our unit, contributes to the body of knowledge on outcome expectation in a defined subgroup of alcoholics.

Most British ATUs prefer lesser interventions whenever possible. Thus, of 140 consecutive new patients seen in one of our ATU's out-patient clinics in 1985, only 41 (29%) were ever admitted to the unit throughout the period ending in December 1987. Most of those patients were admitted for brief periods of detoxification because of severe chemical dependence on alcohol and some were admitted because they were disabled by significant physical illness, significant brain damage or by severe neurotic or psychotic symptoms. Only seven patients (5%) were admitted to our full-scale treatment programme. Simpler interventions involving advice, counselling or support on an out-patient basis were preferred for the majority.

Patients are selected for this treatment programme by a multidisciplinary team who consider all referrals from unit staff or outside agencies. In general, those selected have failed to benefit from less intensive therapies conducted over a lengthy time period and are not disabled by psychosis or significant brain damage.

Assessment, by multiple measures, of outcome at six months and one year following the completion of the programme is reported for 112 participants.

Treatment programmes of different ATUs vary, and thus some description is necessary. Firstly, there is no requirement that participants should be committed to an abstinence goal. The programme includes group therapy, counselling, training in social skills and relaxation techniques, as well as educational material. Structured and unstructured group sessions offer patients an opportunity to consider their life circumstances, their lifestyle and their relationship with alcohol. They are asked to reflect upon the benefits and disadvantages consequent upon their drinking and to decide whether they wish to make changes in their lifestyle and their use of alcohol and, if so, what kind of help would most usefully enable them to do so.

The treatment team do not subscribe to a narrow medical view of alcoholism as an illness and accept that the disposition to drink excessively is widely determined. The programme is, however, conducted in a hospital setting and staff are health care workers. Thus, participants may formulate their problems within a medical frame.

The programme lasts for four weeks and 6-10 patients are admitted *en bloc* to participate in each one. On completion, all patients are offered follow-up appointments as appropriate.

### Method

All 112 alcoholic patients consecutively admitted to a four-week intensive treatment programme between April 1984 and January 1986 were included in this study. Computerised psychometric test scores for this group were midway between those of a group of normal controls and those of an average group of alcoholic patients admitted to this ATU (Acker *et al*, 1984). There were 92 men and 20 women. Of the 112 patients, 104 were followed up for six months and 91 for one year.

**Procedure at intake**

All patients were interviewed at intake by an experienced sociologist who collected basic sociodemographic data relating to age, marital status, socioeconomic status according to the Registrar General's Classification of Occupations (1980), level of education (age at which person left full-time education), and living circumstances.

Further data were obtained through more detailed questioning. Where necessary, specific probes were used and the time of six months before admission was taken as a point of reference. The following variables were investigated in this way.

- (1) 'Employment' - the number of days of employment in the previous six months.
- (2) 'Criminal involvement' - the number of alcohol-related and non-alcohol-related offences.
- (3) 'Admission to hospital' - the number of in-patient days in general hospitals, psychiatric hospitals or alcohol units.
- (4) 'Number of visits to medical and psychiatric facilities' - the total visits to a general hospital, psychiatric hospital, alcohol clinic or general practitioner.
- (5) 'Total number of visits to social agencies' - this includes visits to Alcoholics Anonymous (AA), an alcohol counselling service or similar agency, and religious institutions.
- (6) 'Admissions to a detoxification unit' - the number of separate admissions for detoxification.
- (7) 'Social stability' - this scale is derived from Straus & Bacon (1951). One point was awarded for each of the following (maximum score = 4):
  - (a) married or cohabiting in the previous six months;
  - (b) employed for at least five of the previous six months;
  - (c) no criminal offences in previous six months;
  - (d) living in own home or rented accommodation (as opposed to lodgings, hostels, or being of no fixed abode) in previous six months.
- (8) 'Drinking behaviour' - this includes:
  - (a) number of units consumed on a typical heavy drinking day (unit = ½ pint of beer, 1 glass of wine, or 1 single measure of spirit) assessed through a detailed reconstruction of a recent heavy drinking day;
  - (b) number of units consumed on a typical controlled drinking day, assessed as above;
  - (c) 'pattern of drinking' - categories include frequent and infrequent drinking bouts (frequency and duration recorded) with periods of abstinence or controlled drinking, as well as continuous alcoholic drinking;
  - (d) total number of days abstinent in the previous six months;
  - (e) longest period of abstinence (number of weeks);
  - (f) total number of years of heavy drinking.
- (9) 'Physical complications and consequences of drinking' - the incidence of withdrawal symptoms was graded as mild or severe; delirium tremens, fits, alcoholic amnesias, relief drinking and loss of control was noted (scale 0-10).

- (10) 'Social complications of drinking' - the number of times subject had borrowed or stolen money for drink, pawned or sold possessions, lost a job or had trouble with friends, neighbours or police through drinking was recorded (scale 0-infinity, range 0-109).
- (11) 'Neuroticism' - assessed by self-administered Crown-Crisp Experimental Index (Crown & Crisp, 1979) (scale 0-96; upper limits of normal males 22.5, females 29).
- (12) 'Self-esteem' - assessed by the self-administered Litman Scale (Litman *et al*, 1983) (scale 18-90, lower scores indicate higher levels of self-esteem).
- (13) 'Dependence on alcohol' - assessed by the Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell *et al*, 1983) (scale 0-60, scores greater than 30 indicate severe dependence).
- (14) 'Satisfaction with life situations' - this is a new self-assessment measure. Patients are asked to rate their level of satisfaction with the following life situations on a five-point scale (very satisfactory (1) to very unsatisfactory (5); scale 7-35, lower scores indicate greater satisfaction): (a) Relationships; (b) Employment; (c) Accommodation; (d) Use of day; (e) Use of leisure; (f) Physical health; (g) Mental health.

**Procedure at six-month and one-year follow-up**

With the exception of basic sociodemographic data, all measures and scales were repeated at six months and one year. This yielded two study periods: intake to six months and six months to one year. Also at six months and one year, the 'pattern of drinking' variable included two further categories: abstinent and controlled drinking.

At monthly intervals throughout the study, patients were contacted whenever possible to improve the accuracy of the data collected at formal follow-up stages.

All statistical analyses were carried out using the statistical package SAS (SAS, 1985).

**Results****Drop-outs**

Eight patients dropped out before the six-month follow-up. One patient had died of brain haemorrhage, three patients living in temporary accommodation had moved on and a further four patients who were placed in 'dry houses' left soon after admission. Another 13 patients dropped out between the six-month and one-year follow-ups. Two of these had gone abroad, the remaining 11 had changed address and could not subsequently be contacted.

**Characteristics of the sample**

The mean age of the sample was 40.6 years (s.e.m. 0.75, range 19-61), with an average of 9.11 (s.e.m. 0.51) years of problem drinking. They scored highly on measures of alcohol dependency (SADQ 31.17 (s.e.m. 1.25)) and

TABLE I  
Means (s.e.m.) of social, psychological, drinking and self-rated variables at intake, six months and one year

Variable	Intake (n = 104)	Six months (n = 104)	One year (n = 91)
Social stability	2.00 (0.11)	2.22 (0.12)*	2.46 (0.12)
Self-esteem	50.38 (1.49)	45.57 (1.70)*	42.48 (1.36)
Neuroticism	51.85 (1.45)	38.98 (2.12)**	33.27 (2.34)
Satisfaction with life situations (total scores)	24.06 (0.68)	19.97 (0.79)**	18.8 (0.81)
Days in hospital	16.73 (1.81)	8.99 (1.45)**	5.00 (1.13)
Physical complications of drinking	2.62 (0.11)	1.50 (0.15)**	2.35 (0.33)
Social complications of drinking	10.44 (1.66)	5.95 (1.29)*	5.87 (1.83)
Number of days of abstinence	77.96 (5.62)	130.87 (6.10)**	139.40 (6.68)
Longest period of abstinence (in weeks)	5.53 (0.55)	14.71 (1.003)**	16.39 (1.15)
Number of days off work	121.18 (6.87)	115.14 (7.95)	104.20 (9.21)

\* $P < 0.01$ , \*\* $P < 0.001$ .

neuroticism (Crown-Crisp Index 52.63 (s.e.m. 1.39)), and were of average intelligence on the National Adult Reading Test (NART; Nelson, 1982), scoring a mean of 28.4 (s.e.m. 1.13). As a group, their current social class was lower than their highest ever social class, and 70% were unemployed. Thirty-seven per cent were married or cohabiting, the remainder being single, separated, widowed or divorced. Twenty per cent were of no fixed abode.

#### Changes in sociodemographic and drinking variables

Table I lists various sociodemographic, drinking and self-rated variables at intake, six months and one year. For statistical purposes the means at intake are based on the 104 patients followed up for six months. With the exception of the number of days off work, the improvement between the mean at intake and at six-month follow-up was always statistically significant. Since the means at one year are better than those at six months, it follows that the differences here are also statistically significant. In the case of days off work, the change from intake to the one-year follow-up stage just fails to achieve statistical significance ( $P < 0.06$ ).

There were progressive group improvements in social stability, self-esteem and satisfaction with all life circumstances assessed as well as significant reductions in neuroticism. The mean number of days admitted to hospital progressively fell as did the physical and social complications of drinking experienced. Days of abstinence and longest period of abstinence increased. Days off work were reduced although not to a statistically significant degree.

#### Changes in drinking pattern

At the six-monthly and one-yearly follow-up stages, patients were categorised as 'abstinent', 'controlled', 'improved' or 'unchanged/worse' drinkers. 'Abstinent drinkers' were those patients who did not drink at all over the relevant six-month period. 'Controlled drinkers' were those whose maximum consumption level did not exceed eight units of alcohol a week or four units on any drinking occasion. 'Improved drinkers' were so categorised if there had been a

shift in their drinking pattern to a less pathological drinking style and if this was associated with a marked reduction in units of alcohol drunk per time period. 'Unchanged drinkers' continued to drink as much or more than at intake.

By comparison with the six months before entry to the study, the 'controlled drinkers' had reduced their total alcohol consumption by 98% over both six-month study periods. In simple terms, as a group they now drank in the course of a year what formerly they had drunk in the course of a week.

The group categorised as 'improved drinkers' at the six-month follow-up stage had decreased their consumption by 86% over that time period. Those so categorised at the one-year follow-up stage had decreased their consumption by 82% between the six-month and one-year follow-up compared with consumption over the six months before intake. As a group they now drank in the course of a week what formerly they would have drunk in a day.

These drinking categories are related to other outcome variables in Tables II and III. It is clear that the four groups defined in terms of their drinking status at six months also differ in outcome measured by psychological and social variables. The groups are, however, differently composed with respect to these variables at intake and, in the case of social stability, neuroticism, satisfaction with life situations and physical complications the differences are statistically significant ( $P < 0.05$ ) as assessed by a non-parametric test equivalent to a one-way analysis of variance, the Kruskal-Wallis test (NPARIWAY procedure in SAS (SAS, 1985)). The possibility that differences at six months merely reflected differences at intake was examined by investigating the statistical significance of improvement scores (the difference between scores at six months and scores at intake). Since the four groups differ in their variability as well as their mean levels of improvement this was also assessed by the Kruskal-Wallis test. In all cases the groups were found to be different ( $P < 0.001$ ). A closer examination of the data in Tables II and III reveals that the improvement in the abstinent, controlled and improved drinking groups is essentially the same while the unchanged group always deteriorated.

TABLE II  
Means (s.e.m.) of social and psychological variables of patients grouped by drinking status at six-month and one-year follow-up

Drinking status	Social stability	Neuroticism	Self-esteem	Satisfaction with life situation
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TABLE II  
 Means (s.e.m.) of social and psychological variables of patients grouped by drinking status at six-month and one-year follow-up

Drinking status	Social stability		Neuroticism		Self-esteem		Satisfaction with life situation	
	intake	6 months	intake	6 months	intake	6 months	intake	6 months
<i>At six months (n=104)</i>								
Abstinent (n=30)	2.27 (0.23)	2.73 (0.22)	46.70 (2.79)	20.50 (2.43)	48.66 (2.28)	35.66 (1.70)	23.13 (0.63)	15.03 (0.62)
Controlled (n=8)	2.87 (0.51)	3.37 (0.26)	44.62 (7.16)	25.75 (4.49)	43.75 (7.05)	37.50 (6.74)	19.75 (1.99)	13.87 (0.85)
Improved (n=25)	1.92 (0.26)	2.29 (0.22)	54.71 (2.17)	31.46 (2.45)	50.83 (2.81)	38.75 (2.71)	24.37 (0.83)	17.58 (0.65)
Unchanged/worse (n=41)	1.71 (0.15)	1.58 (0.17)	55.28 (2.23)	59.00 (2.30)	52.61 (2.57)	58.09 (2.48)	25.40 (0.61)	26.12 (0.64)
<i>At one year (n=91)</i>								
Abstinent (n=42)	2.33 (0.20)	2.98 (0.14)	46.71 (2.30)	18.52 (1.83)	48.57 (1.91)	34.09 (1.08)	23.14 (0.60)	14.52 (0.46)
Controlled (n=6)	3.17 (0.54)	3.50 (0.50)	45.33 (8.20)	18.17 (3.71)	43.33 (8.81)	30.83 (2.05)	19.33 (2.17)	14.33 (1.22)
Improved (n=16)	1.81 (0.26)	2.37 (0.18)	59.19 (2.93)	34.25 (4.29)	53.12 (4.05)	43.50 (2.01)	25.19 (1.06)	18.94 (1.09)
Unchanged/worse (n=27)	1.67 (0.17)	1.48 (0.20)	54.22 (2.65)	59.00 (2.93)	50.37 (2.94)	57.52 (1.78)	24.92 (0.73)	26.44 (0.73)

Significance of differences between improvement scores in different drinking status groups for all parameters  $P < 0.001$  (Kruskal-Wallis test).

TABLE III  
 Means (s.e.m.) of variables relating to admission to hospital and complications of drinking of patients grouped by drinking status at six-month and one-year follow-up

Drinking status	Out-patient visits		Days in hospital		Physical complications		Social complications	
	intake	6 months	intake	6 months	intake	6 months	intake	6 months
<i>At six months (n=104)</i>								
Abstinent (n=30)	4.93 (0.62)	2.57 (0.73)	16.23 (4.20)	0.23 (0.23)	2.23 (0.19)	-	8.26 (3.39)	-
Controlled (n=8)	8.37 (1.72)	1.87 (0.81)	8.87 (4.29)	1.75 (1.75)	2.00 (0.50)	-	7.00 (4.27)	0.12 (0.12)
Improved (n=25)	7.29 (0.77)	3.67 (0.77)	22.00 (4.64)	4.46 (1.63)	2.83 (0.23)	1.25 (0.20)	13.29 (3.72)	1.50 (0.54)
Unchanged/worse (n=41)	6.40 (0.84)	7.74 (0.86)	15.57 (1.82)	19.21 (2.79)	2.90 (0.16)	3.02 (0.14)	11.02 (2.46)	13.85 (2.79)
<i>At one year (n=91)</i>								
Abstinent (n=42)	5.67 (0.58)	2.50 (0.65)	16.09 (3.21)	-	2.33 (0.18)	-	9.92 (2.38)	-
Controlled (n=6)	5.50 (1.02)	-	5.33 (2.65)	-	2.16 (0.54)	-	5.50 (4.41)	-
Improved (n=16)	7.94 (1.00)	2.81 (0.71)	20.81 (4.17)	3.94 (1.42)	2.75 (0.28)	3.12 (0.68)	10.93 (4.18)	1.12 (0.46)
Unchanged/worse (n=27)	6.74 (1.21)	5.96 (0.86)	19.63 (3.97)	14.52 (3.03)	2.92 (0.20)	6.07 (0.45)	13.26 (3.62)	19.15 (5.45)

Significance of differences between improvement scores in different drinking status groups, on all parameters  $P < 0.001$  (Kruskal-Wallis test), with the exception of, at the one-year stage, out-patient visits  $P < 0.01$  and days in hospital  $P < 0.05$ .



TABLE IV  
Classification of outcome in terms of drinking status after six months and one year

Drinking status	Six months (n=104)	One year (n=91)
Abstinent	30 (29%)	42 (46.2%)
Controlled	8 (8%)	6 (6.6%)
Improved	25 (24%)	16 (17.6%)
Unchanged/worse	41 (39%)	27 (29.6%)

The groups at one year are differently constituted but the pattern of results is similar. The abstinent, controlled and improved drinking groups improve in terms of all variables while the unchanged group usually deteriorate. In all cases, the differences between the groups are statistically significant as assessed by the Kruskal-Wallis test.

Table IV lists outcome by drinking status at six-month and one-year follow-up. At six months, 30 patients were abstinent and by the year end the situation had improved since a further 12 patients had been recruited to this category.

Table V charts the changes in drinking status which occurred between the six-month and one-year follow-up stages. The italic entries indicate those who maintained the same status at each follow-up stage. Data to the left of these italic figures indicate those who improved between follow-up stages, figures to the right those who deteriorated. Thus, for example, between the follow-up stages, 20 patients improved, 3 deteriorated and 13 were lost to follow-up. For the purpose of analysis all 13 missing patients were allocated to the unchanged group. Thus, 20 patients were regarded as improved and eight as deteriorating. Statistical testing of marginal homogeneity (using the CATMOD procedure in SAS (SAS, 1985)) finds the trend towards improvement between the follow-up stages to be statistically significant ( $P < 0.02$ ).

### Discussion

The assessment of outcome of treatment in alcoholic patients is beset by difficulties. The strategy of this study has been to compare the social circumstances

and drinking status over the six months before treatment with the situation over two consecutive six-monthly post-treatment periods.

Data collected when patients are under research scrutiny are likely to be more accurate than pre-study assessments. For example, at the six-month follow-up stage the data (incomplete) that had been collected by monthly contact with the patients and records of clinical team contacts were available which both improved the accuracy of quantitative data and increased the confidence with which patients could be allocated to drinking-status categories. However, the method of case selection described earlier meant that programme participants had usually been known to the unit for months or years. Their in-patient and out-patient case records were, therefore, available to the research team when collecting retrospective data.

There is no control group or comparison with alternative treatment methods. Thus, it is possible that the sample might have benefited to a similar or greater extent from alternative approaches. The group were selected, however, on the grounds that they had failed to benefit to date from less intensive interventions which included counselling, out-patient attendance and usually one or more admissions for brief periods of detoxification. The time scale of one year is short but the consensus from the literature is that outcome at one year relates closely to outcome in the longer term.

Participation in this treatment programme was followed whenever possible by out-patient follow-up, and those of no fixed abode were placed in appropriate accommodation. Post-discharge experiences of these and many other kinds may have been as important as the index treatment in the determination of outcome, a dilemma common to all outcome studies.

The diversity of patients subsumed under the umbrella term 'alcoholism' is such that it is difficult to feel confident when comparing results of one

study with another population. It is possible that the control group were socially disadvantaged, were unemployed, or lived alone.

Of those who were in the programme at six months and are based on in-patient records they are to some level of agreement shown in Table IV.

Self-reporting is regarded, yet reviewed by Midanik (1985) agrees well with when the specific prime focus of occurrence are not reported by a

Midanik (1985) data, such as days in hospital closely to data that discrepancy reporting from records.

The outcome favourably with studies. Thus, of untreated alcoholics in a controlled follow-up 11-19% dependent (1980) 17% of included the findings.

These results only studies, samples are reported 17% without problem patients and married, relative or no' drinking of patients.

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TABLE V  
Changes in drinking status between the six-month and one-year follow-up stages

Status at six months	Status at one year				
	Abstinent	Controlled	Improved	Unchanged	(Missing)
Abstinent (n=30)	28	-	1	-	(1)
Controlled (n=8)	3	5	-	-	(-)
Improved (n=25)	8	1	10	2	(4)
Unchanged/worse (n=41)	3	-	5	25	(8)
Missing (n=8)	-	-	-	-	(8)
Totals	42	6	16	27	(21)

study with another that they are based on similar populations. Thus, we have outlined as clearly as possible the characteristics of our sample: they were socially disadvantaged; two-thirds were single, separated, widowed or divorced; two-thirds were unemployed; and 40% were either of no fixed abode or lived alone.

Of those who participated in our treatment programme and were available to follow-up, 37% were abstinent or drinking in controlled fashion at six months and one year respectively. These gradings are based on interview assessments and self-report. They are to some extent, however, 'validated' by the level of agreement with other outcome variables shown in Tables II and III.

Self-report in the field of alcoholism is not highly regarded, yet the weight of the research evidence reviewed by Midanik (1988) suggests that self-report agrees well with reports from collaterals, particularly when the specific amount of alcohol taken is not the prime focus of attention. Differences when they occur are not consistently in the direction of under-reporting by alcoholics.

Midanik (1988) also concludes that self-reported data, such as we have used, on drinking arrests, days in hospital and use of other agencies relate closely to data collected from official records and that discrepancies are in the direction of under-reporting from inadequately maintained official records.

The outcome of this treatment group compares favourably with the usual findings in 'no treatment' studies. Thus, Kendell & Staton (1966) reported 24% of untreated alcoholics either abstinent or drinking in controlled fashion at follow-up, Imber *et al* (1976) 11-19% depending on the time interval, and Vaillant (1980) 17% on the basis of pooled studies which included the Kendell & Staton and Imber *et al* findings.

These results also compare favourably with 'advice only' studies, although the characteristics of the samples are very different. Thus, Chick *et al* (1988) reported 17% of patients either abstinent or drinking without problems in 96 attenders at alcoholic out-patients and Edwards *et al* (1977), in a group of married, relatively stable alcoholics, reported 'slight or no' drinking problem in approximately one-third of patients.

There are two points of interest. Firstly, the results of the second six months of the study indicate significant improvements by comparison with the first six months. Secondly, those patient groups who successfully curtailed their drinking achieved considerable improvements on all social and psychological parameters examined.

There are important implications for health care economics. Those who achieved abstinent or controlled drinking status required no days in hospital throughout the subsequent year - a reduction of 16 days and seven days respectively from the six-monthly period before treatment. Those whose drinking was rated as improved had a reduced mean number of days in hospital from an estimated 21 days per six months before treatment to eight days throughout the subsequent year. Those whose drinking remained unchanged required 34 days' admission to hospital during the year following treatment. The pattern of out-patient visits is similar.

Although simpler interventions are preferred for the majority of patients presenting to alcohol clinics, there is support in the literature for the view that the most seriously disadvantaged and severely dependent alcoholics may require more intensive treatments, sometimes involving residential placement. Indeed, on the basis of an extensive literature review, Miller & Hester (1986b) conclude that "more severe and less socially stable alcoholics seem to fare better in in-patient (or more intensive) treatment". The Edwards *et al* (1977) 'treatment versus advice' study of a relatively stable, married alcoholic population has been most influential in promoting simple interventions, but the same research group, in a further analysis of their data, point out that their most highly dependent group, Gamma alcoholics, "appeared to benefit from relatively intensive treatment" (Orford *et al*, 1976).

The present study suggests that a significant proportion of a disadvantaged group of alcoholics benefits from an intensive residential treatment programme both in terms of drinking status and of social and psychological well-being. Nonetheless, 30-40% of the participants did not improve. There are indications from a closer examination of the complete study data (report in preparation) that psychological impairment was the most important predictor of outcome, highlighting the need to look for alternative treatment approaches in the brain-damaged subgroup.

A practical strategy for the management of patients with alcohol-related problems would be to deal with the majority by non-intensive interventions on an out-patient basis; the highly chemically dependent may require detoxification on an in-patient, an ambulatory or a domiciliary basis, and the socially disadvantaged and highly dependent may require more intensive interventions often involving residential placement. Outcome in this disadvantaged group is not universally poor, but those who suffer significant cognitive impairment are likely to do badly and make heavy demands on health-care resources. As yet, the

knowledge and skills to deal effectively with such patients is lacking, implying an urgent need to study their problems and to develop strategies for their treatment and rehabilitation.

#### Acknowledgements

This study was funded by a DHSS Grant no. 10146. Grateful thanks are due to Elmdene Unit treatment staff who run the treatment programme reported on and to Mrs J. Johns for invaluable secretarial assistance.

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## Tiapride in the Prevention of Relapse in Recently Detoxified Alcoholics

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**Background.** The aim was to investigate the effect of tiapride (100 mg three times a day for at least one month) on outcome following detoxification.

**Method.** The setting was a tertiary referral centre. The study design was randomised, double-blind, and placebo-controlled. One hundred routinely admitted alcohol-dependent patients were entered, and 54 completed the trial. Outcome was assessed by considering drinking status at three months and six months follow-up, and by comparing psychological status at intake and follow-up using the Crown-Crisp Experiential Index, the Litman Self-esteem scale and a Satisfaction with Life Situations scale. We also compared performance over the six months before admission with the three and six months of follow-up on measures of health, social and drinking variables.

**Results.** Tiapride proved better (usually at statistically highly significant levels) than placebo at promoting: abstinence, self-esteem, and satisfaction with life situations; and at reducing: alcohol consumption, use of health service resources, and levels of neuroticism.

**Conclusions.** Tiapride merits serious consideration in the longer-term treatment of alcoholic patients.

The achievement of long-term abstinence by chronic alcoholics following detoxification presents difficulties, and there are few helpful drugs. Tiapride, a substituted benzamide, has been reported in a number of European studies to be effective in this regard (Bonnafox *et al*, 1982; Sabourin, 1985). It has proved superior to placebo in improving outcome in addictive alcoholics of anxious or depressive temperament (Shaw *et al*, 1987).

This study measures the effect of tiapride (300 mg daily) on rates of long-term abstinence and consumption of alcohol, measures of social outcome and indicators of psychological status in alcoholic patients.

### Method

#### Sample selection and criteria

The sample was selected from chemically dependent alcoholics admitted for detoxification to a southeast London alcohol treatment unit. All the patients were withdrawn from alcohol using chlormethiazole or carbamazepine as the primary drug, prescribed in reducing dosage over 7-10 days. All patients also received a course of high potency vitamins.

Patients selected were consecutive admissions, between 25 and 60 years of age, who gave informed consent in writing and were subject to exclusion by one or more of the following criteria: an alcoholic hallucinatory syndrome; psychosis or past psychosis unrelated to alcohol abuse; evidence of Wernicke-Korsakoff psychosis; significant physical

illness; renal insufficiency or liver failure; epilepsy; taking psychotropic drugs in the 24 hours before admission; previous tiapride treatment; pregnant or nursing women; taking oral contraception; phaeochromocytoma; Hbs Ag positive status.

#### Study procedure

One hundred patients were randomly allocated to receive either tiapride (100 mg) or matching placebo three times a day under double-blind conditions, commencing during the later stages of detoxification.

Tiapride or placebo were prescribed for three months post-discharge, followed by a three month drug-free period during which time patients were monitored. Throughout, patients were asked to avoid taking other medication, and any such medication taken was noted.

All patients were offered routine clinical follow-up, mainly counselling and support by experienced clinic workers from a variety of disciplines, and in-patient treatment if required.

#### Assessments

All assessments were carried out regularly and were completed before code-breaking.

#### At intake

All patients were interviewed by an experienced sociologist who collected data by means of a

structured schedule on sociodemographic variables such as age, marital status, socio-economic status according to the Registrar General's *Classification of Occupations* (1980) and level of education (age upon leaving full-time education).

Further data were obtained by the sociologist through detailed questioning, using specific probes where necessary, and by self-rating scales on the following variables, taking as a point of reference, if applicable, the six months before admission.

- (a) Living circumstances
- (b) Employment status
- (c) Criminal involvement
- (d) Social stability (from Straus & Bacon (1951), scale 0-4)
- (e) Number of days of abstinence
- (f) Longest period of abstinence
- (g) Daily intake on a heavy drinking day
- (h) Pattern of drinking: continuous heavy drinking; frequent (four or more) or infrequent (three or less) bouts with intervening periods of abstinence or controlled drinking
- (i) Physical complications
- (j) Social complications (scale 0-5)
- (k) Days of hospitalisation
- (l) Visits to out-patient facilities
- (m) Satisfaction with life situations (scale 7-35)
- (n) Self-esteem scale (Litman *et al* (1983); scale 18-90, high scores = low self-esteem)
- (o) Severity of Alcohol Dependence Questionnaire (Stockwell *et al* (1983); scale 0-60)
- (p) Crown-Crisp Experiential Index (Crown & Crisp (1979); scale 0-96).

The details of the variables and of the rating scales have been reported previously (Shaw *et al*, 1987; 1990) and are largely self-explanatory with the exception of 'physical complications', which measures withdrawal symptoms (i.e. tremor, sweating, hallucinations, amnesia, fits and relief drinking) and 'social complications of drinking' which quantifies problems such as getting into debt for drink, pawning or selling possessions, stealing, losing jobs, or being in trouble with the police or with neighbours.

**Biochemical data.** Blood samples were collected and assessments made of serum bilirubin, alkaline phosphatase, aspartate transaminase, gamma-glutamyl transpeptidase, haemoglobin, mean corpuscular volume (MCV) and protein electrophoresis.

#### *At follow-up*

At three and six months follow-up, the intake interview was repeated using the structured and

self-completion schedules. Descriptive variables collected at intake were not repeated.

Attempts were made to collect blood samples to repeat biochemical assessments. However, the interviews were often conducted in the patients' homes by the sociologist, and so collection of blood samples was not always possible.

#### *Categorisation by drinking status*

At follow-up, patients were assigned to drinking status categories as follows:

**Abstinent:** no drinking throughout the relevant three months.

**Controlled drinking:** drinking restricted to a maximum of three occasions in any one week, and the amount taken not more than four units of alcohol on any occasion.

**Improved:** drinking style changed to a less pathological style, in practice always to infrequent bouts with intervening abstinence or controlled drinking (defined above), and by a reduction in consumption of at least 70% compared with the six months before admission.

**Unchanged or worse:** none of the above.

#### **Statistical analysis**

All statistical analyses were carried out using the Statistical Package for the Social Sciences (SPSS/PC and v2.0). Pearson  $\chi^2$  tests were performed using the CROSSTABS procedure or, where relevant, Fisher's exact two-tailed test. The ANOVA procedure in SPSS was used to carry out analyses of covariance.

## **Results**

#### **Patient sample**

Of the 100 patients, two-thirds were living with adult companions, half were married or in stable cohabitation, and half were currently employed. Two-thirds were continuous heavy drinkers, and the other third drank in bouts with episodes of either abstinence or controlled drinking. The group tended to be highly dependent on alcohol, in that the mean result of the Severity of Alcohol Dependence Questionnaire (SADQ) was 32.63 (range 6-52, s.e. = 1.05). The average intake on a heavy drinking day, 36.4 units of alcohol (range 10-128 units, s.e. = 1.80), approximated to a bottle of spirits (300 gm of alcohol), and they had been drinking heavily for a mean of 10.3 years (range 1-34 years, s.e. = 0.74).

The tiapride and placebo groups did not differ significantly on any of these variables.

*Study completers and drop-outs*

Fifty-four patients who complied with medication for at least one month were designated 'study completers' and all were assessed at three and six month follow-up stages by the research sociologist. The remaining 46 patients were defined as drop-outs.

One patient on tiapride was withdrawn from the study following a deliberate overdose of sedative medication. Another patient, also on tiapride, was withdrawn when admitted to a general hospital with bilateral ulnar nerve paralysis. One patient on placebo was withdrawn because of hepatic cirrhosis and four patients, three on placebo and one on tiapride, discontinued because they claimed the medication made them feel ill.

Compared with completers, drop-outs were less likely to be married (39% v. 54%, NS) and more likely to live alone (39% v. 24%, NS). The groups were comparable in terms of drink-related variables.

*Intake measures in study completers*

The sociodemographic characteristics of study completers are shown in Table 1. The tiapride group had a higher proportion of married patients (16 of 24) compared with the placebo group (13 of 30:  $\chi^2=2.92$ , d.f. 1,  $P=0.09$ ), and a higher proportion of patients living with an adult companion: 23 of 24, compared with 17 of 30 ( $\chi^2=10.6$ , d.f. 1,  $P=0.001$ ).

Table 1  
Sociodemographic characteristics of study completers at intake

Characteristic	Tiapride (n=24)	Placebo (n=30)
Mean age (years)	40	42
range	22-55	26-59
Marital status		
married or cohabiting	16 (67%)	13 (43%)
separated, divorced, widowed	2 (8%)	13 (43%)
single	6 (25%)	4 (13%)
Living circumstances		
living with adult companion	23 (96%)	17 (57%)
living alone	1 (4%)	12 (40%)
no fixed abode	0 (0%)	1 (3%)
Employment status		
employed	12 (50%)	19 (63%)
unemployed	12 (50%)	11 (37%)
Social stability		
0	2 (8%)	0 (0%)
1	3 (13%)	3 (10%)
2	3 (13%)	12 (40%)
3	8 (33%)	8 (27%)
4	8 (33%)	7 (23%)

This latter difference has been taken account of in some of the analyses of outcome.

Differences in drinking characteristics between the groups at intake were not marked or statistically significant. The placebo group had been drinking heavily for rather longer (mean 12.23 v. 9.04 years) and drank slightly more on a typical heavy drinking day (mean 35.47 v. 33.25 units). The tiapride group was slightly more dependent on alcohol (mean SADQ 33.62 v. 30.76) and had enjoyed fewer days of abstinence (mean 35.79 v. 47.7 days) in the six months before admission.

*Analysis of outcome**Study completers*

The means and standard errors of outcome variables for study completers, at intake and both follow-up stages, are listed in Table 2.

At intake there were no statistically significant differences between tiapride and placebo groups on any variable. At each follow-up stage, the tiapride group improved on all variables, mostly at high levels of statistical significance ( $P<0.001$ ). The placebo group made significant improvements, at both follow-up stages, in daily intake on a heavy drinking day ( $P<0.001$ ), total number of days of abstinence ( $P<0.01$  and  $P<0.001$ ), social complications ( $P<0.01$ ), and self-esteem (at three months only,  $P<0.01$ ). The tiapride group had more days of abstinence, fewer out-patient visits and fewer days of hospitalisation. They also experienced fewer social complications, gained self-esteem and satisfaction with life situations, displayed milder neurotic symptoms and made greater gains in social stability.

*Study completers at follow-up, controlling for intake values.* Among study completers, there were more people living alone, of no fixed abode or in lodgings in the placebo than in the tiapride group (Table 1). The influence of initial living circumstances on outcome (summing three- and six-month values as a measure of overall outcome) was investigated through an analysis of covariance, in which treatment group (placebo v. tiapride) and living circumstances (alone or of no fixed abode v. living with adult) were both treated as qualitative factors and the intake measure of the variable as the covariate.

Compared to the placebo group, the tiapride group made greater improvements in: consumption

Table 2  
Outcome variables at intake and follow-up for study completers, and significance of mean within-group differences between intake and each outcome stage

Outcome variables	At intake (last 6 months)		At 3 months (last 3 months)		At 6 months (last 3 months)	
	Tiapride (n=24)	Placebo (n=30)	Tiapride (n=24)	Placebo (n=30)	Tiapride (n=24)	Placebo (n=30)
Social stability (0-4)						
mean	2.71	2.60	3.00	2.37	3.00	2.37
s.e.	0.27	0.18	0.22	0.18	0.22	0.18
Daily intake on heavy drinking day						
mean	33.25	35.47	8.46***	20.97***	9.17***	23.37***
s.e.	3.58	3.02	2.03	2.91	2.26	2.70
Total no. of days of abstinence <sup>1</sup>						
mean	17.90	23.85	76.88***	50.30**	77.04***	49.40***
s.e.	5.29	5.64	4.59	6.47	3.80	6.49
Social complications						
mean	1.04	1.17	0.25**	0.70**	0.13***	0.73**
s.e.	0.22	0.18	0.14	0.14	0.07	0.12
Total no. of OP visits <sup>1</sup>						
mean	1.73	2.63	1.38	2.80	0.96*	2.50
s.e.	0.28	0.41	0.18	0.25	0.20	0.26
Total no. of IP days <sup>1</sup>						
mean	5.25	4.72	0.25**	5.87	0.58**	5.53
s.e.	1.68	0.76	0.25	1.38	0.41	1.48
Neuroticism (0-96)						
mean	57.50	55.03	36.38***	51.20*	33.33***	52.77
s.e.	2.15	2.10	2.27	1.90	2.81	2.04
Self-esteem (18-90)						
mean	51.42	47.33	38.54***	44.83*	36.67***	45.97
s.e.	2.18	2.09	1.64	1.58	1.85	1.59
Satisfaction (total score)						
mean	24.38	23.53	17.46***	23.07	17.13***	23.99
s.e.	0.65	0.61	0.97	0.92	0.98	0.88

1. Values at intake halved to approximate to three-monthly periods.  
\* =  $P < 0.05$ ; \*\* =  $P < 0.01$ ; \*\*\* =  $P < 0.001$ .

on a heavy drinking day ( $F_{1,49} = 6.49$ ,  $P = 0.014$ ); days of abstinence ( $F_{1,49} = 7.23$ ,  $P = 0.01$ ); social complications of drinking ( $F_{1,49} = 4.33$ ,  $P = 0.04$ ); days of hospitalisation ( $F = 9.78$ ,  $P = 0.01$ ); out-patient attendances ( $F_{1,49} = 27.56$ ,  $P = 0.001$ ); social stability ( $F_{1,49} = 7.87$ ,  $P = 0.01$ ); neuroticism ( $F_{1,49} = 33.39$ ,  $P = 0.001$ ); self-esteem ( $F_{1,49} = 16.97$ ,  $P = 0.001$ ); satisfaction with life situations ( $F_{1,49} = 34.76$ ,  $P = 0.001$ ).

In contrast, the group whose living circumstances were more favourable made greater improvement only on social complications of drinking ( $F_{1,49} = 7.48$ ,  $P = 0.01$ ) when compared to the less favoured group.

In no instance was the interaction effect between treatment condition and living circumstances statistically significant.

*Assessment of outcome by drinking status.* At the three and six month follow-up stages patients were allocated to the categories as described previously. The data are presented in Table 3. At

three and six months respectively, 22 (41%) and 20 (37%) study completers were abstinent or drinking in a controlled fashion, 11 (20%) and 10 (19%) were rated as improved and 21 (39%) and 24 (44%) as unchanged or worse.

Patients treated with tiapride improved their drinking status significantly by comparison with the placebo group at both follow-up stages ( $P < 0.001$ ).

Table 3  
Drinking status outcome of study completers at three and six months

Drinking status	At 3 months		At 6 months	
	Tiapride	Placebo	Tiapride	Placebo
Abstinent	10	9	10	7
Controlled	3	0	3	0
Improved	9	2	10	0
Unchanged or worse	2	19	1	23
Total	24	30	24	30

*Drop-out group*

Nineteen of the 26 drop-outs allocated to the tiapride group and nine of the 20 allocated to the placebo group had been seen on one or more occasions in an out-patient clinic, or had been admitted to hospital during the follow-up period. Information was available on three further patients, in two cases from cohabitants and in one case from the mother with whom the patient lived. This information was considered sufficiently reliable to allow clinical assessment of drinking status.

Rated at six months only, seven of the 46 drop-outs were abstinent, 12 were improved, 12 were unchanged or worse, and no information was available on 15. There were no significant differences in outcome between those originally allocated to the tiapride group and those allocated to the placebo group.

*Total sample - analysis by intention to treat*

Data on the total sample are presented in Table 4. Drop-outs have been allocated, in the one case to the unchanged category and in the other, to known drinking status. Where all drop-outs are allocated to the unchanged category, at six months 20 subjects (20%) were abstinent or drinking in controlled fashion, 10 (10%) were improved and 70 (70%) were unchanged. Patients taking tiapride improved their drinking status more than those who took placebo ( $P < 0.001$ ).

Allocating drop-outs to known drinking status as described in the previous section, at six months 27% of all patients were abstinent or drinking in controlled fashion, 22% were improved, 36% were unchanged and no information was available on 15%. Thirty-six (72%) of the group taking tiapride were abstinent, drinking in controlled fashion or improved, compared to 13 (26%) of the control group ( $P < 0.001$ ).

Table 4  
Drinking status of the total sample at six months follow-up, allocating drop-outs to known or to unchanged categories

Drinking status	Drop-outs to unchanged category		Drop-outs to known drinking status	
	Tiapride	Placebo	Tiapride	Placebo
Abstinent	10	7	15	9
Controlled	3	0	3	0
Improved	10	0	18	4
Unchanged or worse	27	43	9	27
No information	0	0	5	10
Total	50	50	50	50

*Outcome assessed by drinking category and other outcome parameters*

The relationships between drinking status outcome and other outcome variables are presented in Table 5. The left hand section shows that subgroups, defined by drinking category at three months follow-up, were very similar to each other at intake.

The right hand section compares improvements made between intake and three months follow-up in each of the sub-groups. Differences in degree of improvement between the abstinent and the improved groups were never statistically significant. With the exception of days of hospitalisation and out-patient visits, both abstinent and improved groups improved significantly by comparison with the unchanged group. In the case of days of hospitalisation, the differences only just fail to achieve statistical significance (abstinent v. unchanged,  $P = 0.053$ ). The situation at six-months follow-up (data not presented) was essentially the same.

The unchanged group made modest reductions in days of hospitalisation and in the number of physical and social complications experienced, but did not improve their levels of neuroticism, self-esteem or satisfaction with life situations. Their social stability score deteriorated.

*Long-term maintenance of outcome for study completers*

*Drinking status.* Changes in drinking status between the three- and six-months follow-up stages are reported in Table 6. Figures to the left of or below the bracketed entries indicate improvement between follow-up stages, those to the right or above, deterioration. Bracketed entries indicate identical drinking status at both points.

In general, the situation at three months is maintained at six months but two patients in the tiapride group have improved, one from a rating of improved to abstinence and one from unchanged to improved, while one has deteriorated from abstinence to the improved category. In contrast, no patient in the placebo group improved and four deteriorated to drinking uncontrollably.

*Other variables.* From Table 2 a clear pattern is discernible. All significant changes at follow-up stages are improvements and, with the single exception of the number of out-patient visits, have taken place by the three months stage. In all instances, these improvements are maintained at six months.



Table 5  
Outcome variables at intake in sub-groups categorised by drinking status at three months follow-up, and mean change scores between intake and three months follow-up

Outcome variables	Mean score at intake			Mean change scores <sup>1</sup> between intake and 3 month follow-up		
	Abstinent & controlled (n = 22)	Improved (n = 11)	Unchanged (n = 21)	Abstinent & controlled (n = 22)	Improved (n = 11)	Unchanged (n = 21)
Social stability						
mean	3.00	2.27	2.52	0.41***	0.09*	0.52
s.e.	0.26	0.41	0.16	0.13	0.21	0.16
OP visits						
mean	3.85	3.64	4.35	2.18	2.18	2.67
s.e.	0.70	0.91	0.95	0.85	0.80	1.04
Days of hospitalisation						
mean	9.41	12.82	8.90	8.95	8.81	2.81
s.e.	2.64	6.27	1.21	2.37	7.00	1.95
Physical complications						
mean	3.18	3.91	3.82	3.18***	2.91**	1.33
s.e.	0.27	0.21	0.23	0.27	0.34	0.33
Social complications						
mean	0.86	1.36	1.19	0.82	0.91*	0.19
s.e.	0.24	0.28	0.21	0.23	0.25	0.21
Neuroticism						
mean	52.82	59.54	56.86	17.18***	15.45***	2.57
s.e.	2.39	2.99	2.57	3.11	3.83	1.68
Self-esteem						
mean	51.27	49.82	46.81	13.55***	7.36**	0.48
s.e.	2.42	3.29	2.43	2.20	2.30	1.24
Satisfaction						
mean	22.36	26.82	23.90	7.05***	4.36***	-1.48
s.e.	0.78	0.57	0.60	0.77	1.31	0.42

1. Change scores adjusted if necessary so that positive scores represent improvement.  
\* $P < 0.05$ ; \*\* $P < 0.01$ ; \*\*\* $P < 0.001$ .

### Compliance

Only half of study completers took tiapride or placebo for the full three month period, and so all clinical documents were scrutinised for reasons for this. One patient on placebo was known to have moved away from the area, one on tiapride was withdrawn in order to prescribe antidepressants, and another on tiapride was withdrawn to facilitate investigation of seizures which had occurred before admission to the study. No reason for early discontinuation was reported in any other case.

#### Factors related to duration of compliance

Study completers who discontinued either medication early had fewer total days of abstinence (mean 34.96 v. 48.9 days) in the six months before entry than those who were fully compliant. There is also a suggestion that members of the placebo group discontinuing medication early had experienced more social complications of drinking (mean 1.50 v. 0.95) before intake than continuers.

The 12 study completers who took tiapride for the shortest time (i.e. for the first month of follow-up but discontinuing before the end of month two) were specifically considered. At the one month stage, nine were abstinent, one was drinking in controlled fashion and two had improved. Nine of the 12 felt in better physical health, and eight of the 12 rated their mental health as improved. None complained of undesirable side-effects.

The impression gained was that the usual reason for discontinuation of medication was the belief that it was no longer necessary.

#### Effect of compliance duration on outcome

This was investigated through an analysis of covariance in which treatment group (placebo v. tiapride) and duration of compliance (one v. two v. three months) were treated as qualitative factors and the corresponding intake measure of the variable as covariate. Three and six month values were summed as a measure of overall outcome.

The tiapride group made significantly greater improvement than the placebo group in: daily

Table 6  
Changes in drinking status between three and six months for study completers

Status at 3 months	Status at 6 months								
	Abstinent		Controlled		Improved		Unchanged		
	T	P	T	P	T	P	T	P	
Abstinent									
T (n=10)	(9)				1				
P (n=9)		(7)							2
Controlled									
T (n=3)			(3)						
P (n=0)				(0)					
Improved									
T (n=9)	1				(8)				
P (n=2)						(0)			2
Unchanged									
T (n=2)					1		(1)		
P (n=19)									(19)
Total	10	7	3	0	10	0	1		23

intake of alcohol; total days of abstinence; social complications; social stability; out-patient visits; days of hospitalisation; level of neuroticism; self-esteem; and satisfaction with life situations. Duration of compliance significantly influenced: daily intake of alcohol ( $F_{2,47}=3.72, t=0.032$ ); total days of abstinence ( $F_{2,47}=4.19, t=0.021$ ); out-patient visits ( $F_{2,47}=4.94, t=0.011$ ); neuroticism ( $F_{2,47}=9.41, t<0.001$ ); self-esteem ( $F_{2,47}=3.69, t=0.033$ ); and satisfaction with life situations ( $F_{2,47}=3.92, t=0.027$ ).

The interactions between treatment condition and duration of compliance were significant for total days of abstinence, neuroticism and self-esteem, implying that for these variables the greatest benefits derived from taking tiapride for periods longer than one month.

*Drinking status*

Drinking status at three months related to duration of compliance with medication is reported in Table 7. Eleven of 29 patients who complied for the full three month period were unchanged, as were 10 of the 25 complying for shorter periods. This does not suggest that duration of compliance is relevant but, when the groups are considered separately, a different picture emerges.

In the placebo group, 10 of 20 patients who complied with medication for the full three months were rated abstinent or improved, compared with one of 10 so rated who were compliant for shorter periods ( $\chi^2=8.92, d.f. 4, P=0.06$ ).

In the tiapride group, eight of the nine fully compliant patients were rated as abstinent or

Table 7  
Duration of compliance and drinking status at three months in study completers

Duration of compliance	Drinking categories			
	Abstinent or controlled	Improved	Unchanged	Total
Combined sample				
1 month	3	8	7	18
2 months	3	1	3	7
3 months	16	2	11	29
Total	22	11	21	54
Tiapride				
1 month	3	8	1	12
2 months	3	0	0	3
3 months	7	1	1	9
Total	13	9	2	24
Placebo				
1 month	0	0	6	6
2 months	0	1	3	4
3 months	9	1	10	20
Total	9	2	19	30

improved, compared with 14 of the 15 less compliant patients. However, of those who took medication for one month only, eight of the 12 were rated as improved, three as abstinent or controlled drinkers and one as unchanged, whereas of those who took tiapride for two months or longer, 10 of 12 patients were abstinent or controlled drinkers, one was improved and one unchanged ( $\chi^2=9.83, d.f. 4, P<0.05$ ).

These data support the view that improvement in drinking status within the placebo group tended to occur only in those complying for three months, and that compliance with tiapride for two months or longer was associated with a better drinking status rating than compliance for lesser periods.

**Biochemical data**

Interpretation of biochemical data is limited by the high rate of missing values (41 patients had blood tests at one month follow-up, 29 at three months). Subject to this limitation, both tiapride and placebo groups showed falls to more desirable levels of MCV, bilirubin, aspartate transaminase, gamma-glutamyl transpeptidase and alkaline phosphatase, and slight rises in levels of serum albumin. Analysis of covariance did not reveal important differences between tiapride and placebo groups. All that can be asserted is that tiapride had no adverse effect on these parameters.

### Side-effects

Each patient was asked by the trial doctor (using a structured schedule) whether they had experienced any side-effects during each month of the trial. Six patients, three in the tiapride group and three in the placebo group, complained of side-effects on eight separate occasions.

There were three complaints of numbness, one by a patient on tiapride and two by patients on placebo. Dizziness was complained of three times, by patients in the tiapride group; two patients made this complaint, one in month 1 only, the other complaining of dizziness in months 2 and 3. One patient in the placebo group complained of muscle pain and another complained of loss of libido.

In general, the drug was well tolerated and in this study never of clinical significance.

### Discussion

In this study, patients taking tiapride made major improvements on a range of measures of social functioning and of neuroticism, significantly reduced their use of medical resources, felt increased satisfaction with important aspects of day-to-day living, significantly increased their days of abstinence and reduced their consumption of alcohol on drinking days.

In contrast, controls who received placebo made lesser degrees of improvement on drinking parameters and no major improvement in any other area.

Clinical assessment of drinking status confirmed the benefits enjoyed by the tiapride group. Considering study completers alone, at six months follow-up 54% of patients on tiapride were abstinent or drinking in controlled fashion, 42% were improved and 4% rated as unchanged. In the placebo group, 23% were abstinent and 77% unchanged.

The gradation in drinking status in those taking tiapride, with a significant proportion of the sample rated improved, and the 'all or nothing' abstinent/unchanged response in the placebo group, suggests a drug-related effect but raises questions about the need for an 'improved' category. The need stems from the increasing recognition that a proportion of problem drinkers are able to return to relatively harm-free drinking, highlighting the need for definition beyond the simple drinking/abstinent dichotomy.

We have attempted to establish the validity of our improved category by requiring that allocation to this sub-group required both a clear shift to a less pathological drinking style and a lower overall alcohol consumption. Subjects were only rated 'improved' if they had moved into the 'infrequent

bout' drinking style and if this was associated with a significant reduction in alcohol consumed. Assessed in this way, the mean reduction in alcohol consumption in improved patients was, at the three months follow-up stage, 90% (range 78-97%), and at the six months stage, 88% (range 71-95%).

The improved group made significantly greater improvements on a range of social, medical and psychological variables than those rated as unchanged, and were thus more closely related to the abstinent group in respect of outcome variables.

The study design allowed consideration of the effect of duration of compliance. In both groups, a positive relationship between duration of compliance and drinking status at outcome has been reported. The data showed no relationship between duration of compliance and measures of health resource usage or measures of neuroticism within the placebo group. Within the tiapride group, however, duration of compliance was positively related to improvement in levels of neuroticism and self-esteem.

The placebo group improved only on measures of drinking behaviour, and then only to those who complied with medication for the full three month period. Tiapride on the other hand, was associated with improvements in drinking behaviour, in levels of neuroticism, in use of medical resources, in social stability and in expressed satisfaction with life situations. This followed treatment for as short a period as one month, but those who took tiapride for longer periods achieved greater improvements in drinking behaviour and in levels of neuroticism.

On all measures of outcome, gains achieved over the first three months of treatment were maintained throughout the subsequent, drug-free three months. There was no evidence of further improvements during that drug-free period, no indication of withdrawal effects, and few side-effects.

Self-reported data in the field of alcohol research are not highly regarded, but Midanik (1988), reviewing the literature, considered the consensus to be that self-reported data in the clinical context are very similar to those collected from collateral sources, particularly if the exact quantity of alcohol taken is not the prime focus of interest. Discrepancies are by no means always in the direction of underreporting by patients. Similarly, self-report compares favourably with data collected from official sources such as length of hospitalisation, drunkenness offences and days off work.

However, the debate continues, and Keso and Salaspuro (1990), on the basis of a follow-up of 73 alcoholics, recommended that "no studies should be carried out about the drinking outcome of alcoholism treatment without the use of laboratory markers as

part of the evaluation". On the other hand, Duckert *et al* (1992) concluded that biochemical markers "should be used with caution" and observe that "according to our data a reasonable trustworthiness of self-reports could be assumed".

In common with most studies of alcoholic patients, drop-out rate was high. This limits the confidence in which conclusions can be drawn, but the attention to treat' analysis still found tiapride superior to placebo, as did the analysis taking account of disparities in social support between tiapride and placebo groups.

### Conclusions

The way in which tiapride exerts its beneficial effect is still a matter for conjecture. Since it is known to have anxiolytic and antidepressant effects, it is possible that by improving dysphoric symptoms the need to drink is lessened. A careful consideration of the data does not, however, suggest that a reduction in dysphoria was a usual antecedent to improvement in drinking status. Indeed, within the placebo group, those who discontinued drinking did not improve their level of neuroticism.

Tiapride has been shown to alleviate withdrawal symptoms and might therefore lessen the urge to continue drinking once the drinker has relapsed. In any event, benefits would probably be closely associated with the medication-taking period; this does not seem to have been the case in this study. Tiapride is known to have an effect on a sub-group of dopamine receptors, particularly super-sensitised receptors, in the mesolimbic area. There is increasing evidence from animal studies (Wise & Bozarth, 1987; Wise & Rompre, 1989) that dopaminergic pathways in this area are closely involved with the mechanisms underlying alcohol-seeking behaviour and with dependence on alcohol and other drugs. It is possible that tiapride interferes in a beneficial way with this disturbance at that level.

Tiapride lacks addictive potential, has no adverse effect on vigilance and does not interact with alcohol. These characteristics, taken in combination with the benefits demonstrated in this and other studies,

suggest its usefulness in the treatment of a serious medico-social problem where therapeutic success is currently limited. Further studies, in particular longer term studies, seem justified.

### Acknowledgements

We would like to express our thanks to Delagrang International who financially supported this study, to the nursing staff of Elmdeane Ward, Bexley Hospital, and to Mrs Jean Johns for secretarial and administrative assistance.

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(First received May 1992, final revision September 1993, accepted November 1993)