

B173 Room, Robin

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2

## Sociological Aspects of the Disease Concept of Alcoholism

ROBIN ROOM

### 1. INTRODUCTION

On August 19, 1981, the U.S. Postal Service issued a stamp carrying the message, "Alcoholism: You Can Beat It!", including a caduceuslike symbol associated with the National Council on Alcoholism. Drawing from publicity releases concerning the stamp, the *New York Times* "Stamps" column for August 9 included, along with a thumbnail history of drinking and a favorable mention for the NCA, the following:

Alcohol has been a pleasure to drink and a problem to mankind since the beginnings of ancient civilization. Alcoholism is a disease, until recently a hidden and unrecognized disease.

In the last several decades, there has been a growing recognition that alcoholism is a medical and not a moral problem, and that it is a disease that in most cases can be treated effectively. There has been a marked change in the public attitude toward it. . . .

Morality issues have over the decades been a major factor in holding back treatment for alcoholism. New approaches to alcoholism began after World War II with the founding of Alcoholics Anonymous and the research findings of the Yale School of Alcohol Studies. In 1951 the World Health Organization recognized alcoholism as a disease and the American Medical Association followed suit in 1956. The National Institute on Alcohol Abuse and Alcoholism was founded in 1971.

Gains are being made, although alcoholism claims an estimated 10 million victims in the U.S. Each year, 30,000 deaths are attributed to cirrhosis of the liver alone. Alcohol misuse and alcoholism are implicated in statistics on homicide, suicide, domestic violence, fire deaths and drownings. Fifty percent of fatal accidents on the road are alcohol related.

Alcoholism is definable: a disease in which the drinking of alcoholic beverages becomes a compulsion, a chronic illness characterized by the habitual drinking of

alcoholic beverages to the extent that health and social functioning are impaired. But the root causes of the disease are not yet known to medicine. It is known that alcoholism is treatable, and that alcoholics can and do recover.

On the stamp's day of issue, the *Wall Street Journal* carried a full-page advertisement from NCA, under the headline, "Little by little, we can change the way the nation thinks." "Every time you use this stamp," the text asserted, "you'll be joining the fight against the third largest cause of death in the country. Changing the way people think. Helping reduce the stigma that keeps people from seeking help for this treatable disease."

The major tenets of the alcoholism movement's disease concept of alcoholism are summarized in these quotations. The issuance of the stamp, and the publicity that surrounded it, conforms to the program set out almost 40 years before, in what may be seen as the movement's first manifesto:

The chief obstacle to progress in the scientific solution of problems concerning alcohol lies in the existence of a prevailing body of public opinion which is apathetic to this approach. One would think that science could do without public opinion, but it cannot. This is especially true when the subject requires organized research and, further, calls for popular acceptance of the results of research. . . .

What are the ideas of the least common denominator concerning alcohol which can be most easily established? . . . The first is, that the "alcoholic" is a sick man who is exceptionally reactive to alcohol. . . . In the viewpoint that the alcoholic is a sick man, there is implicit a whole set of ideas which must be explicit and must be inculcated into public opinion. Sickness implies the possibility of treatment. It also implies that, to some extent at least, the individual is not responsible for his condition. It further implies that it is worth while to try to help the sick one. Lastly, it follows from all this that the problem is a responsibility of the medical profession, of the constituted health authorities, and of the public in general. While students of alcoholism might not formulate the essence of their findings in exactly these terms, at least these expressions do not conflict with the findings of science, and they are capable of gathering the emotional tone which a favorable public opinion requires. . . .

The fact that the ideas we wish to advance have been repeatedly expressed in scientific literature in the last 150 years without penetrating the shell of public indifference is not grounds for discouragement. As long as these ideas were confined within the covers of scientific publications, and remained in the terms of scientific formulation, they could not capture the public mind. When the dissemination of these ideas is begun through the existing media of public information, press, radio and platform, which will consider them as news, a new public attitude can be shaped. Fortunately, it will not be difficult to use these media of publicization for this purpose because, no matter how often the idea may be repeated, it will remain news until its acceptance has become universal.

Not that all the problems of alcohol concern the alcoholic alone; but the place to begin is with him. It is here that science can be made to mean something to people in their personal lives (Anderson, 1942, pp. 376-8).

The author of this manifesto, himself a recovered alcoholic, was at the time Director of Public Relations of the Medical Society of the State of New York, and Chairman of the Board of the National Association of Publicity Directors.

His message fell upon ready ears among the scholar-entrepreneurs at what became the Yale Center of Alcohol Studies; E.M. Jellinek invited him to repeat it at both the 1943 and 1944 Yale Summer Schools (see Anderson, 1945, pp. 367-368), and Howard Haggard, the Center's director, persuaded him to raise money to circulate reprints of the 1942 article (Anderson with Cooper, 1950, pp. 72-73). Within a couple of years, another talented recovered alcoholic with public relations expertise, Marty Mann, had joined the staff of the Yale Center as the founding executive director of what eventually became the National Council on Alcoholism. By the late 1940s the senior Center staff were deeply involved in a massive and successful public-relations effort to carry out the programs outlined by Dwight Anderson and Marty Mann, aiming not only to change public opinion but to spread movement institutions—state alcoholism agencies, Yale Plan Clinics, and local NCA chapters—to every corner of the land (see Johnson, 1973; Room, 1978).

Conventionally, discussions of the disease concept of alcoholism do not start with the "alcoholism movement,"\* as we term it here, but rather with Jellinek, Keller, Kerr, Crothers, Rush, or Huss—the long line of nosological or clinical discussions of alcoholism's status and characteristics as a disease. Even to talk of the "alcoholism movement" is itself a sociological innovation; although the phrase is now creeping into common use, it seems to have been first used by a sociologist (Straus, 1960), and by the early 1970s was appearing regularly in sociological discussions. The early pioneers of the modern movement would have described themselves instead in terms of "the new scientific approach to alcoholism." The difference in phraseology reflects a consistent strain between clinical and alcoholism-movement thought, on the one hand, and sociological thought, on the other. For those in the movement, "alcoholism" is a Platonic entity rather than a human construction; it really exists, just as all the other diseases in nosological listings exist—for clinical thought in the modern era has generally been dominated by Platonic assumptions about disease entities (Room, 1970). Against the movement's argument, there has been a small countertradition, still within the Platonic disease-entity frame of reference, arguing that alcoholism does *not* exist as a separate clinical entity. But sociologists have not been heavily involved in this tradition. The distinctive approach of sociologists, throughout the era of the modern alcoholism movement, has rather been a nominalist stance to the disease concept—a view of the concept of alcoholism as a social creation of particular times and situations.

\* Throughout this paper, the term *alcoholism movement* is used to refer to the outwardly directed effort described above. It may seem paradoxical that Alcoholics Anonymous as an institution is thus excluded from the definition. But though AA came into existence in the middle of the preceding decade, though its success was a precondition for the movement we are discussing, and though many of its members as individuals played important roles in the movement, AA as an institution has always directed its attention inwards at self-supported self-help, rather than outwards at building a publicly funded treatment system.

This distinctive stance is much easier to discern now with hindsight than it would have been twenty years ago. Within sociology itself, it is only in recent years that a self-conscious "constructivist" approach to the study of social problems has emerged (Gusfield, 1983), including a substantial tradition of work on the conceptualizations, interests, and implications involved in the concept of alcoholism as a disease (e.g., Gusfield, 1967; Johnson, 1973; Room, 1978; Levine, 1978; Müller and Tecklenburg, 1978; Wiener, 1981; Conrad and Schneider, 1980; Gusfield, 1981). And one can certainly find evidence of adherence by sociologists to the alcoholism movement's conceptualizations. For instance, a glance at many social-problems textbooks, particularly those written by sociologists with no research experience in alcohol studies, would reveal a presentation of alcohol problems in terms of an orthodox alcoholism disease concept. Selden Bacon, the first alcohol sociologist of the modern era, played a leading role in the alcoholism movement in the late 1940s and early 1950s, and one or two sociologists—notably Harrison Trice and David Pittman—have continued to play such roles. The *locus classicus* of late 1950s work in alcohol sociology, *Society, Culture and Drinking Patterns*, reprints two central scholarly expressions, by Jellinek and Keller, of alcoholism movement thought (Pittman and Snyder, 1962, pp. 310–329, 356–368).

Nevertheless, even in the 1950s, when sociologist's populist impulses, and the conviction that here was "a way of dealing with alcoholism that worked," carried them along with the general "capitulation" of researchers to "the lay wisdom of Alcoholics Anonymous" (Keller, 1972), one can find significant divergencies from orthodox alcoholism thought in the work of sociologists. Some sociological work of the time simply ignored the disease concept. John Riley, coauthor of the first nationwide drinking survey, chose to write of "problem drinking" rather than alcoholism (1949), and the survey write-up (Riley and Marden, 1947) used "alcoholic drinking" in the nonmovement meaning of "drinking of alcoholic beverages." Much sociological work, following Bacon's earlier lead (1943), ignored alcoholism movement strictures that the primary research focus should be on the "causes of alcoholism" (Jellinek, 1942; Anderson with Cooper, 1950, pp. 201–202), and studied drinking patterns and problems in a broader context (see Pittman and Snyder, 1962, *passim*). Already in sociological work of the 1950s, the concept of alcoholism was being probed and reinterpreted in ways threatening to the movement's orthodoxy. Trice and Wahl (1958), subjecting Jellinek's classic "Phases of Alcohol Addiction" to empirical testing, concluded that "if the concept of a disease process in alcoholism is valid, only the earliest or the most advanced stages of the process are reliably indicated by the symptoms [drawn from Jellinek's phaseology]." While Lemert's classic work on *Social Pathology* (1951) attributed a high rate of "primary deviation" to chronic alcoholism, "in which inner compulsions more or less irrationally drive the person so afflicted to consume liquor in a manner seldom understandable to a non-alcoholic" (p. 342), his discussion anticipates Levine (1978) and others

in interpreting the existence of the status of "alcoholic" as a culture-bound reflection of "the great premium which our ethos places on self-control" (p. 382). Subjecting the statement "alcoholism is a disease" to critical examination, by the early 1960s Seeley had adopted the archetypal nominalist stance that the statement is "most misleading, since . . . it conceals . . . that a step in public policy is being *recommended*, not a scientific discovery announced" (1962, p. 593).

At about the same time that Seeley's analysis of the disease concept appeared, alcohol sociologists as a collectivity were self-consciously differentiating themselves from the alcoholism movement. Their primary organ, the Committee on Alcoholism of the Society for the Study of Social Problems (SSSP), renamed itself the "Committee on Drinking Behavior" (Snyder and Schweitzer, 1964). Robert Straus, speaking approvingly of an emergent "second generation of alcoholism researchers," noted that earlier researchers had had to contend with "the ever-present militant proponents of an alcoholism movement" and had found themselves "victims of popularization" in which "exploratory research notions . . . were sometimes grabbed up by the fact-hungry alcoholism movement and deified into a gospel" (Straus, 1960). In collaboration with provincial and state alcohol program directors, sociologists—including John Seeley, Harold Demone, and Robert Straus—were actively involved in the 1961 inception and subsequent proceedings of the Cooperative Commission on the Study of Alcoholism, an effort that arose out of dissatisfaction with what was seen as the narrowness of the conception of and approaches to alcohol problems promoted by the National Council on Alcoholism (Johnson, 1973). In its eventual report, the Commission carefully differentiated "alcoholism" from and subsumed it under a wider concept of "problem drinking," and noted that it was avoiding the term *alcoholic* "because it can readily lead to oversimplification and stereotyping of problem drinkers" (Plaut, 1967, p. 43).

By the mid-1970s, most sociological work, at least by researchers who had been in the field for some time, was largely emancipated from alcoholism movement images and models. Only one or two sociologists who held positions in alcoholism movement organs lent it public support on issues involving the disease concept and its implications. But despite the lengthy history of increasing divergence between sociological and alcoholism movement perspectives, the differentiation of views was and has remained lost on the general U.S. public. Drawing on interviews with those involved in the Cooperative Commission, Johnson notes that they "were continually frustrated by their inability to gain the cooperation of the mass media in promoting their ideas"—and that in fact no hint that the Commission's view diverged from the orthodox NCA position appeared in the press coverage of its report (Johnson, 1973, pp. 348–9, 402–3). Gusfield records the continuation today of this gap between sociological perspectives and popular understandings, as exemplified by his experiences in the undergraduate sociology course Jacqueline Wiseman and he teach on Alcohol and Society.

The students . . . expect a strong endorsement of the disease model of alcoholism and a morality which supports a view of the deviant as caught in circumstances beyond his/her control or responsibility. . . . In the struggle between the Enlightened who recognize the problem of alcoholism and the medical status of the alcoholic and the Unenlightened, who do not, Sociology is looked to for confirmation. . . . But our message is not very supportive. We cast great doubt on the "reality" of the disease concept of alcoholism, the increasing severity and extent of alcohol problems, the expanding character of teen-age alcoholism and the actual or potential effectiveness of treatment. We attack those public images which have moved students to interest in the field. . . . Many students respond by ignoring such wisdom and continuing to wax emotional over the plight of the stigmatized alcoholic and the deepening problem of alcohol in American society (Gusfield, 1983).

Gusfield's account of the split in perspectives is confirmed in a letter to the editor of an Australian newsletter from a student in a similar course, taught by Margaret Sargent:

To look at the subject of alcoholism in this sociological way seems to only add to the confusion and denial. It felt like we were looking at the problem through the wrong end of a telescope. The fact that after 13 weeks no one in the course could give a clear answer to the question, "what then, is an alcoholic?", confirmed that confusion reigned supreme! Maybe we should have been asking that question to a group of recovering alcoholics and we may have learned much more than any "expert" could have told us (McKern, 1981).

Even in the scholarly literature, it is the behavioral psychologists, whose professional paradigm brought them squarely up against the movement's absolute commitment to lifetime abstinence, who have been more identified than sociologists with a position antagonistic to the disease concept of alcoholism. Perhaps sociologists could be safely ignored because they were unlikely to have custody of clinical cases (and thus were in no position to do real harm), and because their emergent paradigm did not directly oppose the disease concept but rather proposed to ignore it or to subsume it. Only as sociologists and other social scientists have been drawn into policy discussions and research in the 1970s has their position become worth attacking. Thus Mark Keller, perhaps the staunchest scholarly defender of the classical disease concept, recently attacked the emergent sociological "constructivist" tradition as insidiously linked with alcohol policy directions he dislikes. Keller noted to a medical audience that he saw "the disease concept of alcoholism under powerful increasing attack by influential social scientists whose policy recommendations are listened to by politically influential people" (1981 p. 15).

Repeatedly I come across the statement—in publications by presumably well-meaning social scientists who, however, don't like alcoholism to be a disease—the supposition that it was only for humanitarian reasons, in order to move the bad treatment of

alcoholics out of the hands of the police and get them some humane treatment in the health arena, that alcoholism was, in recent years, pronounced a disease.

That's what they are saying: that the reason why alcoholism was declared a disease was for the practical humane purpose of getting the alcoholics some help, by shifting their care from the law to the health arena, and that it was done only in the 1940s and 1950s by that Yale Group, and its creature the National Council.

Of course, there is an obvious implication, in this statement, that there was something not quite honest about it—an implication that we at Yale knew darn well it is not a disease but, for forgivably humane reasons, we planted the idea that it is a disease. Well, and if, as they imply, and increasingly say, if it is not a disease? Why, then, obviously the doctors have no claim on it. Then it is a social problem, and the social scientists are the ones to take charge of it! And they are trying to take charge. . . . They freely use words they have invented—like medicalization, clinicization, with obvious implications that these are bad—socially undesirable—practices, especially where alcoholism is concerned. . . . It is no accident but a logical coincidence that the proponents of legal measures to combat alcohol problems are the same people who decry, deny and denigrate the disease concept of alcoholism. Their position, it turns out, has an internal consistency: They say, alcoholism is not a disease. The solution of the problem should not be left to the medicalists—biologists. The solution should be put into the hands of us all-knowing social scientists, the expert formulators of social policy (Keller, 1981, pp. 10, 12, 13).

To start with the alcoholism movement in considering sociological aspects of the disease concept, then, is in itself to adopt a particular sociological perspective. But such a starting point recognizes that sociological thought about the disease concept and discussions of its social and cultural aspects in the last 40 years, whether supportive or sceptical of the alcoholism movement's concept, have been defined with respect to that concept; the disease concept has been a governing image (Room, 1973, 1978; Moore and Gerstein, 1981) for North American thought and action on alcohol issues. We have outlined above the gradually increasing emancipation of sociological thought from that governing image. Now it is time to turn to the specifics of the various ways in which sociological work has interacted with the disease concept of alcoholism.

A major difficulty with discussing sociological work on and analyses of the disease concept of alcoholism is the difficulty of pinning down exactly what is meant and implied by the disease concept. "In the beginning all is vague," complained Christie and Bruun (1969), going on to point out the functional aspects of maintaining vagueness in a situation of shifting alliances. Repeatedly, critics of the disease concept have found themselves in the position of having to define the nature of the disease concept in order to critique it. As Pattison and the Sobells realized, in proposing the "traditional model" from which they could distinguish their behaviorist "emerging concepts," this lays the critic open to the charge of having "fabricated a straw man for the purpose of setting it aflame" (Pattison et al., 1977, p. 26). But critics have been left little choice by the state of the literature surrounding the disease concept.



As is illustrated by the two quotations, widely separated in time, at the beginning of this article, the public presentation of the disease concept of alcoholism has been consistently vague or vacuous concerning the *content* of the concept. From the point of view of the alcoholism movement, it was important to present the appearance of precision and professional consensus that alcoholism was a disease, but not particularly important to give the phrase a precise meaning. Often all that has been offered by way of further specification is an analogy: "alcoholism is a disease like bronchitis" or "an allergy" or "diabetes"; by one author or another, alcoholism has been likened to a very wide range of different conditions (Room, 1978). The exact provenance of the movement's concept resists definition, and attempts to trace derivations double back on themselves as on a Moebius strip. Both movement publications and critical discussions often appeal to Jellinek as the ultimate authority; but Jellinek himself gave "alcoholism" at least three quite different meanings in different periods of his work (cf. Haggard and Jellinek, 1942, p. 15; Jellinek, 1952, 1960), and critical discussions (e.g., Robinson, 1972; Pattison et al., 1977) often tie themselves in knots by failing to recognize these differences (see Room, 1972a). Keller is often seen as carrying on Jellinek's tradition, but his presentation of the disease concept differs fundamentally from any of Jellinek's definitions. Conventionally, alcoholism movement presentations of the disease concept reference Jellinek as providing the scholarly underpinning of the disease concept; but the crucial Jellinek papers (1946, 1952) derive in the end from "drinking history" questions designed by and collected by and from a lay rather than a scholarly source—that is, members of Alcoholics Anonymous.

In its classic form, the alcoholism movement's disease concept may be seen as comprising a number of related elements (cf. Pattison et al., 1977, pp. 1–267; Watts, 1981, p. 456):

1. There is a new scientific approach to alcohol issues which replaces the old moralistic approach.
2. This approach involves the recognition that there is a well-defined singular entity called "alcoholism," which some people have and others don't.
3. Those who have "alcoholism" will always be different in their drinking from "normal" drinkers, and therefore should never drink again.
4. The entity should be thought of as a disease in itself (and not, for instance, as just a symptom of another underlying disease), which the alcoholic suffers from involuntarily.
5. It is therefore both rational and humane to help and treat alcoholics as sick, rather than as immoral or criminal.
6. Providing treatment for alcoholism is the most urgent priority for and most adequate method of handling society's alcohol-related problems.



This formulation of the movement's disease concept is made with benefit of hindsight, and there is no single place where all these related propositions can be found spelled out in this form in the movement's literature. In its early years, the movement's founders felt that its primary opponents were apathy and distaste for a stigmatized subject on the part of the population at large and of relevant professionals. The emphasis was therefore more on energizing public authorities and professionals into action—on persuading them that the alcoholic "can be helped and that he is worth helping" (Anderson, 1945, p. 367)—than on claims about the specific nature of alcoholism. In some early formulations (e.g., Anderson, 1942), the alcoholic is described as "a sick man" or "ill," without necessarily implying that alcoholism is a single specific entity.\* From the first, however, Marty Mann, the founding Executive Director of what became the National Council on Alcoholism, took as a first principle that "alcoholism is a disease" (Mann, 1944, p. 357).

In the following pages we will discuss the emergent sociological critiques of each of the points of the alcoholism movement's classic disease concept, as outlined above. Again, we are taking full advantage of our opportunities for retrospection. Some of the relevant empirical work was done within the paradigm of the disease concept, and other work was not initially seen as relevant to the concept; it is only later that its conceptual implications were drawn out. Critical discussions of the various aspects of the disease concept emerged at different times; though we try to indicate the temporal provenance of different arguments, our discussion is oriented to the logical structure of the concept rather than to historical sequence. In this discussion, we will work roughly "from the inside outwards," that is, starting from the intrinsic and central assumptions of the disease concept, and working out to the implications it was seen as holding for society. Thus we will start with points two, three, and four in the list above, before proceeding to points one, five, and six.

## 2. THE ENTITATIVITY OF ALCOHOLISM

The statement that "alcoholism is a disease," as sociologists have pointed out (Seeley, 1962; Room, 1970), includes within it the assertion that alcoholism should be regarded as an entity. In fact, both psychiatric and lay discussions which were couched in terms of alcoholism tended not to raise—at least through the 1950s—the issue of the entitativity of alcoholism; it was an assumption

\* Similarly, AA's "big book" (*Alcoholics Anonymous*, 1939) avoided any claims of a single disease entity—Kurtz notes that Bill W., a cofounder of AA, was always "wary of referring to alcoholism as a 'disease' because he wished to avoid the medical controversy over the existence or non-existence of a specific 'disease-entity': . . . 'therefore we always called it an illness or malady—a far safer term for us to use' " (Kurtz, 1979, pp. 22–23).

buried beneath the discussions of exactly how "it" was to be defined (see Jellinek, 1960, e.g., pp. 55–58).

The main empirical foundation for the movement's implicit assertion of entitativity for alcoholism was laid *ex post facto*, and was occasioned by a desire by Alcoholics Anonymous members to quantify their experience of a very real commonality in their drinking histories. Jellinek's analysis (1946) of the responses to a questionnaire printed in AA's house organ, *The Grapevine*, was regarded as a curiosity—as "Bunky's doodle" (Bacon, 1976)—by his fellow staff members of the Yale Center. The sample size was only 98 cases, from a mailing sent to about 1600; and in his write-up Jellinek distanced himself from the study design and data collection, commenting that "statistical thinking should not begin after a survey or an experiment has been completed but should enter into the first plans for obtaining the data" (1946, p. 5). The 1946 study was Jellinek's only statistical report on the drinking histories Alcoholics Anonymous members submitted to him, but it was by no means his most celebrated presentation in this tradition. A far wider circulation was given to Jellinek's summary description of the "phases of alcohol addiction," originally prepared as a lecture and then printed, first as an Appendix to a World Health Organization (WHO) Report (1952), then in the *Quarterly Journal of Studies on Alcohol*, and eventually in a wide variety of other forms—including the central sociological compilation of alcohol research of the early 1960s (Pittman and Snyder, 1962). A chart of the phaseology of alcoholism, based on Jellinek's 1952 summary, with the addition by Max Glatt of an upward path of "phases of recovery," is probably the most widely diffused artifact of the alcoholism movement (Glatt, 1958).

Jellinek's early quantitative analysis (1946) had invited further work in the same tradition, even appending to his text a sample improved questionnaire for future investigators. One might have expected the lead to be followed primarily by clinicians, who had easy access to appropriate samples and a well-developed tradition of collecting clinical histories as a means of defining and studying disease entities. In fact, a few clinicians outside North America did report studies in the tradition (Varela and Marconi, 1952; Glatt, 1961) or offered their own variations on the phaseology (Rotter, 1962). But in North America, the earliest studies in the tradition were mostly performed by sociologists (Trice and Wahl, 1958; Jackson, 1958; Gibbins, 1962; Park, 1962, 1967; Mulford and Wilson, 1966).

We can offer some speculations as to how it may have come about that this quintessential clinical territory—in which clinical researchers are now well established—was first colonized by sociologists rather than clinicians. The content of the *Grapevine* drinking history was not particularly congenial to dominant modes of psychiatric thought about alcohol problems in the years after Jellinek's 1946 article appeared. Psychotherapeutic thought tended to regard alcohol problems as symptoms of underlying psychic disturbances, rather than as a disease entity *per se* (Roizen, 1977a). To such a habit of mind, the details of first occurrences of particular drinking behaviors and of social and physiological

consequences of drinking would seem like a mapping of surface ripples irrelevant to elucidating the presumed underlying phenomenon. Jellinek himself laid out the conflict of paradigms between psychotherapeutic thought and the Alcoholics Anonymous emphasis on the drinking history in introducing his *Grapevine* analysis:

etiological research . . . concerns itself primarily with psychodynamics leading up to . . . gross inebriety. . . . Phases of inebriety . . . do not appear to be regarded as significant landmarks in the development of alcoholism. Drinking histories of sorts . . . are gathered routinely and seldom form the basis for any theoretical elaborations. . . . The therapist proceeds from the assumption that the function of alcoholic intoxication is to solve a personality conflict. . . . This therapeutic preoccupation explains . . . the lack of interest in the drinking history. . . . Recovered alcoholics, on the other hand, . . . lack the background which would enable them to see the significance of psychological factors not overtly connected with drinking. But they are in a position to understand the relevance of apparently insignificant drinking behaviors, [though] they probably overestimate these factors as much as psychologists underestimate them. The practical disregard of drinking behavior by psychologists and psychiatrists may contribute to some extent to the mixed feelings with which they are regarded by alcoholics and recovered alcoholics (Jellinek, 1946, pp. 1-3).

For sociologists, however, following the lead of the *Grapevine*/Jellinek drinking history analysis was a far more congenial task. Quantifying the phenomena of the drinking history fitted well with the flush of sociological enthusiasm for survey research and analysis in the 1950s and 1960s, and the emphasis in the history on the interplay of drinking with tangible social consequences—loss of job, problems with the spouse, hospitalization, and so forth—directed attention to familiar sociological territories. Furthermore, sociologists were probably more open than clinicians to the populist idea—implicit in the quotation from Jellinek above—that the clients might be able to tell the professionals something about the nature of the phenomena under study. Part of the attraction of general-population survey research, indeed, had been the populist agenda of finding out what “the people” wanted. Reflecting the general interest of alcohol sociologists in survey work, the SSSP Committee on Alcoholism set up the “Research Reference Files” to act as a clearinghouse of alcohol questionnaires. By 1964, Ralph Connor’s “Inventory” of the files listed at least 15 studies using a drinking history—often a “modified Jellinek form”—on clinical or incarcerated samples.

Though the early sociological studies in this tradition all started from the assumption of a unitary alcoholism, in different ways each of them ended up being subversive of the assumption. Joan Jackson (1957a, 1958) started from a critique of prevailing definitions and clinical practice pointing in the opposite direction from Jellinek (1946): where he had seen the lack of attention to the concrete symptomatology as reflecting a preoccupation with preexisting psychopathology, Jackson saw it as resulting from a confounding of the concept with “the assumed social or psychological consequences of heavy drinking” (1957a, p. 243). In her view, the “usual definition of alcoholism . . . does not make

specific symptoms or constellations of symptoms into account, but emphasizes the causal associations between heavy drinking and problems in living" (1957a, p. 240); anticipating Seeley's critique (1959) of the WHO definition in noting that "most illnesses are defined in terms of symptoms rather than in terms of the social consequences of the illness," she pointed out that "a definition in terms of a constellation of related symptoms would be more consistent . . . with the viewpoint that alcoholism is an illness" (1957b, p. 452).

Although the last phrase suggests a certain distancing from the disease concept, the formal purpose of Jackson's papers was thus the development of purified operational measures of alcoholism as an entity, using cumulative scaling techniques. But whatever her intentions, her actual procedures and findings must be regarded as giving relatively little comfort to an entitative concept of alcoholism. Without further explanation, Jackson (1957a) developed not one but rather two cumulative scales—a scale of Preoccupation with Alcohol, and a scale of Psychological Involvement. Furthermore, she treated Hopelessness about Controlling Drinking—a central conceptual area in the Jellinek phaseology—as a separate third dimension. On an empirical level, the level of correlation she found among the three scales (in her first sample, 0.59 Psy/Preocc, 0.62 Psy/Hopeless, 0.38 Preocc/Hopeless) could be regarded as only weakly supporting the notion that they were measuring a common underlying entity. In her later analysis of the time-ordering of the items in her scales (Jackson, 1957b), Jackson herself felt that the "progression hypothesis" was only rather weakly supported by her data. Departing more radically from the assumption of entitativity, Jackson explored in a third article (1958) the empirical support for folk typologies of alcoholics on Skid Row and among Alcoholics Anonymous members—and found differences in patterns between "solitary" and "sociable" alcoholics, and between "belligerent" and "nonbelligerent."

In a somewhat similar vein to Jackson's second article, Trice and Wahl (1958) explored the time-ordering of 14 *Grapevine* study items in AA and non-AA clinical samples, and found some difficulties with the "popular usage" of alcoholism "as a series of drinking and related experiences arranged in a sequence, one following the other." Most of the symptoms tended to cluster at about the same onset age; and quite a few respondents—particularly those not in AA—did not report experiencing a number of the symptoms. Mulford and Miller (1960a,b) followed another lead of Jackson's in deriving their own disjunctive cumulative scales based on the *Grapevine* items, using the items for the first time on a general population survey sample. Their investigation started from a nominal stance on the issue of entitativity:

Contrary to the assumption explicitly or implicitly made in much of the alcoholism literature, the present research does not assume the existence of an "alcoholism" entity—biological, psychological or other. Rather, it is assumed that "alcoholism" is merely a word (Mulford and Miller, 1959, pp. 704–705).

In a series of articles they proceeded to "resolve a loose collection of phenomena usually referred to as 'alcoholism' into four operationally defined and objectively

measured variables" (1960a, p. 290). But in the authors' view, the intercorrelations between the resulting four measures did in the final analysis justify an entitative view of alcoholism: "that the four measures studied constitute a constellation and not just an aggregation of factors was evidenced by a strong interassociation among them" (Mulford and Miller, 1960a, p. 291). Because it was the measure "most predictive of each of the other three," the authors then picked their Preoccupation with Alcohol scale as their best measure of "alcoholism" (see Mulford and Miller, 1960b).\*

The proposition that there was an empirical basis for entitativity was carried on in Mulford's work of the mid-1960s, using both general-population and clinical samples (Mulford and Wilson, 1966). However, Room (1966) subjected the cumulative scaling techniques to a methodological critique, and also pointed out that while Mulford and associates had used much the same items and the same scaling technique as Jackson, they had arrived at substantially different orders of cumulation—a discrepancy which was hard to reconcile with a single-entity model. Collating and comparing the available clinical studies in the *Gravelyne* tradition, he showed that they did not demonstrate the universality of symptoms and unilinearity of ordering that are implied by Jellinek's 1952 description of alcoholism as an entity (Room, 1970). By the late 1960s, then, the tradition of empirical sociological work, primarily on clinical samples, which aimed to elaborate on Jellinek's symptomatology was providing a base for substantial and explicit questioning of the assumption of entitativity.

In the meantime, the assumption of entitativity was being challenged at least by implication in a somewhat separate tradition of sociological analysis of the conceptual basis of definitions and descriptions of alcoholism. Seeley (1959) picked apart the widely used "WHO definition" of alcoholism, describing its logical structure as "an oddment of aggregation." In the course of offering a sociological conceptualization of alcoholism, Sargent (1968, p. 975) took the position that "among the many forms of 'alcoholic' behavior, there can be found no set of symptoms and signs of a single disease type. To view alcoholism as a single entity, as implied in the disease concept, is misleading." Commenting that Seeley had "given the WHO-authorized definitions such a devastating blow that nothing is left—except confirmation of the impression of an unusually low level of preciseness," Christie and Bruun (1969) subjected terms such as *addiction* and *drug dependence* to an equally critical analysis, noting along the way that "conceptually as well as in the selection of research variables, the major hunt within the field of alcohol has been for what is common among the bad users while in the drug field it has been a hunt for what is common in the bad substances." Concluding with a call for "the extermination of 'fat words' " such

\* In later work, Mulford (1968) shifted to a measure related to Mulford and Miller's Troubles Due to Drinking score (1960a) as his preferred indicator of alcoholism. Still later (Mulford, 1977), he adopted a disjunctive definition that combined several of his measures.

as alcoholism and drug dependence, Christie and Bruun noted the functions of such words as instruments of power; for instance, "the hunt for some common attributes among *people* who use alcohol in ways deemed inappropriate, whereas in regard to drugs the hunt is for common features among the forbidden *drugs*, is . . . well suited for the preservation of the status quo. If the bad drinkers can be identified, the good ones can continue in comfort and peace" (1969, p. 69). This recognition of the larger political utility of the conception of alcoholism as an identifiable entity, set apart from normal drinking, became a common theme in American sociological and public-health writing on alcohol issues by the end of the 1970s.

As these excerpts imply, the assumption of entitativity was not the main focus of conceptual critiques by sociologists of the disease concept of alcoholism. Perhaps the main contribution of this tradition concerning entitativity was to raise the issue to consciousness: several of the analyses noted in passing that one of the assumptions underlying a disease conceptualization was the assumption that its referents "have at least enough in common for it to be useful to class them under a single label" (Room, 1970). This self-consciously nominalist perspective in the sociological literature tended to contrast with the much stronger "ontological conception of disease, that is of the existence and epistemological status of disease 'entities' " (Rather, 1959), which has been a characteristic historical feature of the clinical tradition in medicine. Thus, for instance, Clark comments concerning the operational definitions of *alcoholism* used by Robins et al. (1962)—a group of sociologists working within a clinically oriented tradition—that "there is an assumption that there is *one* thing to be detected in the study population, a unitary phenomenon to be called alcoholism" (Clark, 1975, p. 406).

A third line of critical examination of the assumption of entitativity emerged slowly from the tradition of surveys of drinking patterns and drinking problems in the general adult population, a tradition which began to gather strength about 1960. From the first, researchers such as Clark (1966) and Knupfer (1967) took a nominalistic and distanced position on the measurement of "alcoholism" in general populations, signalled by their choice of a terminology of *drinking problems* and *problem drinking* in preference to *alcoholism*.

Our use of the term *problem drinker* here instead of the term *alcoholic* is not accidental. We wish to avoid getting into the question, 'what is a real alcoholic?', or 'does the person have the disease called alcoholism?' We take the point of view that a problem—any problem—connected fairly closely with drinking constitutes a problem (Knupfer, 1967).

As viewed from a clinical perspective (Edwards, 1973), this tradition emphasized measuring "bits of behavior" rather than "syndromes"; the "bits of behavior" were aggregated into about a dozen conceptually distinct drinking-problem dimensions in Clark's and Knupfer's analyses and in those that followed in the same tradition (e.g., Cahalan, 1970; Cahalan and Room, 1974).

The potential relevance of this tradition of research to the question of the entitativity of alcoholism was initially somewhat obscured by the switch in terminology; the existence of a multiplicity of "drinking problems" in the general population did not on its face threaten the entitativity of "alcoholism." Also, some writers in the tradition tended to slide into discussing a unitary category of "problem drinkers" (e.g., Cahalan, 1970, p. 38 et passim; Knupfer, 1972, pp. 257-258); as Cahalan and Room (1974, p. 27) noted, this tended to impute entitativity to "drinking problems" as much as others had to "alcoholism": a summary "problems score . . . by its nature tends to imply a unity in the phenomena it comprehends; that is, [those covered by] an inclusive and eclectic definition of alcoholism." But the main sweep of the tradition was toward what later became known as a "disaggregation" model, following an agenda explicitly stated by Knupfer (1967): "whether one type of problem or another is really the essence of alcoholism, or can be used as an indicator of other types of alcohol-related problems, are matters to be investigated rather than to be assumed." Clark's paper (1966) set the pattern for the succeeding empirical reports, with a careful examination of empirical overlap between eleven drinking-problem dimensions, followed by an analysis in terms of summary multidimensional typologies based on the problem indicators. Clark's paper went one step further, in explicitly matching the operational typologies with Keller's widely quoted definition of alcoholism (1962); the result, as Edwards (1973, p. 38) noted, was a "neat demonstration of the dependence of prevalence estimates on the niceties of definition."

By the early 1970s, the empirical results concerning overlapping of problem dimensions in the general population were being explicitly contrasted to an entitative "alcoholism" model:

There is not a great amount of overlap between different types of problems with drinking in the general population. . . . This suggests that no single programmatic framework will serve all those with identifiable problems from drinking. . . . Our studies suggest that when the traditional unitary notion of "alcoholism" is disaggregated, there are differences in the correlates of different aspects of it (Room, 1972b).

In a later article, the present writer described the disease concept of alcoholism as a "governing image"—the most powerful of several contemporary "summary characterizations," each of which "tends to extend its disease conceptualization to cover the whole field of alcohol problems" (Room, 1973). From the perspective of planning for the prevention of alcohol problems, it was seen as problematic that such disease characterizations carried the assumptions of

entitativity that the clinical tradition, following Sydenham, imputes to diseases. . . . These assumptions show at least a moderately good fit to clinical populations of publicly certified alcoholics. But by definition the topic of prevention looks outside the clinic door; . . . and the assumptions do not fit at all well the picture of quite diffuse interrelationships between drinking problems, both cross sectionally and across time, which is emerging from general-population longitudinal studies (Room, 1973, pp. 15-16).



In the last few years, as attention has turned to prevention issues, what may be termed an "alcohol problems" approach has gained considerable ground in alcohol policy documents—though not, perhaps, in the mass media and popular thought, at least in the U.S. As implied by the term "alcohol problems," one element of the approach has been the abandonment of the assumption of entitativity.

Alcohol problems in the general population . . . do not seem to form a coherent pattern. The problems are too diffuse to be described as part of a single concept of alcohol addiction. Thus, it cannot be assumed that intervention in or treatment for alcoholism will also reduce the prevalence of other alcohol problems. Providing treatment for alcoholism, while a humane imperative, is not an adequate response to alcohol problems in the larger society (Noble, 1979, p. 314).

Until recently, there has been a widespread tendency to conceptualize the whole gamut of alcohol problems as manifestations of an underlying entity, alcoholism. Undoubtedly a wide variety of problems are related to the development of the "alcohol dependence syndrome." . . . It should be pointed out, however, that there are many physical, mental and social problems that are not necessarily related to dependence. Alcohol dependence, while prevalent and itself a matter for serious concern, constitutes only a small part of the total of alcohol-related problems (World Health Organization, 1980, p. 17).\*

### 3. THE IRREVERSIBILITY OF ALCOHOLISM

The idea that anyone who is an alcoholic can never drink normally again is an article of faith with the modern alcoholism movement—perhaps the one article which it has been least willing to compromise or blur. In their eagerness to scotch challenges to it, movement leaders and agencies have been willing to give reflected publicity to contrary research and perspectives. As a result, this has been one aspect of the alcoholism movement's disease concept which has been recognized in the mass media and popular thought to be controversial. In

\* See also Moore and Gerstein (1981)—a report which adopts not only the "alcohol problems" approach but also a "governing idea" characterization of the disease concept of alcoholism. A compromise between clinical and sociological perspectives, adumbrated by Robinson (1972) and pioneered by Griffith Edwards, has been to cede the larger territory of "alcohol-related problems" or "alcohol-related disabilities" (Edwards et al., 1977) to a nonentitative (and nondisease) conceptualization, but to retain as one of the problems a diseaselike entity, the "alcohol dependence syndrome," including a variety of physical and psychological characteristics, as "a psychobiological reality, not an arbitrary social label" (Edwards et al., 1977, p. 9). At the WHO meeting at which this formulation was discussed, the three sociologists present (Ketil Bruun of Finland, Alan Cartwright of England, and the present writer) each entered the room at a different time. It is indicative of the nominalist stance of sociology that each as they came in tried independently but unsuccessfully to turn the interrelations between the components of the syndrome into a question for investigation rather than a matter of assumption.

these controversies, sociologists have played an increasing but by no means a dominant role. In the modern era, the notion that alcoholics could never drink normally again met its first notable challenge in a report by an eminent British clinician, D.L. Davies (1962). The debate over this article in succeeding issues of the *Quarterly Journal of Studies on Alcohol* was largely confined to medical clinicians. But by later in the 1960s, behavioristically inclined clinical and experimental psychologists were caught up in the fray—sometimes joining in with zest, and sometimes stumbling into the battle unawares (see Pattison et al., 1977 and Roizen, 1977a, for relevant references). Those working in a learning-theory paradigm saw no reason why discriminations between “acceptable” and “unacceptable” behavior could not be the object of therapy for alcohol consumption as for other habitual behaviors.

The ensuing battles involved not only exchanges in the research literature, but press conferences and debates in the mass media, and a number of efforts—some successful—by those defending the orthodox disease concept to cut off funding for studies which might lend support to the idea that alcoholics were capable of “controlled drinking.”\* Sociologists played a relatively small role in the exchanges—that is, until the controversy climaxed in a nation-wide battle over a follow-up study conducted by three sociologists, the so-called Rand Report (Armor et al., 1976, 1978). Though the three authors of this report were then new to the alcohol field, and thus probably initially underestimated just how explosive their findings were, they were not inclined to shrink from a fight—the senior author already had scars to show from educational research he had done on the effects of school busing.

Though the Rand authors happened to be sociologists, the stance they took on the disease concept of alcoholism in the Armor et al. report was not particularly inimical to the concept. A brief review of critiques of the disease concept was given, particularly centering on the issue of unidimensionality, but in its subsequent rhetoric and methods the report fell back on an implicitly entitative “alcoholism.” The report actually contained a number of findings which were troublesome for the conventional wisdom on alcoholism treatment (Roizen, 1978), but the whole focus of public controversy was on the issue of whether alcoholics could ever return to being controlled drinkers.

\* The present author knows of two cases where public funding for studies was cut off over the issue of “controlled drinking” in about 1976. The California State Alcoholism Advisory Board adopted a resolution during the Rand controversy (June 11, 1976) that “we stand firmly behind the State Office of Alcoholism in its policy of *not* expending State funds to support research or treatment programs that advocate so-called ‘controlled drinking’ practices” (emphasis in original). Impressionistically, it seems that a prime safe haven for behaviorist psychologists in this period was the Veterans Administration Hospital system. While alcoholism was in the jurisdiction of psychiatrists in that system, they were relatively immune to alcoholism movement pressure, and seem to have been willing to hand over much of the treatment and clinical research efforts to clinical psychologists.

There are already sociological accounts of the Rand Report controversy (Roizen, 1978; Wiener, 1981, pp. 205–214); for present purposes it suffices to say that in the choosing-up of sides in the controversy, only one sociologist—David Pittman—publicly supported the alcoholism movement position that controlled drinking by alcoholics was impossible (Pittman, 1976b).<sup>\*</sup> Around the edges of the political storm, several sociological studies tended to undercut major corollaries of the alcoholism movement position on controlled drinking. A deeply emotive objection to the controlled-drinking idea was that in offering “a scientific excuse for drinking” to recovering alcoholics it meant that “an awful lot of people” would die; “these cases are piling up all over,” said one clinician (*Alcoholism Report*, July 9, 1976, pp. 2–3). But contrary to these assertions, Hingson et al. (1977) interviewed treatment agency staff, homeless men, and a general-population sample, and found that the actual “behavioral impact of the report was meager.” Linked to the “once an alcoholic, always an alcoholic” position of the movement was an assumption that treatment was necessary to achieve this recovery. But an analysis of “spontaneous remission” among those reporting untreated alcohol-related problems in the general population cast doubt on both these positions by showing that “by most criteria, there was a substantial amount of spontaneous remission of drinking problems,” even though only one respondent in the cohort had become an abstainer (Roizen et al., 1978). The Rand authors themselves returned to the debate with a 4-year follow-up study designed to counter many of the methodological objections to the original study (Polich et al., 1981). In this latter report, they took a more distanced view of the disease concept—“the 4-year followup results call into question . . . the idea that alcoholics are a homogeneous group and that alcoholism is a single, undifferentiated ‘disease’ with only one form and one solution”—and spoke of the traditional disease concept as “an elaborate but nonetheless dogmatic doctrine, which dominates treatment practice and public discussion” (p. 219). They concluded that “our data are clearly inconsistent with important propositions derived from traditional theory. Manifestly, some persons labelled as alcoholics engage in drinking without problems.” Although the authors did not stress this aspect, the report also showed that only 7½% of clients of alcoholism treatment centers maintained abstinence throughout the 4½ years of the follow-up; in practice, the abstinence criterion is thus more an aspiration than a realistic goal (Room, 1980a). Ironically, the alcoholism movement’s response to this later Rand report was more muted—as the sponsoring agency, NIAAA successfully deflected controversy by presenting the findings in a distorted but politically palatable form—i.e., as supporting the abstinence standard (see Room, 1980a).

Apart from these issues of the fit of the abstinence standard and its corollaries

<sup>\*</sup> The Rand researchers later riposted that Pittman’s own earlier empirical study (Pittman and Tate, 1969) showed “no systematic evidence in favor of the abstention theory” (Armor et al., 1978, p. 236).

to empirical realities, there has been some sociological analysis of "the abstinence fixation" (Roizen, 1978)—of why in regard to this particular element the alcoholism movement's disease concept has been uniquely sharply defined and uncompromising. Roizen (1978) suggests that the abstinence criterion is not only a part of the movement's public-relations effort but is also central to the therapeutic paradigm of those adhering to the movement, whether in a clinical or an AA setting:

it is the education of alcoholic—convincing him that he is different—that is the major element of the classical treatment ideology. Thus, this ideology does not treat "the alcoholism" in the patient, which is to say it does not attempt to affect the putative constitutional difference that makes him an alcoholic, but rather attempts to alter his conscious knowledge of his own physiology or psyche. The treatment attempts to educate him to the acceptance of the belief that he is different, and that this difference is not a piecemeal or transitory thing. . . . The treatment is itself the inculcation of the disease conception of alcoholism, and, in this domain, the disease concept *means* that a constitutional difference in alcoholics is at the root of troubles with drinking. If the constitutional basis theory is accepted, the alcoholic may be persuaded to give up drinking. Embracing abstinence is thus a sign that the model of alcoholism has been accepted by the patient (Roizen, 1978, pp. 268–269).

Elsewhere, Roizen (1977a) has pointed out that the abstinence standard actually long predates the modern alcoholism movement; Benjamin Rush, the "father of American psychiatry," had written in the eighteenth century that those addicted to spirits "should abstain from them suddenly and entirely," and Samuel Woodward, a leading figure in early institutional psychiatry, had stated that "the grand secret of the cure of intemperance is total abstinence from alcohol in all its forms" (Levine, 1978). "That the intellectual pedigree of requiring abstinence from the reformed alcoholic stretches back to about the turn of the 19th Century suggests that this notion is deeply ingrained in Anglo-Saxon conceptions of drinking problems" (Roizen, 1977a, p. 16). In unpublished material, Roizen has suggested that the abstinence standard is a crucial part of an implied bargain made between the alcoholism movement and the larger society—and between the individual repentant drinker and those who have suffered from his past acts. To make the "moral passage" (Gusfield, 1967) from the derogated status of active "drunk" to the morally superior—even somewhat prestigious—status of "recovered" or "recovering alcoholic" demands not only that the alcoholic disavow and purge himself of his past life—as in the confessional of the AA meeting—but also that he be seen to be giving up something which, by the definition of his condition, he has valued above all else (see Roizen and Weisner, 1979, pp. 104–106). To fail to require abstinence of all who claim the status of "recovering alcoholic" is thus to threaten the social prestige which the movement has painstakingly built up for the status—and also to threaten the individual standing of those who, often in the service of the movement, have publicly claimed the status. In this perspective, the "fixation" on the abstinence standard is thus as strongly linked

to the disease concept as a public-relations effort as it is to the disease concept as a therapeutic paradigm.

During the period of the greatest hegemony of the disease concept of alcoholism, there was a flourishing tradition of sociological work which was highly relevant to the issue of the irreversibility of alcoholism, but which was rarely invoked in discussions of the disease concept. This was the "labelling theory" of deviance, which emphasized the role of societal reactions to the individual's "primary deviant" acts against social norms in cementing the individual into a repetitive pattern of such acts and a self-conscious subculture of "secondary deviance." While an emphasis on conceptually separating behavior from social reactions to it can be found in much of the sociological literature on alcohol problems (e.g., Mulford, 1968; Cahalan and Room, 1974), there was surprisingly little overlap between the sociological literatures on "labelling theory" and on alcohol. "Alcoholism" pretty much drops out of the labelling literature after its appearance as a chapter in what is often regarded as a foundation document of the labelling literature, Lemert's *Social Pathology* (1951)—except for the special arena of Skid Row (see Wallace and Rubington readings in Rubington and Weinberg, 1968). Thus Becker's textbook on *Social Problems* (1966) mentions "alcohol use and alcohol problems" only in a paragraph in the introductory material. Reflecting this lack of attention, Robins' critique of "alcoholism and labelling theory" (1975) cites no specific applications of labelling theory in the alcohol field, but rather uses data on alcohol problems to critique labelling theory in general.\*

For their part, alcohol sociologists, although affected by the general climate of thought which underlay labelling theory, tended to maintain a splendid isolation from the labelling literature (see for instance the unreferenced use of "labeling" in Bacon, 1973). The most prominent exception to this was Roman and Trice's paper (1968) on "The Sick Role, Labelling Theory, and the Deviant Drinker," which brought the labelling tradition explicitly to bear on the disease

\* This neglect of alcohol problems in the labelling literature may have reflected a tendency to assign a larger role to "primary deviance" for alcohol problems than for other social problems. Lemert had set this pattern in asserting that "alcoholism is very similar to stuttering with respect to its high degree of primacy," and that a counterculture of support for secondary deviance was lacking: "no special culture, behavioral system, or social organization of chronic alcoholics is discoverable. . . . The absence of social organization of chronic alcoholics rules out the possibility of drawing self-sustaining rationalizations from a deviant behavior system" (Lemert, 1951, pp. 375, 351, 382). Though many alcohol sociologists today would question these assertions, labelling theorists may have taken them at their face value. Also, the existence of AA as the prototype of modern "societies of deviants" devoted to self-help and the elimination of stigma (Sagarin, 1969), although it posed no problems for Lemert's approach, did not fit well with the tendency of the labelling theorists of the 1960s to emphasize the role of external societal pressures rather than of autonomous actions in the emergence of "secondary deviance". Thus, while in Lemert's approach the emergence of Alcoholics Anonymous can be viewed as one type of further development of the deviant role (Lemert, 1951, pp. 76, 367-9, 385-6), Trice and Roman (1970), in the light of the intervening labelling literature, are moved to invent the terms "delabelling" and "relabelling" to characterize the functions of Alcoholics Anonymous.

concept of alcoholism. Roman and Trice tend to accept the substantial irreversibility of the alcoholism diagnosis. But in their analysis, the irreversibility results more from the social fact of the application of the diagnosis than from an inherent predisposition of the drinker.

The medico-disease concept of alcoholism and deviant drinking 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." The expectations surrounding these sick roles serve to further develop, legitimize, and in some cases even perpetuate the abnormal use of alcohol. . . . The sick role assignment may legitimize deviant drinking patterns since . . . the individual is not held responsible for his illness. . . . [Furthermore,] the labelling process may lead to secondary deviance through a change in an individual's self-concept as well as a change in the image or social definition of him by the significant others in his social life space. . . . [A consequence] which may occur and serve to further "lock in" deviant drinking patterns . . . is the process of rejecting the individual from primary group associations that may result from the presence of the label as well as from intolerance of his deviant drinking. The developing alcoholic seeks out opportunities to affiliate with more tolerant drinking groups. . . . This differential association serves to further legitimize, reinforce, and perpetuate deviant drinking and lead further toward true addiction. . . . The mere processes of labelling and sick role assignment may serve to aggravate and perpetuate a condition which is initially under the individual's control (Roman and Trice, 1968).

Roman and Trice's analysis, offered in the context of an argument on behalf of an alternative strategy of "constructive coercion" as a means of dealing with alcohol-related problems in the workplace, has not been subjected to formal empirical testing. Although Robins (1975) does not explicitly refer to it, the analysis must be set against the evidence she marshals that there is a good deal of turnover in the occurrence of alcohol problems from one time to another (see also, for example, Clark, 1976), and that the outcome for treated (and thus labelled) populations of alcoholics is at least not worse than the outcome for equivalent unlabelled populations (see also Polich et al., 1981, p. 140). Of course, neither Robins' arguments nor Roman and Trice's analysis offers much comfort to the alcoholism movement's view of alcoholics as inherently different from normal drinkers and of alcoholism as an irreversible condition.

#### 4. ALCOHOLISM AS AN INVOLUNTARY DISEASE

The question of whether alcoholism constitutes a disease in its own right is logically separate from the question of its entitativity, and has long been a vexed issue between the alcoholism movement and psychotherapeutic thought, which has often viewed alcoholism as a symptom of an underlying psychodynamic condition rather than as a disease in its own right (see quotation above from Jellinek, 1946). Apart from occasional discussions of the history of controversy (Roizen, 1977a), very little empirical or conceptual attention has been



paid to the issue by sociologists. Sociologists' nominalist tendencies disposed them against organizing their research around the assumption of underlying clinical entities; as we noted above, it was they rather than clinicians who initially followed the lead of Jellinek's *Grapevine* survey in mapping the concrete phenomenology of the drinking history.

Sociological analysis and research has nevertheless proceeded in several directions that are relevant to the issue of treating alcohol problems as a sickness. One line of work has been the elucidation of the assumptions and implications involved in calling a set of phenomena a disease. After exploring the "lack of definition of disease" in medical dictionaries and handbooks, Jellinek retreated to the position that "a disease is what the medical profession recognizes as such" (1960, p. 12). But this eminently sociological position (see MacAndrew, 1969, p. 499) still begs the question of what are the common characteristics of phenomena thus recognized, and further leaves open the issue of whether distinctions are made between different kinds of disease. Several sociologists have attempted to tackle these questions (see Seeley, 1962; MacAndrew, 1969; Room, 1970, 1972a, 1978; Robinson, 1972). The present author has proposed that defining a set of phenomena as a disease involves at least five assumptions: that the phenomena have enough in common to be usefully classed under a single label (the "entitativity" assumption, discussed above); that they represent a condition rather than an event; that they represent a departure from "normality" which it is considered desirable to eliminate or alleviate; that they are located within an individual person, rather than being attributes of any collective entity; and that they do not occur entirely by the will of the affected individual (Room, 1978, pp. 29-37). Such a broadly defined set of assumptions obviously encloses a very large range of phenomena which can be—and have been at one time or another—considered to be diseases. On the other hand, the assumptions do act as potential limits on our frame of reference. Thus it has been argued that the emphasis on the condition assumption in the era of the alcoholism movement has constrained our understanding of alcohol's role in serious events (Aarens et al., 1977, pp. 580-584).

Although the general sociological literature has tended to talk in terms of an implicitly singular "medical model," there are in fact a variety of specific models of disease serving as guides to action and interpretation for the doctor and the patient (Room, 1978, pp. 19-27). Clinicians, with a *modus operandi* of optimistic pragmatism, often fill in ill-defined areas of the nosological map by resort to analogy (Room, 1972a). Robinson (1972) has remarked on the wide variety of different diseases which might be invoked as analogies for alcoholism—and a wide variety have in fact been invoked (Room, 1978, pp. 20-21). The different analogies hold very different implications in terms of clinical and patient responsibilities, and for that matter in terms of the moral standing of those suffering from the illness. Although Talcott Parsons' ideal-type characterization of "the sick role" is one of the most widely diffused artifacts of medical sociology, the more recent sociological literature has tended to reemphasize the



wide range of expectations concerning the sick role, varying among other things by the *kind* of illness that is seen as being involved (Gordon, 1956; Levine and Kozloff, 1978). For instance, Kurtz and Giacomassi's study (1975) of 201 medical students and 198 social-work students found that

in general, those with physical conditions were judged to enjoy the highest legitimacy for assumption of the sick role; legitimacy decreased as problems became more mental, addictive, and socially deviant. . . . Respondents were least ambivalent about physical conditions and most ambivalent about addictive and socially deviant conditions (Levine and Kozloff, 1978, p. 322).

Those working within the paradigm of the disease concept of alcoholism have often had a clear, pragmatic understanding that different illnesses imply different kinds and degrees of responsibility or irresponsibility. Thus while the choice of illness analogies for alcoholism is influenced by other factors such as therapeutic utility and face logic, the analogies are clearly chosen to be maximally physical and respectable: "alcoholism is a disease like" an allergy rather than a psychosis, like bronchitis rather than tuberculosis, like diabetes rather than heroin dependence.

Related to the issue of the extent and nature of the application of the "sick role" to alcoholism is the question of the meaning and consequence of the acceptance of the idea that "alcoholism is an illness" among professionals and in the general population. A collation of surveys by public opinion polls and sociologists suggests that those agreeing to the view of the alcoholic as sick and of alcoholism as an illness rose quite dramatically from about one-fifth of the population in 1946-1951 to about three-fifths in 1955-1960 (Haberman and Sheinberg, 1969, p. 1211; but see Roizen, 1977b); in the early 1960s, several surveys found about 65% agreement with these views (Room, 1972a, p. 1050). But several of the sociological investigations looked a little deeper into this indubitable triumph of the alcoholism movement's efforts at public education, and found considerable question whether underlying public attitudes changed as dramatically as the face value of the survey responses suggested; as Haberman and Sheinberg put it, "although alcoholism has been widely defined as an illness since the midfifties, a considerable portion of this public acceptance seems to be little more than lip service" (1969, p. 1215; see also Mulford and Miller, 1964, pp. 314-315). Along with acceptance of the disease concept was supposed to go acceptance of the corollary that therefore the alcoholic was not responsible for his/her own behavior. As implied by Jellinek's designation (1952) of "loss of control" as the pathognomic symptom, the *involuntariness* of alcoholism was indeed the main differentiation between the alcoholic and the plain drunk.

The key word . . . is "choice," and this is the vital difference between the heavy drinker and the "occasional drunk" (who, like the alcoholic, may get in trouble, in the news, the courts, and jail or the hospital, as the result of a drinking bout), and the true alcoholic. The alcoholic . . . *does not choose*. He has lost the power of choice

in the matter of drinking, and that is precisely the nature of his disease, alcoholism. . . . With alcoholics, choice is no longer possible, whether to drink or not to drink, or of the amount consumed, or the effects of that amount upon them, or the occasions upon which drunkenness occurs (Mann, 1958, p. 9; emphasis in original).

The question of volition was widely recognized as the salient issue in determining whether the alcoholic should be punished or treated: "it should be loss of control which determines whether a skid-row drunkard should be subjected to criminal sanctions or treated for disease" (Anonymous, 1966; see also Room, 1970, pp. 4–6). And Cumming and Cumming's analysis of their 1951 survey of attitudes in a Canadian prairie town suggests that the public's resistance to a disease concept in the early 1950s did indeed center on the issue of volition. Drawing on an earlier survey by Shirley Star, the Cummings offered their sample a vignette of a "spree drinker" who loses jobs, neglects his family, and feels guilty. Of the 75% of their sample who said that he was not mentally ill, a majority "said alcoholism is not mental illness because 'he is all right in between, and he knows he does wrong' " (Cumming and Cumming, 1957, pp. 96–97). "By far the largest group of respondents told us that [he] suffered from an error of character; they described him as 'no good' and 'weak-willed' ". The authors added that, despite the rejection of a disease concept, "almost everyone used the term 'alcoholic' in their responses; the word appears to have displaced the word 'drunkard' in lay vocabularies and the meanings of the two terms seem to have overlapped" (p. 97).

In 1951, then, while the Cummings' respondents had adopted the term *alcoholism*, a majority thought the alcoholic was weak-willed and did not accept a mental-illness concept of alcoholism. The intention of the alcoholism movement's public education campaign was to replace a "moral" conception of alcohol problems—in terms of weakness of will—with a disease conception. But what seems to have happened instead was a growth of public acceptance of the disease concept *without* any corresponding decline in a moral-weakness concept. Thus, in Mulford and Miller's 1961 Iowa sample, the proportion who defined the alcoholic as a "sick person" had grown to 65%—but three-quarters of the sample nevertheless defined him as "morally weak" or "weak-willed." Fully 41% of the sample defined the alcoholic as both mentally weak and sick (Mulford and Miller, 1964, p. 316). In fact, among San Francisco white males in 1971 those who accepted that "alcoholism is a mental condition or mental illness" were *more* likely than those who rejected the statement to also agree that "alcoholism is a sign of moral weakness" (49% vs. 34%; Room, 1972a, p. 1050. See also Orcutt, 1976, p. 426). A 1975 nation-wide probability sample of adults distributed itself as follows:

Which of these statements most nearly describes alcoholism?

17% An illness that strikes without warning; people do not have personal control over whether they get it or not

- 19% An illness people have little control over whether they get it or not
- 29% An illness that people have a great deal of control over whether they get it or not
- 28% It's not a real illness. People bring it on themselves
- 7% Don't know

While response patterns were not greatly differentiated by demographic groups, those agreeing "It's not a real illness" were disproportionately poor, rural, and with less formal education. There was no demographic category in which more respondents chose the first pair of categories than chose the second pair (Rapaport et al., 1975, p. 107). It seems clear that, for a substantial portion of the public, the disease concept of alcoholism does not absolve the alcoholic from moral responsibility for his/her plight.

The increasing survey probing of what the public had in mind by the disease concept reflected in part the growing emancipation of sociologists from an earlier role simply of registering the extent to which the slogan "alcoholism is a disease" had penetrated into the consciousness of the general population. The same trend underlay a growing tendency by sociologists to reexamine what professionals and the alcohol literature meant by the disease concept. Mulford submitted a set of hypothetical cases systematically varying the presence or absence of: alcohol-related arrests and job troubles, symptomatic drinking patterns (*preoccupation*), *personal effects* as reasons for drinking, and three frequencies of intoxication (Q-F), not only to a Cedar Rapids general population sample, but also to a sample of local community service professionals and a national sample of "alcoholists." All three samples were most willing to apply the term *alcoholic* to the two cases which manifested *troubles*, *preoccupation*, and regular intoxication—but still only 50–60% of the professionals, and about 45% of the general population, were willing to choose *alcoholic* rather than *problem drinker* for these cases. For all samples, assignment of the label fell off rapidly when one or more of the three case elements were removed. Mulford concluded that there was no clear separation in any of the samples, in terms of what should be done about the case, between *alcoholic* and *problem drinker* (Mulford, 1968, pp. 14–24).

Reexamining the alcoholism movement's literature, sociologists began to suggest that it was not only in the public's mind that the disease concept and a moral concept overlapped. An elucidation of the origins of AA underlined that its action model owed at least as much to moral as to medical antecedents (Blumberg, 1977). AA's "big book" itself gave primacy to the "spiritual" side of the illness: "we have been not only mentally and physically ill, we have been spiritually sick. When the spiritual malady is overcome, we straighten out mentally and physically" (Anonymous, 1939, p. 77). Following Gusfield (1967), Trice and Roman (1970) emphasized the importance of the "repentant role" in AA's model of action for its members. As exemplified in the following abstract

of a 1965 article by two industrial physicians, the professional literature often tied itself into knots over the issues of "will power":

Within recent years alcoholism has been looked upon as a disease rather than a personal weakness. It is not a matter of will power. . . . The most important factor in rehabilitation is the alcoholic's willingness to help solve his own problem. . . . An alcoholic must stop drinking altogether (cited in Room, 1970, p. 4).

In this light, Roizen has suggested that the seeming "philosophical inconsistency in popular opinion should be traced more directly to the substance itself of the classical disease concept."

As it has been disseminated through countless high school classrooms, mass media spots, and the propagandist efforts of AA members and their families, the classical AA Jellinekian conception of alcoholism involves both choice and compulsion. In this view alcoholics might have a good measure of control over whether or not to begin drinking on a particular occasion, but little control over stopping drinking once started. Thus, the picture of alcoholism might lead one consistently to answer both—that alcoholism is an addiction and that an alcoholic drinks because he wants to (Roizen, 1977b, pp. 24–25).

Accordingly, Roizen showed that, in a 1975 San Francisco general-population sample, those who subscribed to the classical Jellinek definition of "gamma alcoholism"—inability to stop once started—were *more* rather than less likely than others to add a moral dimension to a medical characterization of alcoholism. He offered some provocative suggestions about the possible meaning of this finding. While Orcutt (1976) suggested that the empirical overlap of medical and moral ideologies "may reflect a *transitional* state in the historical shift from a moralistic ideology to a medical ideology," Roizen proposed that the ideology might itself have become a carrier for moralism:

[the] classical ideology, rather than secularizing alcoholismic behavior and enhancing the role of involuntary factors in it, in fact may perform quite contrarily. Against the background of increasingly entrenched secularism in the U.S., three-quarters through the 20th century, . . . the disease concept that once championed scientific humanism may have instead become a sort of ideologically reactionary portal through which human will and spirit reappear in the explanation of alcoholismic drinking. . . . Moralism is more strongly a part of the classical disease concept than it is part of the background . . . climate of opinion (Roizen, 1977b, pp. 24, 26).

From the perspective of the alcoholism movement, of course, a crucial question is whether a conflated "moral-medical" concept implies a better or a worse social standing for the alcoholic than a straight "medical" concept. To the extent this question has been faced, the social science literature has found equivocal results. Both Rule and Phillips (1973) and Orcutt (1976), using samples of convenience, found little difference between the concepts in the curability imputed to alcoholism. But Orcutt found that college students holding the "moral-medical" concept were more likely to say they would feel uncomfortable around an alcoholic, while Rule and Phillips' high school sample did not differentiate between medical and medical-moral case-presentations in terms of felt social distance,

and were more likely to say they "liked" the case presented in a medical-moral frame than the case presented in a straight medical frame.

## 5. THE ALCOHOLISM CONCEPTION AS A NEW SCIENTIFIC APPROACH

As the quotation from Roizen reminds us, a crucial component of the alcoholism movement's efforts to promote the disease conception of alcoholism has been the claim that the disease concept represented a "new scientific approach." The Yale Center staff's insistence that their approach was above all "scientific" in fact predated the emergence in institutional form of the alcoholism movement. It is no accident that "science" is included in the title of *Alcohol, Science and Society*, a widely distributed early monument of the Yale Center's approach. In his introduction to the volume, Jellinek repeatedly invokes the mantle of "science"—in fact, he introduces a little homily about "what is meant by scientific study" by acknowledging that "I have used the words 'science', 'scientific study' and 'scientific school' repeatedly" (Jellinek, 1945, p. 5). For the early leaders of the movement, the claim of "science" had a specific political function: it was intended to signal that they were claiming a status of neutrality in the residual political battles over temperance issues—they were neither "wet" nor "dry." In the second specifically labeled "Editorial" in the history of the *Quarterly Journal of Studies on Alcohol*, entitled "The 'Wets' and 'Drys' Join Against Science," Haggard stated the case specifically, outlining the basis for the budding alliance between "the scientist" and "the recovered alcoholic":

The scientist who wishes to work dispassionately on the problems of alcohol finds that he is in the same bed with the rehabilitated alcoholic—viewed with suspicion and stigmatized by both "wet" and "dry" factions. The scientist has attempted—and with growing success—to popularize the humane belief that alcoholism is an illness and that the alcoholic deserves not moral degradation, not jail sentences, but the dignity of the medical care which is the right of every man who is ill. The scientist has advocated clinics and other institutions for the cure and rehabilitation of alcoholics. He has demonstrated that rehabilitation is possible.

But the conception of alcoholism as an illness and the founding of clinics for rehabilitation are taken as subtle anti-"wet" and equally subtle anti-"dry" propaganda. . . . Legitimate scientific research and scientifically oriented clinical and educational work on alcohol have suffered greatly through public mistrust generated by the conflict of the "wets" and "drys". . . . The scientist does not take sides. He is interested only in the truth and in its humanitarian application. . . . In spite of obstacles the growing numbers of scientists interested in the problem and the growing numbers of rehabilitated alcoholics, in close cooperation, will—in spite of opposition—gain the needed public support (Haggard, 1945, pp. 133–134).

There was a nice symmetry about the antithesis between "wet" and "dry" in Haggard's argument. And certainly alcoholic beverage industry interests and the alcoholism movement often had divergent viewpoints: Haggard and Jellinek

fought a losing battle to keep the Research Council on Problems of Alcohol, in whose name the *Quarterly Journal of Studies on Alcohol* was initially published, from becoming a liquor industry (LBI) front (Keller, 1976); and LBI interests initially preferred the term *problem drinker* to *alcoholic* (see Hirsh, 1949; Rubin, 1979). On the other hand, temperance interests had initially welcomed the activities of the Yale Center (Gusfield, 1955; Rubin, 1979). But in the middle and late 1940s, as the liquor industry was deciding it had more to gain than to lose from the new movement (Rubin, 1979), the Yale Center staff took several steps that were bound to alienate themselves from the temperance movement (see Rubin, 1979)—including making the claim, repeatedly denied by temperance leaders (Warner et al., 1945; McPeck, 1945; Squires, 1945), that the temperance movement was opposed to providing treatment for the alcoholic. Haggard's editorial must be read—and was read (Squires, 1945)—as primarily aimed at putting distance between the temperance movement and the nascent alcoholism movement. In the rhetoric of the leaders of the alcoholism movement, the primary counterfoil to the new "scientific" approach was the old "moralistic" approach of the temperance movement.\*

With their general liberal and libertarian proclivities, sociologists tended to be quite out of sympathy with what were seen as the reactionary politics of the temperance movement (see Lee, 1944), and in the forefront of attacks on a "moralistic" approach (see Bacon, 1949, p. 15; 1967). The present writer has suggested that part of the appeal for sociologists of the "ambivalence" explanation of American alcoholism was that it tended to put the onus for a presumptively high U.S. rate on the temperance movement (Room, 1976a, pp. 1052–1053). As late as 1974, the sight of a sociologist dispassionately discussing moral issues in the course of a consideration of the status of drunkenness in the criminal law could provoke a visceral reaction from alcohol sociologists who had been in the field in the 1950s:

The word "moral" just makes me sick at the stomach, when I think of all the crimes that have been committed by the moral entrepreneurs in terms of exacerbating the problems not only of the alcohol abusers but of many other comparable groups (Pittman, 1976a, p. 212).

But by the early 1960s sociologists were beginning to distinguish between scientific research and the interests of the alcoholism movement. We have already quoted Seeley's dictum (1962) that the statement "alcoholism is a disease" must be seen as a public policy recommendation, and not a "scientific discovery." For Straus (1960), the "conflicting forces ready to use scientific findings for nonscientific causes" included not only the "alcoholic industry" and the "professional dry groups," but also "the ever-present militant proponents of an alcoholism movement" (p. 28). In Straus' eyes, science was on the side of a nascent

\* The appropriation of the mantle of "science" by the alcoholism movement must have particularly rankled with the temperance movement, which had long emphasized its own "scientific" basis, as in such journal titles as the *Scientific Temperance Journal*.



"second generation in alcoholism research," which wanted "the freedom to think . . . free from biases introduced by outside pressure," and which was "free, remarkably free, from contamination of an emotional involvement with the alcohol problem" (p. 30).

Throughout the history of the alcoholism movement, those with an antiquarian interest in the subject were aware that the idea of alcoholism as a disease was not at all new. The received wisdom on the history of the disease concept was summed up by Jellinek in the first few pages of *The Disease Concept of Alcoholism* (1960): the primary antecedents of the "renewed approach" of the 1940s were the small inebriates' home movement led by a few doctors in the late nineteenth and early twentieth century, and the movement's organ, the *Quarterly Journal of Inebriety*. In keeping with the views of the Yale Center staff 15 years before, Jellinek saw the temperance movement as having been unrelentingly hostile to the inebriates' home doctors: "the temperance and prohibition movements regarded the Society as inimical to temperance goals. . . . The idea of inebriety as a disease weakened the basis of the temperance ideology and thus the efforts of the Society had to be rejected in toto" (p. 6). As evidence for these contentions, Jellinek reprinted as an appendix part of a nineteenth-century tract, "Drunkenness a Vice, Not a Disease" (Jellinek, 1960, pp. 207-210).

Jellinek's view remained unchallenged in the sociological literature, as elsewhere, for some years. Gusfield's pathbreaking presentation (1967) of historical changes in the definition of the drunkard, for instance, draws on the conventional contrast between a temperance and an alcoholism perspective. In 1976 (published 1978), the sociologist Harry Levine proposed a new interpretation fundamentally "contrary to the prevailing wisdom." Drawing on primary sources, Levine argued that many temperance writers had indeed given support to the inebriates' home movement. In fact, the particular tract Jellinek had reprinted was not written by a temperance supporter; it had drawn a critical response the next year from a temperance writer (p. 158). More fundamentally, Levine set out and provided evidence for an argument that the modern disease conception of alcoholism was in its essentials derived from the central ideology of the nineteenth-century temperance movement.

The essentials of the modern or post-Prohibition understanding of alcoholism first emerged in American popular and medical thought at the end of the 18th and beginning of the 19th century. Around that time a new paradigm was created; or, in Foucault's terms, the "gaze" of the observer shifted then to a new configuration—a new gestalt. This new paradigm or model defined addiction as a central problem in drug use and diagnosed it as a disease, or disease-like. The idea that alcoholism is a progressive disease—the chief symptom of which is loss of control over drinking behavior, and whose only remedy is abstinence from all alcoholic beverages—is now about 175 to 200 years old, but no older. (1978, p. 143)

There was, of course, one significant innovation in the post-Repeal "rediscovery" of alcoholism. "In order for a disease conception to be acceptable to masses of people in the 20th century, the idea that alcohol was an inherently addicting



substance had to be abandoned. . . . Now alcohol could be understood as a socially acceptable, 'domesticated' drug which was addicting only to some people for unknown reasons. Thus alcoholism became the only popularly and scientifically accepted person-specific drug addiction" (p. 162; see also Christie and Bruun, 1969, on the last point).

Levine's argument received concurrent support from historical work on "temperance tales" of the nineteenth century, which pointed out the numerous and unmistakable antecedents of Jellinek's celebrated chart of the "phases of alcohol addiction" in nineteenth-century "drunkard's progresses" (Lender and Karnchanapee, 1977, pp. 1354-1360). To my knowledge, Levine's fundamental argument has not been challenged, although Beauchamp (1980) has disagreed concerning the significance of the alcoholism movement's "person-specific" innovation.

It is a necessary corollary of Levine's argument that "medical and moral definitions of addiction are not mutually exclusive." In an appendix to his paper, he shows that "the 19th century by no means had a monopoly on moralistic views of addiction," quoting the psychiatrist Wexberg, "who criticizes the Temperance Movement for being moralistic and condemnatory." In Wexberg's view, the "malignant habit of addiction, [which] deserves to be classified as a disease," is characterized by "the 'metastatic' invasion of the total personality and deterioration of its value system" (Levine, 1978, p. 169; Wexberg, 1951).

## 6. THE TREATMENT RESPONSE AS RATIONAL AND HUMANE

The sociological literature relevant to the disease concept of alcoholism is generally marked by a liberal "humanitarian" rather than a "tough-minded" stance: in general, primacy is given to the interests of those to be identified and treated as alcoholics over the interests of those surrounding them or of the larger society. With few exceptions, then, the sociological literature has been in harmony with the alcoholism movement in seeking the "best deal" possible for those with alcohol-related problems. But there has been increasing disagreement between the two streams of thought about what constitutes the best deal. In part, this has reflected that different kinds of presumptive clients have different interests. There is a long and strong tradition of sociological research on Skid Row, and many sociologists have combined their research interests with advocacy on behalf of those at the bottom of the social order (see references in Bahr, 1970; Room, 1976b; Giffen and Lambert, 1978).<sup>\*</sup> On the other hand, it has been a staple of alcoholism movement publications, acting on behalf of the social standing of

<sup>\*</sup> Much of the postwar sociological literature on Skid Row was initially funded as part of urban renewal programs; some of the advocacy thus took the form of arguing that Skid Row inhabitants would actually be better off with Skid Row demolished, while other work insisted that the Skid Row drinker's lifestyle represented a positive affiliation with a lively subculture (see Room, 1976b).

"alcoholics" in general—and perhaps of those who treat them—to insist that most alcoholics are not on Skid Row, and indeed to reposition the public image of "the alcoholic" as far as possible from the Skid Row stereotype (Kurtz and Regier, 1975). While sociological research findings in fact contributed to this shift in the image of alcoholic (Straus, 1976), the continuing tradition of sociological research on Skid Row has often reemphasized the discrepancy in perspectives between the Skid Row men and the treatment and other social institutions which serve them (e.g., Wiseman, 1970; Spradley, 1970; Rooney, 1980; Mauss, 1982). It is particularly in the context of homeless men that sociologists have joined forces with civil-liberties lawyers to insist that treatment can be a worse option for the client than frank punishment.

Who said alcohol should be combated by punishment? The poor alcoholic is a sick person. He ought not to be punished, he ought to be treated. Treatment is a help. Consequently, considerations of justice do not apply, and the homeless man can be placed for a considerable length of time in an institution intended to give treatment or help, even though the building sometimes is the same one as that used earlier for punishment.

This is an old story. Scandinavian criminology as well as sociology of law and sociology of medicine in these countries has been eagerly engaged in disentangling its major components for several years (Christie and Bruun, 1969, p. 71).\*

Sociological writers have in general been supportive of the provision of treatment and other help for those who desire it. There is a whole tradition of sociological studies of the actual functioning of AA, for the most part sympathetic; much of the energy in this literature is devoted to reinterpreting AA's ideology and *modus operandi* into the general theoretical frameworks of sociology (Bales, 1962; Maxwell, 1962; Thune, 1977; Robinson, 1979; Tournier, 1979). Some sociologists have worked in the field of evaluation of medical and other clinical treatment programs; while their work has partaken of the generally skeptical attitude of this literature, much of it has not been specifically sociological (see for example Fry and Miller, 1975; Armor et al., 1978; Polich et al., 1980). The task of mapping out what actually happens in the treatment process

\* Compare the statement of Peter Barton Hutt—The ACLU counsel on the chief legal cases attempting to establish that Skid Row public drunkenness offenders were suffering from a disease, alcoholism, and that it was therefore unconstitutional to punish them—to a National Council on Alcoholism meeting: "we have not fought for two years to extract DeWitt Easter, Joe Driver and their colleagues from jail, only to have them involuntarily committed for an even longer period of time, with no assurance of appropriate rehabilitative help and treatment. The euphemistic name 'civil commitment' can easily hide nothing more than permanent incarceration" (quoted in U.S. Supreme Court, 1968, p.1266). Quoting these words in turning back Hutt's brief on behalf of decriminalization, Justice Marshall noted that "one virtue of the criminal process is, at least, that the duration of penal incarceration typically has some outside statutory limits." Referring to an actual incident in the District of Columbia (Beauchamp, 1973), Marshall concluded that, if an alcoholism defence against a charge of public drunkenness were accepted, "we run the grave risk that nothing will be accomplished beyond the hanging of a new sign—reading 'hospital'—over one wing of the jail-house" (U.S. Supreme Court, 1968, p. 1265).

and for that matter the social ecology of the treatment system has not yet been fully addressed (see Room, 1979).

A distinctively sociological position which is more discomfiting to alcoholism movement interests is the recognition that treatment is among other things a form of social control (see Room, 1982; Weisner, 1983)—and particularly so in a field like the treatment of alcohol problems, which is concerned with often conflictual values and behaviors. A recognition of this social control function of treatment agencies is a matter-of-fact feature of many sociological discussions of alcohol problems (e.g., Lemert, 1951, p. 365). This has been accompanied by a keen sensitivity to the issue of whose interests exactly are being served by submitting a case to treatment, and a line of analysis emphasizing the problems of combining in one institution or agency the conflicting action paradigms of deterrence and rehabilitation (Christie, 1965). These concerns fit into a more general sociological concern about and analysis of "the medicalization of deviance" (Conrad and Schneider, 1980). Mäkelä's response to the question "What Can Medicine Properly Take on?" is a forthright statement of these general concerns as applied in the alcohol field:

There are two basic types of deviance: disease and bad conduct. The distinction is based on whether we regard the behaviour or condition as dependent or independent of the volition of the individual. Diseases are treated by the medical profession, but bad conduct is dealt with by the legal and moral authorities. In the course of the last two centuries or so, an ever-growing number of types of behaviours and conditions have been reclassified as diseases rather than as bad conduct, and the domain of the medical profession has correspondingly been broadened. . . .

Even if we do not morally blame an alcoholic for his drinking, the concern for heavy drinkers is, in many countries, in perhaps the majority of cases motivated by the harm their drinking causes to their families and social environment. This being the case, the medicalisation of alcohol problems only leads to the blurring of the social role of the medical system as opposed to those authorities whose explicit task is to maintain social order.

It is especially unfortunate if a medical disguise is given to efforts to control deviant drinking in order to safeguard the environment of the patients. It should not be up to the medical profession to take care of public order and the safety of the drunkard's family, which easily happens when social sanitation is couched in treatment terminology. In Finland, . . . involuntary commitments have been used as a convenient way to solve family crises and social conflicts caused by heavy drinking. It should be borne in mind that a shift of compulsory control of deviant use of alcohol from "punishment" to "treatment" often actually means the application of more severe measures (Mäkelä, 1980, pp. 225, 229).

As Mäkelä intimates, sociological thought, following Foucault and Rothman, now tends to see the "medicalization of deviance" as a general historical tendency of the last two centuries; in this light, Levine's work (1978) can be seen as tracing the specific working-out of the tendency in the field of alcohol. But there is also a clear recognition that the tendency took on a specific historic form in industrialized countries in the period following the Second World War. In the U.S., as in other industrial countries, the societal resources devoted to

welfare and health services grew dramatically, in a development often described as "the rise of the welfare state" (Morgan, 1981). The increase in support for treatment services for alcoholism in the U.S., at first at the state level in the 1950s and then at the federal level in the late 1960s and 1970s, can be seen as part of this general trend (Morgan, 1980). In this view, then, the alcoholism movement succeeded not only because of its internal characteristics but also because its message fitted the temper of the times.

In recent months, Reagan and Thatcher and their counterparts in other nations have brought the "fiscal crisis of the welfare state" to the notice of even the most oblivious. In this context, an international research group, primarily composed of sociologists, has warned that

there is a growing conflict between increased concern about alcohol problems and the economic interests of the alcohol trade that is exacerbated by static or declining markets. In a situation of increased acceptance of drinking in everyday life, policies may tend even more toward individual control of deviant drinkers. In an era of contracting public welfare resources, this tendency may be expressed more in punitive than in treatment-oriented measures (Mäkelä et al., 1981).

A convergent line of analysis in the U.S. has focused on the issue of the relation between the recently much-expanded treatment system for alcoholism (in absolute terms the greatest growth in the U.S. has been since 1970) and the "need for services" in the population at large. The findings of survey research studies about rates of drinking-related problems in the population tend to have been loosely translated in the policy arena into rates of "alcoholism," and these rates have been commonly regarded as defining the population "in need of services." That the numbers showing alcohol-related problems in the population were very much higher than the numbers in treatment for alcoholism fitted an already prevailing rhetoric about a huge pool of "hidden alcoholics" in the general population, who were in need of but not receiving services. But this perception failed to recognize that alcohol problems showed a much more sporadic and diffuse character in the general population than in clinical populations—and that many thus defined as "in need" of services were unlikely to feel the need themselves. In fact, many facilities in the expanded treatment system find themselves with empty beds or treatment places—perhaps particularly those with finely divided categorical emphases such as "teenage alcoholism" (Chauncey, 1980). Increasingly, treatment agencies seem to have been resorting to compulsion as a means to fill their caseloads—including various forms of formal and informal diversion from the criminal justice system (see Room, 1980b for a fuller exposition). In this perspective, the alcoholism treatment system is gradually shifting from operating under a medical rubric to operating under a legal rubric, with a rhetoric of justification in terms of "tough love." It is remarkable, at least to the present writer, how little acknowledgement of this trend or discussion of its consequences has appeared in alcoholism movement organs. So far, it is primarily sociologists who have paid attention (see articles in Ward, 1982).

One consistent sociological concern about the treatment response to alcohol problems, then, is a wariness about and concern to explore the extent and nature of the social-control functions that are hidden under the disease concept's rhetoric of help and cure. More generally, sociologists have worried about the implications of the trend towards the medicalization of deviance—particularly the shorter-term trend in the welfare-state era—pointing out that medicalization is a two-edged sword, with disadvantages as well as advantages for both the client and the society. Clearly, ethical as well as scientific agendas underlie these concerns. In the special arena of occupational alcohol problems, Roman and Trice (1968) have taken these sociological concerns to a logical conclusion. Having criticized the disease concept of alcoholism for its potentially counter-productive effects on the client, Roman and Trice support instead a straightforward deterrent approach of "constructive coercion." The approach, with its label softened to "constructive confrontation," has indeed become the standard approach in "employee assistance programs."

In general, however, although sociologists have taken the role of "challengers" of "medical deviance designations" in recent years (Conrad and Schneider, 1980, p. 274), they have shrunk from supporting demedicalization. The conclusion of Conrad and Schneider's recent synthetic work on deviance and medicalization (1980) provides an example. After an extended historically grounded critical analysis of medicalization and demedicalization in a number of topical areas, they lay out both the "brighter side" and the "darker side" of medicalization (pp. 245–252). Then, somewhat lamely, they conclude that "the medicalization of deviance will continue and is likely to expand and . . . the questions raised in this book will remain pertinent to the future" (p. 276). To some extent this may reflect a sociological reluctance to "take sides" (Gusfield, 1983), but it also may reflect sociologists' political and ethical discomfort with the likely alternatives to medicalization.

## 7. ALCOHOLISM AS THE KEY TO HANDLING ALCOHOL PROBLEMS

Perhaps the most consistent difference between sociological researchers and alcoholism-movement thought has been over the issue of the centrality of the alcoholism concept to the field of alcohol studies. The issue was joined even before the institutional emergence of the movement, in the initial manifesto of the first sociologist of the alcoholism movement era, Selden Bacon. Jellinek (1942) had proposed and the Research Council on Problems of Alcohol had adopted a program of research which gave first priority to "the origins of inebriety and addiction" and deemphasized studies of "the effect of alcohol on society." Looking back on this period, Dwight Anderson, a founding ideologist of the alcoholism movement, describes the climate to which Jellinek's policy statement was responding:

We ex-alcoholics watched the work of the Council with enthusiasm not unmixed with awe. We regretted that it focused its attention on alcohol rather than on alcoholism. . . . But with all these eminent men interested, we felt that sooner or later the emphasis would change. We helped where we could, those of us who had skills or contacts which might be useful. We proposed the names of influential people for membership and helped to raise funds. But we felt somehow remote from the undertaking. . . .

Meanwhile, it had become evident that the program should be reoriented. In the first place, the Council found a vast swell of interest . . . from people and institutions which were concerned chiefly with alcoholism. . . . So the Council announced that it had reoriented its policy to place the accent on action—measures to treat and prevent alcoholism. . . . (Anderson, 1950, pp. 201–203).

As a young assistant professor of sociology newly interested in alcohol problems, Bacon responded to Jellinek's program with a lengthy memorandum, which Jellinek published in the *Quarterly Journal of Studies on Alcohol* (1943). Bacon's manifesto emphasized the importance of studying *all* of drinking, and not just "inebriety": "a factor which has delayed and discouraged an adequate analysis of drinking behavior has been the failure to recognize the relation of inebriety to all other forms of drinking" (p. 409). As I have previously commented:

The contrast between Jellinek's and Bacon's perspective is prototypical of a persistent strain between social science alcohol researchers and the rest of the alcohol field. The strain tends to occur over how the dependent variable is to be defined. In the era of the alcoholism movement, it has been alcoholism, defined as a clinical entity, that is to be explained. So long as social scientists accepted this definition of the dependent variable uncritically, and investigated its social epidemiology, their efforts were welcomed and, indeed, heralded. . . . But social scientists, and perhaps particularly sociologists, have not been willing to confine themselves to alcoholism as a dependent variable (Room, 1979, pp. 254–255).

Bacon's own subsequent career includes a period of leadership in the alcoholism movement, during which his writings tended to accept the restricted focus on alcoholism (Room, 1978). For example, in a paper of practical advice on "The Administration of Alcoholism Rehabilitation Programs" he complained of temperance organizations that they were "reluctant to see that prevention emerges from rehabilitation and allied education" (1949, p. 15). But in his later work he returned to an emphasis on the importance of a "phenomenological" rather than solely a "problem" orientation (1976), arguing for broadening the perspective beyond the limits of alcoholism:

When, during the 1940s, the walls of avoidance surrounding alcohol phenomena began to crumble, there was a call for research . . . from lay public sources. . . . The call for new recognition, new research, and new action was *not* directed at the problems of alcohol, but was directed at one subtype of these problems—namely, something called alcoholism. . . . The proponents of the new approach adopted the slogan that alcoholism was a disease, [and] this was the orientation for research (1971, pp. 485, 487).

Instead, he proposed, "the name of the field of knowledge which needs organization, data, insight, systematic and testable understanding . . . is alcohol beverage and its use. Within that field are what are called problems of alcohol beverage and its use, but they will not be effectively researched unless positioned in that larger field" (p. 491). Still later, he commented ruefully on his earlier role in the movement:

Alcoholism has been the great cult excitement of the last 34 years. I was one of the people who helped build up the cult, in the early days before I got thrown out when I said, "Well, that wasn't quite what I meant." Alcoholism was to be the wheelhorse of change; it was not to be the change. . . . I don't feel that alcoholism is the core center at all. . . . Recently the cult has become so powerful, 1960-1972, that it has taken over traffic problems and youth problems, and they are all called alcoholism, which is of course a lot of nonsense if the word is to refer to a disease-like entity of some sort or a life disorder of some sort. Alcohol problems are much, much bigger than that (Bacon, 1979, p. 306).

One aspect of the divergence in views between the alcoholism movement and alcohol sociologists, then, was the question of research focus: should all research be focussed around the question of the causes of alcoholism? On this question, sociologists and anthropologists (see Levine, 1981) have been relatively constant—except perhaps for a few years in the mid-1950s—in giving a negative answer. But there was also another aspect of divergence, on which there has been somewhat less unanimity: in public policy on alcohol issues and problems should the sole or at least the prime focus be on providing treatment for alcoholism? This policy question lay beyond the boundaries of an academic research role, and thus could be relatively easily avoided by sociologists and other social scientists. Gradually, however, researchers in the field began to take responsibility for pursuing the practical implications of their research paradigm and findings. As mentioned above, sociologists took an active role in the formation and activities of the Cooperative Commission on the Study of Alcoholism, in part out of frustration at the narrowness of alcoholism movement goals in the 1950s. Most research-oriented alcohol policy committees and documents in the last 20 years have had a substantial presence and influence from sociologists, and more broadly from social scientists. Sociologists have played a particularly strong role in focusing attention on expanding the range of strategies for the prevention of alcohol problems (see Room and Sheffield, 1976).

Perhaps the most controversial of these involvements—particularly in terms of disagreements among sociologists—has been the participation by social scientists in alcohol control policy debates, centering around the implications of the postwar rise of alcohol consumption in the U.S. and other industrialized countries. Researchers at the Addiction Research Foundation—particularly Seeley, Popham, de Lint, and Schmidt (in terms of disciplinary training a sociologist, two anthropologists, and a legal scholar)—played a major role in renewing this research and policy agenda in North America (see Bruun et al., 1975; Schmidt and Popham, 1978; Room, 1978*a,b*). Schmidt and Popham have described (1978)



how their initial reports in the late 1960s ran against "the climate of ideas which [then] prevailed. . . . The dominant view among social scientists in the field as well as non-researchers favored increasing the availability of alcohol and encouraging the adoption of drinking styles modelled especially on those of Italy and France." Christie has also conveyed the reluctance with which social scientists found themselves seated at the policy table, as "the only counter-forces left" to alcohol beverage industry interests. "Being apart from the producers, but with unusual interests in the field of alcohol, researchers are forced to take the empty seat" left by the decline of the temperance movement, and to "use considerable energy as advocates for interference at the general social level. . . . If researchers do not take this role, the field remains completely open to the producers. The sheer imbalance in this situation seems to call for more rather than for less political engagement of alcohol researchers" (Christie, 1976, p. 3).

For some U.S. alcohol sociologists—including many of those with long experience in the field—this stance is uncomfortable or indefensible (see reactions by Bacon, Pittman and Cisin in Room and Sheffield, 1976; and see Pittman, 1980). For the alcoholism movement of the 1970s, the issue has also proved uncomfortable. In 1978, Ernest Noble, as director of NIAAA, influenced by the alcohol control literature, proposed a national goal of stopping further increases in consumption. The Coalition for Adequate Alcoholism Programs, the alcoholism movement umbrella group, under pressure from alcohol beverage industry representatives, opposed Noble's initiative, and successfully deflected it (Wiener, 1981). However, recent events suggest that the longstanding tacit coalition between the alcoholism movement and beverage industry interests (Rubin, 1979; Beauchamp, 1980) is in the process of disintegration. This reflects a gradual shift in perspectives within the alcoholism movement towards a broader "alcohol problems" perspective.

## 8. CONCLUSION

This paper has primarily been based on a North American literature. While this may reflect some ignorance on the part of the author, it also reflects the peculiar conjunction in North America of a strong alcoholism movement and relatively strong traditions of social problem-oriented sociological research. Other places with similar sociological traditions—notably the Nordic countries and Britain—have also made contributions to the present topic, which have indeed been drawn upon here; but neither in Britain nor in Scandinavia did a lay-led alcoholism movement attain the prominence it did in the U.S., and the issues posed by the movement's alcoholism concept were thus less obtrusive on the agenda of social research. In other places, such as Latin America, the disease concept of alcoholism has served as a strong governing image (Caetano, 1982), but the requisite sociological research tradition did not exist or come into being.

In Canada, the existence and multiple functions of the Addiction Research

Foundation of Ontario considerably muted the discordance between sociological research and alcoholism movement interests throughout the last 30 years. In the U.S., however, the discordance has been strong, particularly in the period from the mid-1960s to the end of the 1970s. Sociologists—and more generally, social science researchers—have often felt that the more alcoholism movement figures knew about and understood their research, the less they would like it. With the gradual shift of the alcoholism movement towards a broader policy orientation, this is now becoming less true. Ironically, this reconciliation, symbolized by the devotion of a plenary session of the 1982 National Council on Alcoholism sessions to the National Academy of Science report on *Alcohol and Public Policy* (Moore and Gerstein, 1981), comes at the moment when the Reagan administration's hostility to social science research, emboldening biomedically oriented research administrators, threatens to decimate the funding support for sociological research on drinking practices and problems.

In their critique of the classic disease concept of alcoholism, behaviorally oriented psychologists and psychiatrists have felt impelled to offer a counterconception (e.g., Pattison et al., 1977). No such coherent counterconception can be found in the sociological literature; instead, there is a diffuse "post-addiction model" (Levine, 1978) predicated on the disaggregation of "alcoholism" into its constituent alcohol-related problems. Gusfield (1983) would suggest that this reflects a habitual stance of sociologists: as he puts it, when asked, "which side are you on?", their response is "on the side." But, with respect to alcoholism, it also reflects a critique of a model of research and of public discourse in terms of "simplifying conceptions," such as the alcoholism movement's disease concept, to cover complicated research and policy terrains (see Room, 1973, 1978; Moore and Gerstein, 1981).

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#### REFERENCES

- Aarens, M., Cameron, T., Roizen, J., Roizen, R., Room, R., Schneberg, D., and Wingard, D., 1977, *Alcohol, Casualties and Crime*, Social Research Group, Report No. C18, Berkeley, California.
- Anderson, D. 1942, Alcohol and public opinion, *Q. J. Stud. Alcohol*, 3(3):376.
- Anderson, D., 1945, Analysis of wet and dry propaganda, in: *Alcohol, Science and Society*, pp. 355-369. Journal of Studies on Alcohol, New Haven.

- Anderson, D., with Cooper, P., 1950, *The Other Side of the Bottle*, A. A. Wyn, New York.
- Anonymous, 1939, *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*, Works Publishing, New York.
- Anonymous, 1966, Alcoholism, Public Intoxication and the Law, *Columbia J. of L. and Soc. Probl.* 2:109.
- Armor, D. J., Polich, J. M., and Stambul, H. B., 1976, *Alcoholism and Treatment*, Rand Corp. Publication R-1739, Santa Monica, California.
- Armor, D. J., Polich, J. M., and Stambul, H. B., 1978, *Alcoholism and Treatment*, John Wiley, New York.
- Bacon, S. D., 1943, Sociology and the problems of alcohol: Foundations for a sociologic study of drinking behavior, *Q. J. Stud. Alcohol* 4(3):402.
- Bacon, S. D., 1949, The administration of alcoholism rehabilitation programs, *Q. J. Stud. Alcohol* 10(1):1.
- Bacon, S. D., 1967, The classic temperance movement of the U.S.A.: Impact today on attitudes, action and research, *Br. J. Addict.* 62(1,2):2.
- Bacon, S. D., 1971, Fragmentation of alcohol problem research, in: *29th International Congress on Alcoholism and Drug Dependence*, (L. G. Kiloh and D. S. Bell, eds), pp. 481-495, Butterworth, Australia.
- Bacon, S. D., 1973, The process of addiction to alcohol: Social aspects, *Q. J. Stud. Alcohol* 34(1A):1.
- Bacon, S. D., 1976, Concepts, in: *Alcohol and Alcohol Problems, New Thinking and New Directions*, (W. J. Filstead, J. J. Rossi, and M. Keller, eds.), pp. 57-134, Ballinger, Cambridge, Massachusetts.
- Bacon, S. D., 1979, Discussion comment, in: *Research Priorities on Alcohol: Proceedings of a Symposium Sponsored by the Rutgers Center of Alcohol Studies and Rutgers University*, pp. 305-306, Journal of Studies on Alcohol Supplement No. 8, New Haven.
- Bahr, H., ed., 1970, *Disaffiliated Man: Essays and Bibliography on Skid Row, Vagrancy, Outsiders*, University of Toronto Press, Toronto.
- Bales, R. F., 1962, The therapeutic role of Alcoholics Anonymous as seen by a sociologist, in: *Society, Culture, and Drinking Patterns* (D. J. Pittman and C. R. Snyder, eds.), pp. 572-576, Wiley, New York.
- Beauchamp, D. E., 1973, *Precarious politics: Alcoholism and public policy*, Ph.D. dissertation, Political Science and Public Administration, Johns Hopkins University.
- Beauchamp, D. E., 1980, *Beyond Alcoholism: Alcohol and Public Health Policy*, Temple University Press, Philadelphia.
- Becker, H. S., ed., 1966, *Social Problems: A Modern Approach*, Wiley, New York.
- Blumberg, L., 1977, The ideology of a therapeutic social movement: Alcoholics Anonymous, *J. Stud. Alcohol* 38(11):2122.
- Bruun, K., Edwards, G., Lumio, M., Mäkelä, K., Pan, L., Popham, R. E., Room, R., Schmidt, W., Skog, O.-J., Sulkunen, P., and Österberg, E., 1975, *Alcohol Control Policies in Public Health Perspective* Vol. 25, Finnish Foundation for Alcohol Studies, Helsinki.
- Caetano, R., 1982, Looking southward: Manifestations and perceptions of alcohol-related problems in the Americas, in: *Legislative Approaches to the Prevention of Alcohol-related Problems: An Inter-American Workshop*, (Alan K. Kaplan, ed.), Institute of Medicine, National Academy Press, Washington, D.C., pp. 64-105 and 110-126.
- Cahalan, D., 1970, *Problem Drinkers*, Jossey-Bass, San Francisco.
- Cahalan, D., and Room, R., 1974, *Problem Drinking among American Men*, Rutgers Center of Alcohol Studies Monograph No. 7, New Brunswick, New Jersey.
- Chauncey, R. L., 1980, New careers for moral entrepreneurs: Teenage drinking, *J. Drug Issues* 10(1):45.
- Christie, N., 1965, Temperance boards and interinstitutional dilemmas: A case study of a welfare law, *Soc. Probl.* 12(4):415.
- Christie, N., 1976, Goals, ethics, and politics of preventing alcohol problems, in: *The Prevention of Alcohol Problems: Report of a Conference* (R. Room and S. Sheffield, eds) pp. 2-11, Office of Alcoholism, State of California, Sacramento.

- Christie, N., and Bruun, K., 1969, Alcohol problems: The conceptual framework, in: *Proceedings of the 28th International Congress on Alcohol and Alcoholism, Lectures in Plenary Sessions Vol. 2* (M. Keller and T. G. Coffey, eds.), pp 65-73, Hillhouse Press, Highland Park, New Jersey.
- Clark, W. B., 1966, Operational definitions of drinking problems and associated prevalence rates, *Q. J. Stud. Alcohol* 27(4):648.
- Clark, W. B., 1975, Conceptions of alcoholism: Consequences for research, *Addict. Dis.* 1(4): 395.
- Clark, W. B., 1976, Loss of control, heavy drinking and drinking problems in a longitudinal study, *J. Stud. Alcohol* 37(9):1256.
- Conrad, P., and Schneider, J. W., 1980, *Deviance and Medicalization—from Badness to Sickness*, C. V. Mosby, St. Louis.
- Cumming, E., and Cumming, J., 1957, *Closed Ranks: An Experiment in Mental Health Education*, Harvard University Press, Cambridge, Massachusetts.
- Davies, D. L., 1962, Normal drinking in recovered alcohol addicts, *Q. J. Stud. Alcohol* 23(1):94.
- Edwards, G., 1973, Epidemiology of Alcoholism: A Review and an Examination of Purposes, *Q. J. Stud. Alcohol* 34(1A):28.
- Edwards, G., Gross, M. M., Keller, M., Moser, J., and Room, R., eds., 1977, *Alcohol-Related Disabilities*, World Health Organization. WHO Offset Publication No. 32, Geneva.
- Fry, L. J., and Miller, J., 1975, Responding to skid row alcoholism: Self-defeating arrangements in an innovative treatment program, *Soc. Probl.* 22(5):675.
- Gibbins, R. J., 1962, *Parental attitudes towards drinking and the prevalence and character of filial alcoholism*, Ph.D. Thesis, University of Toronto.
- Giffen, P. J., and Lambert, S., 1978, Decriminalization of public drunkenness, in: *Research Advances in Alcohol and Drug Problems Vol. 4* (Y. Israel, F. B. Glaser, H. Kalant, R. E. Popham, W. Schmidt, and R. G. Smart, eds.), Plenum Press, New York and London.
- Glatt, M. M., 1958, Group therapy in alcoholism, *Br. J. Addict.* 54(2):133.
- Glatt, M. M., 1961, Drinking habits of English middle-class alcoholics, *Acta Psychiatr. Scand.* 37(1):88.
- Gordon, G., 1966, *Role Theory and Illness: A Sociological Perspective*, College and University Press, New Haven, Connecticut.
- Gusfield, J. R., 1955, Organizational change: A study of the Women's Christian Temperance Union, Ph.D. dissertation, Sociology, University of Chicago.
- Gusfield, J. R., 1967, Moral passage: The symbolic process in public designations of deviance, *Soc. Probl.* 15(2):175.
- Gusfield, J. R., 1981, *The Culture of Public Problems: Drinking-Driving and the Symbolic Order*, University of Chicago Press, Chicago.
- Gusfield, J. R., 1983, Choosing sides: The messages of social problems theory, in: *Social Problems Theory* (J. Kitsuse, ed.), in press.
- Haberman, P. W., and Sheinberg, J., 1969, Public attitudes toward alcoholism as an illness, *Am. J. Public Health* 59(7):1209.
- Haggard, H. W., 1945, Editorial: The 'wets' and 'drys' join against science, *Q. J. Stud. Alcohol* 6(2):131.
- Haggard, H. W., and Jellinek, E. M., 1942, *Alcohol Explored*, Doubleday, Doran and Co., Garden City, New York.
- Hingson, R., Scotch, N., and Goldman, E., 1977, Impact of the 'Rand Report' on alcoholics, treatment personnel and Boston residents, *J. Stud. Alcohol* 38(11):2065.
- Hirsh, J., 1949, *The Problem Drinker*, Duell, Sloan and Pearce, New York.
- Jackson, J., 1957a, The definition and measurement of alcoholism: H-technique scales of preoccupation with alcohol and psychological involvement, *Q. J. Stud. Alcohol* 18(2):240.
- Jackson, J., 1957b, H-technique scales of preoccupation with alcohol and of psychological involvement in alcoholics: Time order of symptoms, *Q. J. Stud. Alcohol* 18(3):451.

- Jackson, J., 1958, Types of drinking patterns of male alcoholics, *Q. J. Stud. Alcohol* 19(2):269.
- Jellinek, E. M., 1942, An outline of basic policies for a research program on problems of alcohol, *Q. J. Stud. Alcohol* 3(1):103.
- Jellinek, E. M., 1945, Introduction to the curriculum, in: *Alcohol, Science and Society*, pp. 1—12, Quarterly Journal of Studies on Alcohol, New Haven.
- Jellinek, E. M., 1946, Phases in the drinking history of alcoholics: Analysis of a survey conducted by the official organ of Alcoholics Anonymous, *Q. J. Stud. Alcohol* 7(1):1.
- Jellinek, E. M., 1952, Phases of alcohol addiction, *Q. J. Stud. Alcohol* 13(4): 673.
- Jellinek, E. M., 1960, *The Disease Concept of Alcoholism*, Hillhouse Press, New Haven.
- Johnson, B. H., 1973, The alcoholism movement in America; a study in cultural innovation, Ph. D. dissertation, sociology, University of Illinois at Urbana-Champaign.
- Keller, M., 1962, The definition of alcoholism and the estimation of its prevalence, in: *Society, Culture and Drinking Patterns* (D. J. Pittman and C. Snyder, eds.), pp. 310—329, Wiley, New York and London.
- Keller, M., 1972, On the loss of control phenomenon in alcoholism, *Br. J. Addict.* 67(3):153.
- Keller, M., 1976, Problems with alcohol: An historical perspective, in: *Alcohol and Alcohol Problems: New Thinking and New Directions* (W. J. Fildstead, J. J. Rossi, and M. Keller, eds.), pp. 5—28, Ballinger, Cambridge, Massachusetts.
- Keller, M., 1981, Perspective on medicine and alcoholism, delivered at the National Council on Alcoholism—American Medical Society on Alcoholism Medical-Scientific Luncheon, April 13, New Orleans, Louisiana.
- Knopfer, G., 1967, The Epidemiology of Problem Drinking, *Am. J. Public Health* 57(6):973.
- Knopfer, G., 1972, Ex-problem drinkers, in: *Life History Research in Psychopathology* Vol II. (M. Roff, L. N. Robins, and M. Pollack, eds.), pp. 256—280, University of Minnesota Press, Minneapolis, Minnesota.
- Kurtz, E., 1979, *Not-God: A History of Alcoholics Anonymous*, Hazelden Educational Services, Center City, Minnesota.
- Kurtz, N. R., and Regier, M., 1975, The uniform alcoholism and intoxication treatment act: The compromising process of social policy formation, *J. Stud. Alcohol* 36(11):1421.
- Kurtz, R. A., and Giacomassi, D. J., 1975, Medical and Social Work Students' Perceptions of Deviant Conditions and Sick Role Incumbency, *Soc. Sci. Med.* 9:249.
- Lee, A. M., 1944, Techniques of social reform: An analysis of the new prohibition drive, *Am. Soc. Rev.* 9:65.
- Lemert, E., 1951, *Social Pathology: A Systematic Approach to the Theory of Sociopathic Behavior*, McGraw-Hill, New York.
- Lender, M. E., and Karnchanapee, K. R., 1977, 'Temperance Tales': Antiliquor Fiction and American Attitudes toward Alcoholics in the Late 19th and Early 20th Centuries, *J. Stud. Alcohol* 38(7):1347.
- Levine, H. G., 1978, The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in American History, *J. Stud. Alcohol* 39(1):143.
- Levine, H. G., 1981, Manifesto for a new alcohol social science, *Drinking Drug Practices Surv.* 1981(17):20.
- Levine, S., and Kozloff, M. A., 1978, The Sick Role: Assessment and Overview, *Ann. Rev. Soc.* 4:317.
- MacAndrew, C., 1969, On the notion that certain persons who are given to frequent drunkenness suffer from a disease called alcoholism, in: *Changing Perspectives in Mental Illness* (S. C. Plog and R. B. Edgerton, eds.), pp. 483—501, Holt, Rinehart & Winston, New York.
- McKern, B., 1981, Sociological Clutter, *Connexions* (Chatswood, NSW, Australia) 2(8):2.
- McPeck, F. W., 1945, The role of religious bodies in the treatment of inebriety in the United States, in: *Alcohol, Science and Society*, pp 403—418. Journal of Studies on Alcohol, New Haven.
- Mäkelä, K., 1980, What Can Medicine Properly Take On?, in: *Alcoholism Treatment in Transition* (G. Edwards and M. Grant, eds.), Croom Helm, London.

- Mäkelä, K., Room, R., Single, E., Sulkunen, P., Walsh, B., with 13 others, 1981, *Alcohol, Society and the State. I: A Comparative Study of Alcohol Control*. Addiction Research Foundation, Toronto.
- Mann, M., 1944, Formation of a National Committee for Education on Alcoholism, *Q. J. Stud. Alcohol* 5(2):354.
- Mann, M., 1958, *New Primer on Alcoholism*, Holt, Rinehart & Winston, New York.
- Mauss, A., 1982, Salvation and survival on Skid Row: A comment on Rooney, *Soc. Forces* 60(3):898.
- Maxwell, M. A., 1962, Alcoholics Anonymous: An interpretation, in: *Society, Culture, and Drinking Patterns* (D. J. Pittman and C. R. Snyder, (eds.)), pp. 577-585, Wiley, New York.
- Moore, M., and Gerstein, D., eds., 1981, *Alcohol and Public Policy: Beyond the Shadow of Prohibition, Report of a Panel on Alternative Policies Affecting the Prevention of Alcohol Abuse and Alcoholism*, National Academy Press, Washington, D.C.
- Morgan, P., 1980, The state as mediator: Alcohol problem management in the postwar period, *Contemp. Drug Probl.* 9(1):107.
- Morgan, P., 1981, Systems in crisis: Social welfare and the state's management of alcohol problems, *Contemp. Drug Probl.* 10(2):243.
- Mulford, H., 1968, 'Alcoholics', 'alcoholism', and 'problem drinkers': Social objects-in-the-making: The 'experts' contribution, presented at the 28th International Congress on Alcohol and Alcoholism, September, revised October; Washington, D.C.
- Mulford, H., 1977, Stages in the alcoholic process: Toward a cumulative, nonsequential index, *J. Stud. Alcohol* 38(3):563.
- Mulford, H., and Miller, D., 1959, Drinking in Iowa: I. Sociocultural distribution of drinkers, *Q. J. Stud. Alcohol* 20(4):704.
- Mulford, H., and Miller, D., 1960a, Drinking in Iowa: IV. Preoccupation with alcohol and definitions of alcohol, heavy drinking and trouble due to drinking, *Q. J. Stud. Alcohol* 21(2):279.
- Mulford, H., and Miller, D., 1960b, Drinking in Iowa: V. Drinking and alcoholic drinking, *Q. J. Stud. Alcohol* 21(3):483.
- Mulford, H., and Miller, D., 1964, Measuring public acceptance of the alcoholic as a sick person, *Q. J. Stud. Alcohol* 25(2):314.
- Mulford, H., and Wilson, R., 1966, *Identifying Problem Drinkers in a Household Health Survey*; National Center for Health Statistics, PHS Publication 1000, Series 2, No. 16, USGPO, Washington, D.C.
- Müller, R., and Tecklenburg, U., 1978, La médicalisation de l'alcoolisme. *Drogalcool (Lausanne)*, 1978(February):15.
- Noble, E. P., ed., 1979, *Third Special Report to the U.S. Congress on Alcohol and Health: Technical Support Document*, DHEW Publication No. (ADM) 79-832, U.S.G.P.O., Washington, D.C.
- Orcutt, J. D., 1976, Ideological variations in the structure of deviant types: A multivariate comparison of alcoholism and heroin addiction, *Soc. Forces* 55(2):419.
- Park, P., 1962, Drinking experiences of 806 Finnish alcoholics in comparison with similar experiences of 192 English alcoholics, *Acta Psychiatr. Scand.* 32:227.
- Park, P., 1967, A rough ordering of symptoms of alcoholism, presented at the Annual Meeting of the Society for the Study of Social Problems, August, San Francisco.
- Pattison, E., Sobell, M. B., and Sobell, L. C., 1977, *Emerging Concepts of Alcohol Dependence*. Springer, New York.
- Pittman, D. J., 1976a [Commentary on Mäkelä's "Criminalization and punishment in the prevention of alcohol problems"], in: *The Prevention of Alcohol Problems: Report of a Conference* (R. Room and S. Sheffield, eds.), pp.208-212, Office of Alcoholism, California Health and Welfare Agency, Sacramento, California.
- Pittman, D. J., 1976b, Phone statement contained in press package released at the NCA Press Conference, July 1, Washington, D.C.

- Pittman, D. J., 1980, *Primary Prevention of Alcohol Abuse and Alcoholism: An Evaluation of the Control of Consumption Policy*. Washington University, Social Science Institute, St. Louis.
- Pittman, D. J., and Snyder, C. R., eds., 1962, *Society, Culture, and Drinking Patterns*, Wiley, New York.
- Pittman D. J., and Tate, R. L., 1969, A comparison of two treatment programs for alcoholics, *Q. J. Stud. Alcohol* 30(4A):888.
- Plaut, T. F. A., 1967, *Alcohol Problems: A Report to the Nation by the Cooperative Commission on the Study of Alcoholism*, Oxford University Press, New York.
- Polich, J. M., Armor, D. J., and Braiker, H. B., 1981, *The Course of Alcoholism: Four Years after Treatment*, Wiley, New York.
- Rappeport, M., Labaw, P., and Williams, J., 1975, *The Public Evaluates the NIAAA Public Education Campaign* Vol. II, Opinion Research Corporation, Princeton, New Jersey.
- Rather, L. J., 1959, Towards a philosophical study of the idea of disease, in: *The Historical Development of Physiological Thought* (C. M. Brooks and P. F. Crane, eds.), pp. 351-373, Hafner, New York.
- Riley, J. W., 1949, The social implications of problem drinking, *Soc. Forces* 27:301.
- Riley, J. W., and Marden, C. F., 1947, The social pattern of alcoholic drinking, *Q. J. Stud. Alcohol* 8(2):265.
- Robins, L. N., 1975, Alcoholism and labelling theory, in: *The Labelling of Deviance: Evaluating a Perspective* (W. R. Gove, ed.), pp. 21-33, Halsted Press, New York.
- Robins, L. N., Bates, W. M., and O'Neal, P., 1962, Adult drinking patterns of former problem children, in: *Society, Culture and Drinking Patterns* (D. J. Pittman and C. Snyder, eds.), pp. 395-412, Wiley, New York.
- Robinson, D., 1972, The alcoholist's addiction: Some implications of having lost control over the disease concept of alcoholism, *Q. J. Stud. Alcohol* 33(4A):1028.
- Robinson, D., 1979, *Talking Out of Alcoholism: The Self-Help Process of Alcoholics Anonymous*, University Park Press, Baltimore.
- Roizen, R., 1977a, Alcoholism Treatment's Goals and Outcome Measures: Conceptual, Pragmatic and Structural Sources of Controversy in the Outcome Debate, Report submitted to National Institute on Alcohol Abuse and Alcoholism, Social Research Group, Paper F61, Berkeley, California.
- Roizen, R., 1977b, Barriers to Alcoholism Treatment, Report submitted to NIAAA, Social Research Group, Paper F145, Berkeley, California.
- Roizen, R., 1978 [Comment on the Rand Report], in: *Alcoholism and Treatment* (D. J. Armor, J. M. Polich, and H. B. Stambul, eds.), pp. 265-275 (reprinted from 1977 comment in *J. Stud. Alcohol*), Wiley, New York.
- Roizen, R., and Weisner, C., 1979, Fragmentation in Alcoholism Treatment Services: An Exploratory Analysis. Social Research Group, Report C24, Berkeley, California.
- Roizen, R., Cahalan, D., and Shanks, P., 1978, 'Spontaneous remission' among untreated problem drinkers. in: *Longitudinal Research on Drug Use: Empirical Findings and Methodological Issues* (D. B. Kandel, ed.), pp. 197-221, Hemisphere, Washington, D.C.
- Roman, P. M., and Trice, H. M., 1968, The sick role, labelling theory, and the deviant drinker, *Int. J. Soc. Psychiat.* 14(4):245.
- Room, R., 1966, Notes on 'Identifying problem drinkers in a household health survey' by Harold Mulford and Ronald Wilson . . . , Drinking Practices Study, November (now working paper F10 of the Alcohol Research Group), Berkeley, California.
- Room, R., 1970, Assumptions and implications of disease concepts of alcoholism, delivered at the 29th International Congress on Alcoholism and Drug Dependence, Feb. 2-14, Sydney, Australia.
- Room, R., 1972a [Comment on Robinson's "The alcoholist's addiction"], *Q. J. Stud. Alcohol* 33(4A):1049.



- Room, R., 1972b, Notes on alcohol policies in the light of general-population studies, *Drinking Drug Practices Surv.* 6:10.
- Room, R., 1973, Governing images and the prevention of alcohol problems, *Prev. Med.* 3(1):11.
- Room, R., 1976a, Ambivalence as a sociological explanation: The case of cultural explanations of alcohol problems, *Am. Soc. Rev.* 41(6):1047.
- Room, R., 1976b [Drunkenness and the law: Comment on 'The Uniform Alcoholism and Intoxication Treatment Act'], *J. Stud. Alcohol* 37(1):113.
- Room, R., 1978, Governing images of alcohol and drug problems: The structure, sources and sequels of conceptualizations of intractable problems, Ph.D. dissertation, Sociology, University of California, Berkeley.
- Room, R., 1979, Priorities in Alcohol Social Science Research, *J. Stud. Alcohol. Suppl.* No. 8, pp. 248-268, New Haven.
- Room, R., 1980a, New curves in the course: A comment on Polich, Armor and Braiker, 'The course of alcoholism', *Br. J. Addict.* 75(4):351.
- Room, R., 1980b, Treatment-seeking populations and larger realities, in: *Alcoholism Treatment in Transition*, (G. Edwards and M. Grant, eds.), pp. 205-224, Croom Helm; London.
- Room, R., 1982, Alcohol, science and social control, in: *Alcohol, Science and Society Revisited* (E. L. Gomberg, H. R. White, and J. A. Carpenter, eds.), pp. 371-384, University of Michigan Press, Ann Arbor, Michigan.
- Room, R., and Sheffield, S., eds., 1976, *The Prevention of Alcohol Problems: Report of a Conference*, Office of Alcoholism, California Health and Welfare Agency, Sacramento, California.
- Rooney, J. F., 1980, Organizational success through program failure: Skid row rescue missions, *Soc. Forces* 58(3):904.
- Rotter, H., 1962, Über der Bedeutung der Phasen für die Dynamik des Alkoholismus (On the meaning of phases for the dynamic of alcoholism), *Wiener Medizinische Wochenschrift* 112(38):704.
- Rubin, J. L., 1979, Shifting perspectives on the Alcoholism Treatment Movement 1940-1955, *J. Stud. Alcohol* 40(5):376.
- Rubington, E., and Weinberg, M. S., eds., 1968, *Deviance: The Interactionist Perspective*, Macmillan, New York and London.
- Rule, B. G., and Phillips, D., 1973, Responsibility versus illness models of alcoholism: Effects on attitudes toward an alcoholic, *Q. J. Stud. Alc.* 34(2A):489.
- Sagarin, E., 1969, *Odd Man In: Societies of Deviants in America*, Quadrangle, Chicago.
- Sargent, M. J., 1968, The conception of alcoholism as a mental illness: Comment on the article by R. A. Moore, and a sociological alternative, *Q. J. Stud. Alcohol* 29(4A):974.
- Schmidt, W., and Popham, R. E., 1978, The Single Distribution Theory of alcohol consumption; a rejoinder to the critique of Parker and Harmon, *J. Stud. Alcohol* 39(3):400.
- Seeley, J., 1959, The W.H.O. definition of alcoholism, *Q. J. Stud. Alcohol*, 20(2):352.
- Seeley, J., 1962, Alcoholism is a disease: Implications for social policy, in: *Society, Culture and Drinking Patterns* (D. J. Pittman and C. R. Snyder, eds.), pp. 586-593, Wiley, New York and London.
- Snyder, C. R., and Schweitzer, D. R., eds., 1964, *Proceedings; Research Sociologist's Conference on Alcohol Problems*, April 30-May 1, Carbondale, Illinois.
- Spradley, J. P., 1970, *You Owe Yourself a Drunk: An Ethnography of Urban Nomads*, Little, Brown, Boston.
- Squires, F. D. L., 1945, Correspondence (response to Haggard), *Q. J. Stud. Alcohol*, 6(4):408.
- Straus, R., 1960, Research in the problems of alcohol: A twenty-year perspective, in: *Multidisciplinary Programming in Alcoholism Investigation: Proceedings of a Conference* pp. 28-31, Division of Alcoholic Rehabilitation, California State Department of Public Health, Berkeley, California.
- Straus, R., 1976, Problem drinking in the perspective of social change, 1940-1973, in: *Alcohol and Alcohol Problems: New Thinking and New Directions* (W. J. Filstead, J. J. Rossi, and M. Keller, eds.), pp. 29-56, Ballinger, Cambridge, Massachusetts.

- Thune, C. E., 1977, Alcoholism and the archetypal past: A phenomenological perspective on Alcoholics Anonymous, *J. Stud. Alcohol* 38(1):75.
- Tournier, R. E., 1979, Alcoholics Anonymous as treatment and as ideology, *J. Stud. Alcohol* 40(3):230.
- Trice, H. M., and Roman, P. M., 1970, Delabeling, relabeling, and Alcoholics Anonymous *Soc. Probl.* 17(4):538.
- Trice, H. M., and Wahl, J. R., 1958, A rank order analysis of the symptoms of alcoholism, *Q. J. Stud. Alcohol* 19(4):636.
- U.S. Supreme Court, 1968, Leroy Powell, Appellant, v. State of Texas, *United States Supreme Court Reports, Lawyers' Edition, Second Series, October Term 1967*, pp. 1254-1288.
- Varela, A., and Marconi, J., 1952, Adicción alcohólica: Estudio de la evolución de la enfermedad, *Revista de Psiquiatría* 17(1,2):19.
- Ward, D. A., ed., 1982, The use of coercion in the prevention and treatment of drug abuse (special issue), *J. Drug Issues* 12(1):1.
- Warner, H. S., McPeck, F. W., and Jellinek, E. M., 1945, Philosophy of the Temperance Movement: A panel discussion, in: *Alcohol, Science, and Society*, pp. 267-285, Journal of Studies on Alcohol, New Haven.
- Watts, T. D., 1981, The uneasy triumph of a concept: The "disease" concept of alcoholism, *J. Drug Issues* 11(4):451.
- Weisner, C., 1983, Treatment as social control: The political economy of alcohol problem management, *J. Drug Issues* 13(1):117-133.
- Wexberg, L. E., 1951, Alcoholism as a sickness, *Q. J. Stud. Alcohol* 12:217.
- Wiener, C., 1981, *The Politics of Alcoholism: Building an Arena around a Social Problem*. Transaction Books, New Brunswick, New Jersey.
- Wiseman, J., 1970, *Stations of the Lost: The Treatment of Skid Row Alcoholics*, Prentice Hall, Englewood Cliffs, New Jersey.
- World Health Organization, 1952 *Expert Committee on Mental Health; Alcoholism Subcommittee: Second Report*, World Health Organization Technical Report Series 48, Geneva.
- World Health Organization Expert Committee on Problems Related to Alcohol Consumption, 1980, *Problems Related to Alcohol Consumption*, World Health Organization Technical Report Series 650, Geneva.