Governing Images of Alcohol and Drug Problems:
The Structure, Sources, and Sequels
# of Conceptualizations of Intractable Problems

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ABSTRACT

This work considers the social definition and handling of intractable problems, using as an example the case of alcohol and drug problems. Intractable problems are assigned to one or another social rubric — the problem is seen as a criminal problem, a medical problem, a disability problem, and so on. Assignment to a particular social rubric implies that the problem is handled by particular social institutions and occupations, which have a well-defined perspective on how problems in their jurisdiction are to be conceptualized.

Within each social rubric are a number of potential specific models for conceptualizing a given problem, which affect and are affected by such "external" matters as the moral standing of the problem and interrelations with other rubrics and their custodians, and by such "internal" matters as persuading the client of a proper definition of the situation, and serving as an "action model" for the custodian concerning the appropriate course of action. As an illustration of the last-named factor, the meaning of classifying phenomena as a disease is explored, in terms of both of the assumptions involved and of the function of such a classification as an action model for the doctor.

The social handling of intractable problems is argued to be the subject of a complex and continual process of implied negotiation in a society, in which major elements are the "governing images" of the problems propounded by moral and other ideological entrepreneurs. A governing image is a summary characterization which specifies a social rubric and usually also a specific model for the problems. Three such governing images of alcohol and drug problems are described and analyzed in terms of their structure of argument and implications: the classic disease concept of alcoholism promoted by the alcoholism movement of recent decades; characterizations of alcohol and drug problems in terms of epidemic and contagion; and explanations of alcoholism in terms of cultural ambivalence. The historical context in which these governing images arose is explored in terms of both ideological and material factors. The recent history of the social handling of the intractable problem of chronic public drunkenness is explored as a case study in the consequences of the adoption of governing images. Successful images, it is argued, assume a historical role partially independent of their progenitors' intents. Finally, recent developments in governing images of alcohol problems are discussed in terms of the distention and attenuation of the alcoholism movement's disease concept, and the emergence of potential "post-addiction models."

John A. Clausen

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CHAPTER 1: Introduction

This dissertation is concerned with the social definition and handling of problematic events and conditions — particularly of problems which are seen as intractable, not easily solved or avoided, and specifically of intractable problems which are viewed as being alcohol or drug problems. We are interested in the nature, the formative context, and the consequences of particular ways of conceptualizing alcohol and drug problems. In Chapter Two, we start from a consideration of modes of explanation of intractable problems, of the powers attributed to alcohol and drugs in the explanation of intractable problems, and of the kinds of problems commonly given an alcohol or drug explanation. For most of the remainder of the work, our attention is focussed on the social definitions and processes which follow when a problem has been given an alcohol or drug explanation.

There are a limited number of social institutions in a given society which potentially have custody over intractable problems. Prominent on this list are such institutions as the criminal law, medicine, the church, and social work and relief agencies. An important characteristic of a social definition of an intractable problem is what we term here the social rubric to which the problem is assigned: which social institution has primary custody over the problem? More than one such institution may be involved in the problem, but usually one institution will have primacy: the problem is primarily a criminal problem, a medical problem, a moral problem, a disability problem, and so on.

The primary social rubric for an intractable problem in a particular society may change from one period to another, in a process described by Gusfield (1967) as "moral passage." Such changes are often promoted by interested social groups. Sociological discussion has usually focussed on the role of "moral entrepreneurs" in such changes (Becker, 1963), but recent analyses of drug politics have reemphasized the role of economic interests (Watts, 1976; Best, 1977) in many "moral passages," and the frequent intermingling of moral and professional interests (Morgan, 1978).

In the twentieth century for alcohol and drugs, as for many other intractable problems, the medical and criminal rubrics have been leading contenders as primary social rubrics. Alcohol and drug problems have moved in both directions across this boundary: in the 1920's, opiate dependence was successfully removed from medical to criminal custody (Duster, 1970; Musto, 1973); on the other hand, by the early 1970's, the alcoholism movement had secured the assent of no less a luminary than Attorney General Mitchell to the proposition that for alcoholism the goal was "to cure and not to punish" (Mitchell, 1971).

As a matter of definition clearly recognized by ideological entrepreneurs, the choice among social rubrics for an intractable problem holds fateful consequences in terms of institutions and professions which have custody and in terms of the public repute of the problems and its carriers. The choice of social rubric also holds implications concerning the nature of the problem. These are less commonly recognized, since such definitions of the problem are often a matter of inarticulate and unexamined assumptions. In a sense, the answer to the question, "What is a crime?", is to hand the questioner a copy of the criminal code. But the criminal code reveals little of the deeply held beliefs of those who staff the criminal justice system — and of the larger society — about what constitutes a crime, regardless of what the laws may say or of which particular statute may be at issue. Similarly, a diagnostic manual will reveal little of doctor's beliefs about what constitutes a disease — about the commonalities which underlie this catalog of specific conditions.

This question of the underlying common denominators of the invocation of a particular social rubric is tackled through a case study of the meaning of calling a set of phenomena a disease. While sociologists have given considerable attention to role expectations surrounding illness and to the implications of of applying the "medical model," there has been little attention to the effect of a disease identification on how a problem is conceptualized. In Chapter Two this issue is approached from two perspectives: in terms of the context of action in which disease concepts are used, that is, in terms of clinical practice and its methodology of differential diagnosis; and in terms of a set of minimum underlying assumptions which we propose are invoked when any phenomena are regarded as a disease. While these assumptions are stated in general terms, much of our commentary on them concerns alcohol and drug problems as diseases as a specific set of cases. Often, indeed, the underlying assumptions become most easily visible in territories, like alcohol and drugs, where their applicability is to some degree questionable.

In Chapter Three, a distinction is drawn between the "social rubric," the assignment of custody over a problem, and the "specific model," which is the "conceptual package" (Scheff, 1966) with which the practitioner with custody over the problem organizes actions in response to the problem. Previous discussions of "models" of alcoholism or drug addiction have mixed together the levels of choice of rubric and of specific models within rubrics (e.g., Siegler and Osmond, 1968; Siegler, Osmond and Newell, 1968), although often with a recognition that there were different "medical models" and "moral models."

The general sociological literature on "the medical model" has given little attention to the very different models of action applied in different circumstances. It is not only that the therapeutic regimen differs for lung cancer, syphilis, influenza, a broken leg, and schizophrenia: there are variations also on such dimensions as the moral status of the patient and expectations concerning "sick role" performances. In propounding an action plan for an ill-organized clinical territory such as alcohol or drug problems, there is a strong tendency for clinicians to resort to plausible analogies; we cite several such analogic arguments concerning the nature of alcoholism. For alcohol and drug problems, there are, in fact, a number of plausible action models potentially available.

There are thus often several possible rubrics and a number of possible action models for handling intractable problems in a given society. Since by definition any particular solution to an intractable problem can be seen as not "working," arrangements for the social handling of the problem have a built-in element of instability, and offer a fertile field for ideological entrepreneurship. In Chapter Four it is argued that the social handling of an intractable problem is the subject of a complex and continual process of implied negotiation, involving potential differences within as well as between the relevant social institutions. Major elements in this process are what are here termed the governing images propounded by moral and other ideological entrepreneurs as the appropriate conceptualization of the problem and its solution. A governing image is a summary characterization of the problem organized around a coherent perspective which determines the social rubric and usually also the action model for the problem, both for social policy and in terms of individual cases. Governing images are thus instruments of ideological entrepreneurship which are forged from the available cultural material of problem conceptualizations in terms of social rubrics and specific models.

The latter part of Chapter Four presents and contrasts three such governing images which have had currency for alcohol and drug problems in recent decades. While all three operate under the social rubric of disease, they involve very different characterizations of the disease and very different action models. The remainder of the work is devoted to elaborating and critiquing the assumptions and structure of argument of these three governing images (Chapters 5-7); discussing the social and ideological context in which each governing image developed (Chapter 8); and presenting a case study in the interplay of a governing image and other factors in a historical change in societal responses to an intractable problem (Chapter 9).

Chapter Five examines the dominant governing image of alcohol problems in the last thirty years, the classic disease concept of the alcoholism movement. This concept, which was primarily formed from the lay experience of Alcoholics Anonymous members and turned into scholarly form by Jellinek (1946,1952), proposed that alcoholism was a disease defined by loss of control over drinking behavior and characterized by a sequence of symptoms which occurred in a fixed and cumulative order: the disease was unilinear and accretional in its course. The disease was seen as immanent: it was caused by a "predisposing factor X" which existed prior to onset. In the latter part of the Chapter, data collected by empirical studies in the tradition of Jellinek's original study are collated to suggest that the assumptions of the classic disease model are untenable without considerable modification as an empirical description of clinic populations under treatment for alcoholism.

The governing image of the epidemic disease as a characterization of alcohol and drug problems is discussed in Chapter Six. Since this image has been more explicitly proposed and acted upon in the recent past in the area of drug problems than in the area of alcohol problems, primary attention is given to the image in the drug literature, and to the assumptions and implications it carried with it. It is noted that empirical testing of the usefulness of the model is hampered by the imprecision of the model concerning the exact nature of the problem it covers. The image is directed more at specifying the social processing of the problems and at underlining the urgency of solution than at identifying the nature of the problems.

Chapter Seven considers a governing image of alcohol problems that draw on sociological analyses of cultural differences in alcohol problems. The governing image is of a cultural ambivalence about alcohol which is proposed as the root cause of alcohol problems in America. Showing the frequency with which ambivalence is used as an explanation is apparently independent discussions, we argue that, given certain assumptions about society and deviance and given a generally liberal political stance antagonistic to the temperance tradition, ambivalence as an image was a logical necessity. In a critique of this use of the ambivalence image, we argue that its apparent explanatory power derives from connotations applicable to the social situations of the original psychotherapeutic usage of the term but inapplicable to extended uses of the term as in its use to cover drinking norms. A normative explanation of drinking problems would do well to examine the content of norms as well as the possibility of their conflict.

In Chapters Five, Six and Seven, the primary emphasis is on the assumptions and implications of the three governing images and on their internal logical structure. In Chapter Eight we turn to the relation of the images to the material and ideological context in which they arose — the influences upon the adoption of each of the three governing images of historical circumstances and experiences. Developing the analysis of the previous chapter, it is argued that the invocation of the ambivalence governing image was a logical consequence of (a) a perception that alcohol problems in the U.S. are especially severe; (b) an assumption that drinking was natural, and abstinence unnatural, for mankind — an assumption perhaps reinforced by the institutional need of alcohol researchers to distance themselves from the temperance movement; and (c) an assumption that the genesis of drinking problems is to be found in individual defects rather than in institutional or cultural supports for heavy drinking. Evidence is cited of a retreat in sociological writing of the 1940's and 1950's from structural analyses of alcohol issues, and of a substantial though incomplete conformance of sociological thought to the alcoholism movement's conceptualization of alcohol problems.

For the epidemic image, the interrelation of historical context and invocation of the image is examined for several instances of its appearance. Assuming as it does a rapid increase in the rate of problems, the imagery of contagion can be found in contemporary reports on drinking in eighteenth century London, where the rapid increase in drinking problems among the urban poor understandably alarmed policymakers (Coffey, 1966). While the imagery of contagion can be found in nineteenth-century temperance writings, it is often mixed with other imagery of disease or evil, and is not a governing image in temperance thought. In the contemporary alcohol literature, contagion imagery has made a halting appearance in the writings of social scientists who, concerned about the rise in alcohol consumption in recent years and seeking to fill the "empty seat" in policy discussions left by the collapse of the temperance movement, have assumed the mantle of public health epidemiologists in arguing for a renewed structural emphasis in alcohol policy discussions.

In the recent opiate literature, epidemic imagery has played a major role as a vehicle for expressing in technical terminology the depth and urgency of public concerns about heroin-use. As a reflection of this context, the clinicians who have been most closely identified with writings in the research literature applying an epidemic governing image have been appointed to the leading positions on the public health side of the narcotics establishment.

Drawing on Levine's (1978) recent analysis, it is noted that the alcoholism movement's disease concept shares many characteristics with the nineteenth-century temperance movement's conceptions of inebriety, as well as with the small late-nineteenth-century inebriates'-home movement. Jellinek's (1960b) discussion of contextual and ideological factors in the failure of the latter movement are discussed, and some other possible factors mentioned. In discussing factors in the success of the modern alcoholism movement, emphasis is laid upon the central role of the Yale Center of Alcohol Studies in the late 1940's and early 1950's. Yet the adherence of the Yale Center to the movement presents a puzzle, in that both of the most widely known Center researchers — Bacon and Jellinek — took positions before and after their period of maximum involvement in the movement which differed from their position of adherence to the movement's governing image in the interim. Possible explanations of this puzzle include temperance movement charges of a sellout to the liquor industry (Gordon, (1946), and Keller's account of a "capitulation" to the Alcoholics

Anonymous governing image on pragmatic grounds — as "a way of dealing with alcoholism that worked" (Keller, 1972). Neither of these explanations is seen as fully persuasive. Instead, it is argued, the Yale Center researchers, out of a mixture of altruism and ambition, offered themselves as leading functionaries in a social movement fueled by the aspirations and newly released energies of thousands of recovered alcoholics.

In Chapter Nine, we turn to an examination of the interplay of a governing image and other ideological and material interests in the historical process. The Chapter is devoted to a case study of recent efforts to change the social handling of an intractable social problem, the problem of chronic public drunkenness, and identifies the ideological positions and roles in events of the major parties involved in the reform effort: the alcoholism movement, the law enforcement establishment, the judicial system — particularly the municipal court judges — and the civil liberties lawyers.

The governing image of alcoholism as a disease and the alcoholism movement's efforts to secure humane treatment for the alcoholic undoubtedly contributed to the general climate of opinion in which those involved in the "drunk court" system came to see its operations as inhumane, self-defeating, undignified, and wasteful of resources. And the alcoholism movement's disease concept played a specific role in the crucial legal arguments about the punishability of chronic public intoxication. But the solution which emerged from the reform effort — short-term drying out in detoxification centers — went against movement conceptions of alcoholism as a deep-rooted condition requiring lengthy treatment, and against the drift of the alcoholism treatment literature in the preceding years towards compulsory long-term treatment. The divergence was papered over only by expert assurances that after detoxification most Skid Row alcoholics would voluntarily enter treatment — assurances that were, in Lemert's view (1976), contrary to the available research and that have been falsified, as we show, by subsequent experience. In a further break with alcoholism movement preferences, the public drunkenness reform effort focussed unwanted attention on a disreputable part of the drinking population, and, contrary to movement ideology, identified the alcoholism concept with this disreputable population.

The public drunkenness reform movement, as a partially successful effort to transfer the handling of public drunkenness from the criminal to the health rubric, thus leaned heavily on the alcoholism movement's governing image. But the reform effort did not adopt the political agendas of the alcoholism movement that went along with the governing image. Once successfully disseminated, the image took on a life of its own as a common cultural property available for invocation in the pursuit of various divergent interests.

In the concluding chapter, recent developments in governing images of alcohol problems are discussed. The classic alcoholism movement disease concept has on the one hand become attenuated and on the other hand been stretched to cover an ever wider roster of alcohol problems. While there has been controversy over the movement's disease concept with behavioral psychologists and others, it is the new array of pragmatic system and program managers at all governmental levels, whose presence is a result of the movement's successes, that ironically pose the most serious threat to the movement's governing image. The era of the "post-addiction model" may be marked by a swing to themes more reminiscent of temperance thought, or by a shift to a "disaggregationist" line that abandons governing images in favor of pragmatically differentiated approaches to the various alcohol-related problems, each on their own terms.

CHAPTER 2: Drinking and Drugs in the Explanation of Intractable Problems

In every society and time there are intractable problems. A man neglects to support his family, a job does not get done on time, a crop fails, a store is robbed, a woman is injured in the street, a sacred place is profaned — all these are in one or another society seen as intractable problems — events or conditions which are on the one hand deviant or problematic, and which on the other hand regularly recur in spite of the best efforts of the society.

It is a sociological commonplace that what constitutes a problem is a matter of social definition: what is defined as meat in one time and place is defined as poison in another. Even in a given society, the social definition of how problematic a behavior or condition is can change with considerable rapidity. This is obvious in times of revolution, but also true at other times: for instance, the social definition of how problematic marijuana smoking is has greatly changed in the U.S. in the last fifteen years. Yet there are continuities in the definition of behaviors or conditions as problematic, reflecting continuities in the power of particular moral or material interests with a stake in defining the behavior or condition as a problem. Unauthorized appropriation or destruction of property is usually seen as a problem by property owners in societies with private property rights. Though notions of decorum in sacred places may change, the keepers of sacred places have a permanent interest in defining breach of decorum as a problem. Small businessmen everywhere are concerned about factors which may impinge on their trade. If in a particular society a drunken person is potentially regarded by customers as something to be avoided, the shopkeeper will not welcome the drunk sitting down on his doorstep. In such a society, so long as there are shopkeepers, public drunkenness in commercial districts will be a problematic behavior — even though there may well be other interests in the society tending to push public drunkenness and the shopkeeper into the same territory.

Continuity in what is defined as problematic is not entirely a matter of continuities in the social interests upholding the definition. Involved in many problems are objective conditions or occurrences — death, or pain, or destruction of property — which exist independently of how a society chooses to define or explain them. While it is possible to think of circumstances where the occurrence of such events or conditions is socially sanctioned — as for capital punishment, flagellant cults, potlatches — in most societies under most circumstances their occurrence is problematic. While sociologists have tended to stress the social definitional aspect of deviance, the objectifiable aspect is also recognized, as in the concept of "victimless crime," which proposes that there are at least two classes of crime, differentiated not by their social definition as crimes but by whether or not there is some objective harm to a "victim" resulting from the criminal event.

The intractability of problems thus is a product of the continuity of moral and material interests in defining events and conditions as problems, and also in many circumstances a product of the objective nature of the event or condition. On the other hand, intractability is equally a product of the persistence of events and conditions regarded as problematic. Problems can be socioculturally defined as due to a human agency, or to chance or nonhuman forces. Where no human act is seen as involved in the occurrence of a problem, the persistence of problems becomes a theological or natural-science question. But the persistence of problems involving a human agency despite inherent or social sanctions against the precipitating behavior is a potential issue for social science. For many social thinkers, this side of the intractability of problems does not excite curiosity: the doctrine of original sin, Hobbes, and Bentham would agree on the sufficiency of inherent tendencies of the individual human being as accounting for the persistence of problematic behavior. But a substantial sociological literature has been directed at pointing out the potentially social nature also of this side of the question of the persistence of problems. For instance, through such concepts as "secondary deviance," attention has been directed to counter-cultural sources of norms supporting or requiring behavior regarded as problematic in the larger social entity, and through such concepts as "role conflict" incongruities between a society's applicable norms for a given circumstance have been identified as a source of the persistence of deviance.

There are thus both objective and social elements in the persistence of the definition of events or conditions as problems, and extrahuman individual and social elements in the persistence of the occurrence of events or conditions despite their definition as problems. Every society to a greater or lesser extent faces its own set of intractable problems, defined by the interaction of physical circumstances, behavior patterns, and social definitions, and for whatever reasons recurrent and resistant to elimination.

In all ages, people have sought to understand and explain the occurrence of intractable problems. This impulse arises from several motivations: to provide solace or satisfaction to those affected; to determine responsibility and liability for the problem; to undo so far as possible the effects; to give clues on the prevention of its recurrence. The range of modes of explanation available is similarly diverse: for instance, the problem can be viewed in terms of supernatural intervention, natural causes, or human agency; as inevitable, as preventable, or as justified by offsetting gains; as a problem in its own right, or as a symptom or part of more fundamental problems. The occurrence of an isolated problem can easily be explained as the result of a mistake or a nonhuman agency. People will say, "it was a terrible mistake" or "accident" or "disaster," acknowledging on the one hand the seriousness of the problem and on the other that it was unavoidable because unexpectable. But, particularly in a culture such as ours, tending to see problems as soluble rather than in fatalistic terms, explanations in terms of mistake or natural forces quickly wear thin for intractable problems. The more repetitive the occurrences of a problem, the more likely we are to tilt the explanation toward human culpability, in terms of acts of omission as well as commission. If someone drowns in a flood, instead of blaming the weather or fate or Jupiter Pluvius, we may see it as a state agency's fault for not inspecting the dam that broke, even after another dam broke somewhere else last year; or the fault of the meteorological and emergency services for not giving people sufficient warning in what they should have recognized as as emergency. The further the network of predictive or preventive information and countermeasures is spread, the more the explanation for the persistence of a problem is tilted toward human culpability. Thus our cultural commitment to control over rather than reaction to problems, children as we are of the Enlightenment and of the protestant, bourgeois, scientific and industrial revolutions, forces the explanation of the intractability of problems more and more into terms of defects in the individual human or in social arrangements. Accordingly, those seeking to reduce highway casualties have proposed that crashes should no longer be referred to as "accidents," since such a term tends to downplay the role of lack of forethought and preparedness in the occurrence of crashes (Perrine, 1975).

In everyday language, we have a variety of rhetorics for explaining a problem's occurrence in terms of the culpability of the individual person. It happened because he was "wicked" or "sick" or "tired" or "a born loser" or "a dope fiend" or "drunk" or "depressed." Different rhetorics of explanation will differentially appeal to various interested parties according to the problem involved and its circumstances. The social legitimacy of different rhetorics also varies by cultural situation and historical period: a preferred explanation in terms of "possession by the. devil" may give way to "affective schizophrenia," an explanation in terms of depravity to one in terms of deprivation (Gusfield, 1967).

In our era, a major rhetoric of explanation of problems as due to human failings is in terms of the effects of alcohol or of other drugs. Such explanations have two major forms: in terms of intoxication on a specific occasion leading to the problem; and in terms of a history of use over a period of time resulting in a physical or psychological state (addiction, depression, depravity, DT's, withdrawal, alcoholic psychosis, etc.) which in turn leads to the problem.

In some circumstances, explanations of problems as due to alcohol or drugs exonerate. For instance, a defendant who was unknowingly given alcohol or a drug and was unaware of its effects can plead that as a complete defense to a criminal charge (Epstein, 1977). In many circumstances, explanations of problems as due to alcohol or drugs mitigate the blame. Thus in common parlance "Boy, I was really loaded" or "I was so drunk I didn't know what I was doing" often are used as explanations that excuse. For all its unwillingness to allow defenses in terms of what is seen as the results of voluntary behavior, the criminal law has moved to reducing the seriousness of the offense in homicides by drunken defendants (Epstein, 1977). McCaghy (1968) found that many persons convicted of child molesting preferred to be thought of as drunks rather than as child molesters. In everyday thought, alcohol or drugs serve as explanations that distance the problematic behavior from the "real" person, so that the behavior is not seen as characterizing or conferring a master status on the person — "it was the alcohol talking."[1]

In other circumstances, explanations of problems as due to alcohol or drugs aggravate the blame. The clearest example is drunk driving. In many jurisdictions, over half of all drunk driving arrests are following an accident, and the arrest in those circumstances carries consequences in terms of liability as well as criminal responsibility. While drunkenness is not an explicit consideration in assessing liability in general tort law, it does increase liability in some particular areas of tort law, and is often used as contributory evidence in other areas (Dooley and Mosher, 1978). The mitigating power of an argument that a typewriter was stolen to help support a heroin habit is certainly dubious. At aggregate, societal levels, explanation of a problem in terms of heroin use has in fact had in recent years perhaps a unique power to summon extreme and repressive action from the polity.

Though circumstances alter the attractiveness to the relevant parties of alcohol and drug explanations of problems, there is a common thread of the substantial willingness of contemporary American rhetoric to ascribe great power to alcohol and to some other drugs as causes of problems. For alcohol, at least, the powers ascribed are quite varied and often contradictory: it makes you depressed, it stimulates you; it disinhibits you, it calms you down; it makes you sociable and voluble, it makes you quiet and morose.

The variety of powers ascribed to alcohol is more than matched by the astonishing panoply of problems which have at one time or another been given an alcohol explanation. At one time or another, for instance, the problems of roadside litter, of world hunger (through the diversion of foodstuffs to alcohol production), and of the supposed spontaneous combustion of drunkards (de Moulin, 1975), have been as least partially ascribed to alcohol. In terms of intractable problems in the sense we have discussed them, however, problems which have been seen as alcohol-related mostly fall within a few broad classes:

(1) Problems of illness or mortality due to drinking.

(2) Casualties — injuries, deaths, and property damage — due to drinking.

(3) Alcohol's role in violent and property crimes, family abuse, and suicide.

(4) Problems of demeanor while and after drinking, such as public drunkenness.

(5) Drinking-related problems of the default of major social roles, notably family roles and work roles.

(6) Mental or existential problems related to drinking, notably including the experience of loss of control over drinking behavior.

An enormous variety of incommensurate and partially overlapping intractable problems are thus often given an alcohol attribution — at least some part of the problem is seen as being "due to" drinking. The alcohol attribution is in itself a partial explanation of the problem, pointing the social gaze in particular directions for definitions of the situation and solutions. To focus on drunk driving as a cause of accidents is to point attention to behavioral patterns at the expense of such other elements of the situation as road hazards and car design; it was least convenient to the automobile industry, in the wake of Ralph Nader's and other attacks on unsafe auto designs, that public attention was particularly directed at drunken driving as a factor in road accidents in the late 1960's.

But although an alcohol attribution limits the possibilities, it does not in itself specify the way an intractable problem is to be socially defined and handled. An alcohol problem can be seen in any of a number of ways: as a sin, as a crime, as a disease, as a result of deprivation, as a failure of social planning, as a consequence of the social or economic system. Its handling will accordingly tend to be defined as a matter for priests, for lawyers, for doctors, for social workers, for social planners, for revolutionaries. However the problem is defined, there will be options in its means of handling: some crimes are felonies, some misdemeanors, some bailable, some probationable, some trivial; a disease can be "like the plague" or "like bronchitis" or "like cancer."

In the next chapter we will consider in greater detail these contingencies of the social definition and handling of intractable problems.

CHAPTER 3: The Categorization of Intractable Problems: Rubrics and Specific Models

The idea that intractable alcohol or drug problems are subject to competing social definitions is scarcely novel. As Norman Kerr put it in the late nineteenth century, "in drunkenness of all degrees of every variety, the Church sees only the sin; the World the vice; the State the crime. On the other hand the medical profession uncovers a condition of disease" (quoted in Davies, 1974). We may describe these competing conceptualizations of the problems and who has custody of them as social rubrics. For different problems and different sets of historical circumstances the roster of lively alternative conceptualizations will vary, although the list of possible alternative rubrics is never very lengthy.

But while the existence of competing social rubrics for the handling of intractable problems is widely recognized, it has not been handled in a systematic fashion. In the alcohol and drugs literature, discussions have usually been in terms of alternative models of addiction or use (see Siegler and Osmond, 1968; Siegler, Osmond and Newell, 1968; Evans, 1969; Cahn, 1970; Bruun, 1971; National Commission on Marihuana . . ., 1972; Cahalan and Room, 1974). In this and similar literature, the term "model" has been used in a variety of meanings. Sometimes "model" refers to what we have here termed a "social rubric," so that there are numerous discussions of the "medical model" with the denotation simply that the problems are seen as the responsibility of doctors and medical institutions. In other work, such as that of Siegler and Osmond (1968), Siegler, Osmond and Newell (1968), and Bruun (1971), there is recognition of the existence of alternative models within as well as between social rubrics; for instance, Siegler, Osmond and Newell (1968) distinguish three different models which define alcoholism as a disease.

The existence of separate and potentially competing models within each social rubric has not commonly been discussed. Thus sociological discussions concerning the applicability of labelling theory to mental illness, alcoholism, etc. have commonly talked in terms of an undifferentiated "medical model." But calling alcoholism or drug addiction a disease sooner or later invites the question of what kind of disease is involved. And here, as Christie and Bruun remark, "the conceptual frame seems to be all chaos" (1969, p. 65). In this regard, Robinson has noted "the importance of teasing out and attempting to delineate the models of different peoples' disease concepts of alcoholism" (1972, p. 1038).

In conceptualizing ill-defined conditions, one common solution is a resort to analogy. For alcoholism, the analogies invoked to explain what kind of disease it is have been many and diverse.

> True alcoholism is an allergic state, the result of gradually increasing sensitization by alcohol over a more or less extended period of time. . . . The development and course of these cases are quite comparable with the history of hay fever patients, in many respects. One may enjoy absolute freedom for many years from any susceptibility to pollen. Year after year, however, there gradually develops a sensitivity to it in certain individuals, culminating at last in paroxysms of hay fever that persist indefinitely when the condition is fully established (Silkworth, 1937).

> The vicious cycle (of drinking bouts and guilt) . . . is part of what I (have) described as the "malignant habit" of addiction. The uninhibited growth of a malignant tumor is paralleled by the ever accelerating momentum of addiction and the increasing toleration of the addict. Just like cancer the addictive habit exists and grows parasitical at the expense of the total organism or personality without giving anything in return. As cancer consists of embryonic immature tissue, the addictive habit involves regression to an infantile (oral) stage of libido development (Wexberg, 1951).

> Those who will . . . continue to talk of alcoholism as a disease . . . should point out its similarity to venereal disease. . . . Both are transmitted, in the main, by intercourse (sexual in the one case and social in the other), and licensing of bars is a response of society which may be viewed alongside licensing of brothels (Davies, 1974).
>
> Perhaps the analogy of the peptic ulcer would better enable (skeptics) to understand that a patient may totally heal certain manifestations of his disease but remains prone to its recurrence to such an extent that the medical dictum remains, "Once a peptic ulcer, always a peptic ulcer." In that sense, the patient is not "cured." There are numerous diseases that present such a pattern (e.g., ulcerative colitis, bronchial asthma, rheumatoid arthritis), and alcoholism should be numbered among them (Gitlow, 1973).

Even more common than the argument by analogy are definitions in terms of a general class of diseases or conditions in which alcoholism belongs and/or of a presumed etiology. A partial quotation from a listing of psychodynamic theories is suggestive of the profusion of such definitions:

> Brill considered alcoholism as a flight from homosexual impulses, incestuous thoughts and masturbatory guilt. Jones suggested that alcoholism is a symptom of epilepsy and psychosis, while Glover related addiction to sadistic drives and oedipal conflicts. Sachs viewed alcoholism as the compromise between hysterical and obsessive compulsive neuroses, while Rado suggested that alcohol addiction is mainly a problem of despression. . . . Menninger emphasized the self-destructive drives of the alcoholic and termed alcoholism "chronic suicide". . . . The evidence from the present study suggests that by psychoanalytic classification addictive alcoholism is an oral perversion (Chafetz, 1959).

In his study of The Disease Concept of Alcoholism, Jellinek (1960b) quotes from the literature of the period 1935 - 1957 thirty-three "explicit and implicit formulations of 'alcoholism' as a psychological illness," thirteen "formulations of 'alcoholism' as a symptom of psychological illness," forty "formulations of 'alcoholism' in physiopathological and physical terms," and twenty-two "formulations of 'alcoholism' . . . implying a pharmacological process of addiction."

While the wild profusion of forumlations reflects the operation of a variety of influences, one factor certainly is the diversity of purposes for which such formulations are used. We may distinguish several broad classes of functions affecting the choice of specific models within a social rubric.

(a) The choice of specific models affects the moral standing of those covered by the model. The effect may be as strong as the effect of choice of social rubric. Thus a venereal disease is likely to be regarded differently from a genetic defect, and arthritis differently from a compulsive behavior. The choice may also be related to the social handling of those covered: whether they are treated in a hospital, a mental hospital, a veteran's hospital, a military hospital; whether they are treated by a doctor, a nurse, a physiotherapist, a nutritionist. We shall return below to a consideration of the effect of choice of rubric and of specific model on the standing and handling of those affected.

(b) The choice of specific models is affected by and potentially affects interrelations between professions operating under different social rubrics. For intractable behavioral problems such as alcohol and drug problems, there tends not to be a single unequivocal and final choice of social rubric, and representatives of the various relevant rubrics find themselves in a continuing implied negotiation not only about the custody of the problem area generally but also about the disposition of particular cases. The particular specific model adopted by a profession is often deeply influenced by this environment of competition or enforced cooperation between professions from different social rubrics. Christie (1965) has noted that "at the borderline between [medical and legal] institutions, a demand arises again and again for compromises, for personnel from the one institution to take over techniques of the other — for lawyers to treat and doctors to judge — or for the creation of new solutions which combine techniques from two or more institutions." Christie regards such solutions as "deviations from more traditional approaches," and it may indeed be true that attempts to meld the approaches of different rubrics into a single frame are especially a modern phenomenon. But combined or sequential action by representatives of different rubrics is by no means limited to modern times. The medieval church's practice of handing those ecclesiastically adjudged of heresy over to the "secular arm" for execution of the sentence is one example of such combined action —as is the earlier precedent of the enforcement of local religious determinations by Roman secular authority in the crucifixion of Jesus.

The specific model used for a particular condition or event is greatly affected by interrelations with other rubrics inherent in the circumstances in which the professional is pursuing his calling. A doctor in the hospital operating theater will feel impelled to pursue heroic measures to maintain life, but a doctor's duty at a legal execution is not to attempt to revive or maintain life, but rather to certify to the fact of death. In medieval times, the agents of state power were constrained to limit the exercise of their functions in situations falling under an ecclesiastical rubric, and these practices survived until the eighteenth century in England in such legal concepts as sanctuary on consecrated ground and the plea of "benefit of clergy" (Howson, 1970).

As implied by these examples, normally one rubric will have hegemony in a situation where more than one rubric is involved. While the institutions associated with each rubric will usually have territories of action within which they are hegemonous, there is a tendency towards a hierarchy among rubrics in mixed circumstances, with the hierarchy varying from one social order to another. In medieval Europe, the ecclesiastical rubric claimed and could often enforce hegemony; in the era of the modern nation-state, it is the rubric of the criminal law and its enforcement which is usually dominant.

Thus the clinical rubric finds itself in a variety of circumstances operating in an environment of compulsion enforced by the legal authorities. The hegemony of legal compulsion can be seen clearly in Christie's description of the mixed welfare/legal institution he studied, the Norwegian temperance boards. Thus the standard formal "warnings" sent out by the boards include an unmistakeable threat:

> The temperance board is a public institution and we demand that our letters and requests be taken seriously. The law . . . gives the boards the right to initiate action against people that abuse alcohol. . . . It can be decided that the abuser has to go to a home for drinkers or be placed at a work camp. The board still hopes, however, that you will understand the dangers in the road you have chosen and stop in time. We will therefore restrict ourselves this time also to a serious warning, and we appeal to your pride and feeling of honor (Christie, 1965).

Clinicians have long worked in situations dominated by compulsion, for instance as doctors in the military. These environments radically influence the clinician's specific model, particularly when dealing with behavioral problems. In a study of military psychiatric diagnosis, Daniels comments that

> the parameters of the psychiatric world . . . are set by the military regulations. They define what is to be considered mental illness and what is not and then they indicate how the psychiatrist is to apply these interpretations. Military regulations also define the consequences which may befall any person who is certified as fitting within one or the other of these categories (Daniels, 1969).

In other circumstances, the doctor's specific model has included the partial subordination of civil authority to the clinical rubric, as during epidemics. The Board of Health of New York City, during the cholera epidemic of 1832, exercised its "full and ample" powers at the instance of a "Special Medical Council that made the key decisions in fighting the epidemic" (Rosenberg, 1962, p. 84).

In recent years, there has been increasing recourse to "criminal diversion" models of therapeutic handling of alcohol and drug problems. In many such programs, the relative authority of the legal and therapeutic systems is clear: for instance, the state civil commitment program for narcotics addicts in California is a responsibility of the Department of Corrections, despite the therapeutic intentions for the program (McGlothlin, 1976). But often the lines of authority have been unclear, leaving unclear also the lines of action for the professionals involved: thus a report on a program for treatment of those caught drunk driving notes the "inherent confusion" of the alcohol therapists involved on "role identity, ethics, treatment methodology and public accountability." The confusion was shared by those from the legal system: one probation staffer was quoted as commenting that "the probation officer doesn't know if he is a cop or a social worker half of the time" (Aiken and Weiner, 1974).

(c) Besides the functions we have noted in the "external relations" of the problem area and social rubric, the choice of specific model also strongly relates to the day-to-day social handling of the problems by a social rubric's institutions and professions. A crucial part of the performance which is at the heart of professional action (Room, 1965) is to portray and to convince the client of the professional's definition of the problem and of the appropriate course of action. In medical practice, it is often this function of therapeutic persuasion which has fueled the persistent resort to analogies. Thus Siegler describes his presentation of alcoholism to the patient in terms of a "psycho-biological allergy":

> using an allergy in asthma as an example of physical allergy, [the patient] is told that due to his sensitivity the asthmatic keeps away from ragweed, and in the same way the alcoholic patient should keep away from alcohol (Seliger, 1938).

And another psychiatrist comments on Seliger's presentation that

> I was rather impressed with Dr. Seliger's example of psychopathological allergy. For a long time I have been trying to get something to explain their illness to them. I have tried to put it on the grounds of illness like typhoid. I have tried to explain it in a way of chemistry, of changes in the water content of the brain, changes in colloids (Brush, 1938).

Balint has remarked on the strength of the "apostolic mission" whereby the clinician takes it upon himself to convince patients of an action model for their disease:

> Every doctor has a vague, but almost unshakably firm, idea of how a patient ought to behave when ill. Although this idea is anything but explicit and concrete, it is immensely powerful, and influences . . . practically every detail of the doctor's work with his patients (Balint, 1957, quoted in Scheff, 1966).

(d) A crucially important function of the choice of specific model is as a guide to the practitioner's own perceptions and actions. Scheff (1966) discusses the process of "typification" whereby clinicians and other service workers deal with their clients in terms of "'normal cases' in which diagnosis, prognosis and treatment are somewhat standardized" into a series of "conceptual packages."[2] For the professional, thus, the choice of a specific model is not an abstract matter of the social standing of a category of persons or problems, but rather an action model which prescribes his or her professional actions and expectations.

As an action model for the professional, the choice of specific model is thus intimately related to the profession's operating paradigm. For the doctor, for instance, a specific action model exists in the environment of the Sydenhamian tradition of clinical thought in terms of specific remedies for discrete disease entities. For the lawyer, the action model is similarly preconditioned by a conceptual structure in terms of legislation, case law and court procedures defining specific kinds of legal actions and lines or "theories" of prosecution and defense.

While considerable sociological attention has been given to the external consequences of professional action — the implications for the client of the label the professional may apply in carrying out his or her professional paradigm — less attention has been given to the internal conceptual structure and logic of the professional paradigm. However, since it so profoundly affects the professional's actions in handling a set of intractable problems, the conceptual basis of a profession's actions is worth detailed exploration. For the present, we will take as a case study the meaning for the clinician of applying a disease label.

The purpose for which the clinician exists is quite simply to help or at least not hurt the individual client who comes inside the clinic's door. The clinician must devise a regime for each client which yields the maximum net benefit. The essential tools of clinicians in this task are their powers of observation and the body of organized experience in their memory or at their reach; with these the clinician tries to find the most appropriate match between the case at hand and elements of the prior experience. This matching is primarily accomplished by a "decision tree" process known as differential diagnosis; the ultimate criteria for the branches in this tree are in principle the differential probabilities of success of different courses of treatment. In operational terms, what is known as a disease entity is thus the collection of phenomena lying between adjoining decision lines at the farthest reaches of the decision tree. In theory, each case should be sortable into one and only one of these residual spaces between decision lines — a principle which is embodied in medical recordkeeping in the practice of assigning a single master diagnostic category to each case.

Like a well-designed machine, the clinical engine of differential diagnosis is superbly designed for its intended purpose of deciding between competing possibilities, deciding which disease it is that the patient has, but does not function so well when pressed into the service of other purposes.

A. The method of successive comparisons between competing possibilities is not well equipped to handle a problem which has only one side; that is, to deal with the question of whether there is a disease present at all. The fact of illness is initially presumed to be inherent in the case's presenting himself at the clinician's door, just as, for example, the fact of a crime's occurrence can usually be assumed by a detective in his daily work; the clinician's task is to "solve the disease." A growing suspicion that "there's really nothing wrong," as possibility after possibility is ruled out, is usually taken by the clinician as a cause for frustration and recriminations rather than as a signal of a successful resolution. Although the problems of "overdiagnosis" which result from this starting assumption are well recognized in the medical literature (Meador, 1965), they are usually seen as demanding a sharpening of diagnostic skills rather than alternative methodologies. But it would seem that the methods of legal hearings and inquests, for instance, are more directly addressed to the presence-versus-absence comparison than is the method of differential diagnosis. Clinicians are, in fact, unprepared for the role of gate keepers on legitimate time-out from normal responsibilities which the institution of sick leave has forced on them: they are hampered not just by humanitarian impulses, but also more crucially by the operating assumptions of their calling.

B. The method of differential diagnosis assumes that diseases are fundamentally to be viewed in terms of presence versus absence rather than of thesis versus antithesis or of a greater or lesser degree or strength of presence. This assumption puts the model at odds with many common assumptions about mental processes. Thus Hamilton (1968) has noted the "fundamental incompatibility between modern classification and psychodynamic theory. . . . Psychoanalytic theory regards all mental disorder as resulting from varying relationships between a few dynamic procresses. Its whole outlook is therefore completely different from that of modern medicine which originated from Sydenham's work in cutting up clinical phenomena into blocks; the syndromes" (p. 555).

C. The method of differential diagnosis is ill-suited to dealing with overlapping possibilities. When cases which fit two categories at once are found, the usual nosological response is either to collapse the categories into a single disease or syndrome of which the original categories are now mere manifestations, or to create a third category which differs from the original pair by the very fact of overlapping. Neither of these solutions is very satisfactory for material which, like many behavioral problems, shows substantial but not overwhelming overlapping.

As we have noted, diseases may be operationally defined as the cells in a pragmatic decision-making system. But the characteristics of this system, and its history and circumstances, mean that to call something a disease carries implications beyond the fact of classification.

In answering the question of what is implied by calling a behavior or condition a disease, medical sources are of little help. Mercier's remark that "doctors have formulated no definition of what is meant by a disease" (1916, p. 228) is still to a considerable degree true. After exploring the "lack of definition of disease" in medical dictionaries and handbooks, Jellinek in The Disease Concept of Alcoholism retreated to a description in terms of the division of labor; "a disease is what the medical profession recognizes as such" (Jellinek, 1960b, p. 12). But while such a description is in itself unexceptionable, it very much begs the question of what sorts of phenomena get to be recognized as diseases by the medical profesison. To assess this, we need to look beyond the empty formalities of medical textbook definitions. For although the boundaries of what doctors will accept as within their competence may seem arbitrary, they undoubtedly have a recognizable configuration — as Samuel Butler demonstrated by inversion in Erehwon. We would propose that defining a set of phenomena as a disease makes at least five assumptions about that set:

(1) That the phenomena have at least enough in common for it to be useful to class them under a single label. As Crookshank put it in 1923, "it has long been convenient, for the purpose of ready reference and communication, to recognize the fact that, in different persons, like groups of manifestations of disorder of health occur and recur, by constructing certain general references in respect of these like groups. These general references constitute disease-concepts" (Crookshank, 1956, p. 341). A more recent exposition notes that "one talks of the alcoholic syndrome in the same sense as one talks of Parkinson's syndrome. Taxonomic attempts of this order have given rise to the description of clinical forms which supply the observer with a reassuring framework and prevents [sic] him from losing himself" (Fouquet, 1974). It should be noted that this assumption applies when reference is made to "a disease," and not to "disease" in general — a distinction which has sometimes been lost in discussions of alcoholism as a disease (e.g., Wilkerson, 1966, p. 4). Also it must be recognized that this is a minimum, nominalistic position on the unity implied by a disease-entity label. The clinical tradition in medicine, particularly, has tended towards a much stronger "ontological conception of disease, that is of the existence and epistemological status of disease 'entities'" (Rather, 1959, p. 358). The battle between the clinical view and the nominalist critique that the clinician "treats his idea of the disorder as if it were an actually existing thing instead of being the creature of his own imagination and mode of thinking on it" (Oesterlen,

quoted by Rather, 1959, p. 362) has wavered back and forth several times in medical history (see Rather, 1959 and Temkin, 1963); Crookshank records that he "met with but scant applause" from an audience of English epidemiologists when he presented a nominalist critique of the view that "'diseases' are Platonic realities" (Crookshank, 1956, pp. 354, 342).

Despite attacks from psychological and sociological perspectives, Platonic assumptions remain strong in clinical thought. What presents itself to the clinician in the patient is interpreted as but symptoms and signs, mere outward manifestations of a presumed underlying reality. This habit of "typification" appears to be common in all service professions (Scheff, 1966), but has been reinforced in clinical medicine by the history of pragmatic successes of germ and analogous models of disease associated with very strong clusterings of cases and specific microscopic etiologies.

The assumption that what is to be explained and controlled is seated elsewhere than in the external manifestations often results in a lack of attention to the intrinsic meanings of these manifestations. Cirrhosis of the liver, for instance, tends to be neglected in American discussions of alcohol problems partly because it is so often (as in the Jellinek formula) regarded as a mere symptom or indicator of something else. The assumption also means that an impeccably narrowly-conceived disease may yet include an "ever-increasing range of conditions and behaviors" which are, as Robinson notes, "conceptualized as related to stages in a disease process" (Robinson, 1972), since the clinician imposes no more constraints on himself than would Sherlock Holmes concerning the limits of what is to be regarded as a diagnostic clue or symptom. For instance, one clinical discussion states that "any tattooed patient must be considered an alcoholic until proven otherwise" (Bates, 1963). Most crucially, Platonic assumptions mean that a diagnostic category which is a set of "symptoms" without a recognized etiology or treatment is a source of embarrassment, an unorganized territory ripe for the discovery or invention of new underlying entities. The ideal relief for the embarrassment is of course the discovery of a microscopic pathogen or lesion; failing this, the blank space on the map is often filled in with plausible hypotheses erected by an analogy. The characteristic clinical style of optimistic pragmatism means that the analogy chosen is often a notable success story, a disease which is newly understood or newly controlled. Thus the discovery of a lesion underlying general paresis helped result in the strong turn-of-the-century conviction that under every mental illness was an as-yet-undiscovered physiological lesion (Grob, 1966). The Platonic assumption that empirical events are merely the projected shadows of underlying realities blurs the distinctions between testable mechanisms, plausible models and hypothetical analogies, since assertions about underlying realities are not easily falsifiable. Analogies adduced originally for purposes of argument may take on a life of their own without ever being subject to critical scrutiny; statements about what alcoholism is like easily slide over into statements of what alcoholism is. Whole programs of treatment and prevention may be based on a theory of identity which began as an illustrative analogy. For instance, the contagion analogy is used as a warrant for drastic U.S. Federal efforts directed against heroin use (Jaffe, 1973). The combination of optimistic pragmatism and Platonic realism thus leaves unorganized territories on the clinical map (like alcoholism) open and exposed to the winds of clinical fashions and preferences; the result is a desultory profusion of analogies with other diseases which are almost never subjected to critical comparative tests.

(2) That the phenomena represent a condition rather than an event. Commenting on the "patent absurdity of Jellinek's definition" of alcoholism in his late writings as "any use of alcoholic beverages that causes any damage to

the individual or society or both" (Jellinek, 1960b, p. 35), Davies noted that some of the absurdity, "perhaps all, would disappear if one were to qualify the word use, by adding some such adjective as repeated. . . . A phrase such as intermittent or continual use would be appropriate" (Davies, 1976). Diseases are thought of as processes which extend in time, and have a "natural history" which the clinician must observe and interpret. In a clinical perspective, events are interesting only to the extent that they can be viewed as signs or symptoms of the underlying condition. The disposition to view diseases as conditions is thus related to the Platonism of clinical thought discussed above.

(3) That the phenomena represent a departure from a "normal" state, and that it is considered desirable (whether for the sake of the affected individual, for his family, for society, or for humanity) to eliminate or alleviate discomfort resulting from these phenomena. Labelling the phenomena as "a disease" thus involves a moral or ethical judgment about their desirability; as Seeley notes, "even if we say that disease is something that interferes with normal functioning or destroys or abbreviates life, there is an implicit prior judgment that normal function is to be desired, or the destruction or abbreviation of life to be not-desired" (1962, p. 587).

The disease model shares this characteristic with many competing conceptualizations: a social problem, a vice, a misdemeanor, or a bad habit (Reinert, 1968) are also undesirable departures from an often rather abstract "normal" state. A "problem," as Herndon remarks, "is something which is not supposed to happen, something which happens all the time of course, or it wouldn't be a 'problem,' but which isn't supposed to happen. A problem. You were supposed to believe in, and work toward, its non-existence" (Herndon, 1968, p. 18).

(4) That the phenomena are to be regarded as attributes of an individual person, rather than of any collective entity, although the causes of the phenomena

may be collective — in genetics, culture, interaction, social structure, environment, etc. In this characteristic, a disease differs from a social problem. The social problem of poverty, for instance, may be considered as an attribute of an individual, a family, a neighborhood, or a social order, but "the locus of [a] disease is . . . 'in' the patient" (Seeley, 1962, p. 588).[3]

This property of "the health-and-disease model," as M. Brewster Smith notes, "biases us toward a presumptive concern with the individual organism, so to speak in vitro, and, by extension, with intrapsychic processes. It predisposes us to neglect the context of structured social relations in which effectiveness or ineffectiveness is displayed, which contributes to their genesis, and which must be dealt with by programs of intervention that aim at increasing the balance of effectiveness" (Smith, 1968, p. 100). Therapeutic efforts thus tend to be focused on the patient rather than on his social surroundings. This may well explain why the liquor industry has felt reasonably comfortable with a disease conceptualization of alcoholism, since it tends to substitute a public concern with "curing" those afflicted with the disease for the temperance movement's concern with changing social factors contributing to the "liquor problem" — for example, by regulating taverns and conditions of sale.

The issue of the location of disease entities within the individual or at aggregate levels has been somewhat confused by medical terminology. For instance the term "etiology" is used to mean not only the "explanatory" factors which "cause" the disease, but also covers where the disease is considered to be located. This confusion is related to the still strong effect on current clinical and epidemiological thought of the major directions of advance in medical research in the last two centuries. Many of the most striking advances have resulted from successive increases in the powers of magnification of microscopes which have pushed ideas both of the potential location and of the potential carriers of disease into ever smaller bodily units, reaching, as in current concepts of sickle-cell anemia, the molecular level. In this now-lengthy history, the questions of the cause and the location of the disease have been seen as a single puzzle — to know the cause would imply the location, or vice-versa —so that the question of the location of disease has not been distinguished from questions of cause, and the location of disease has continued to be seen as within the individual.

The assumption of location within the individual becomes much more questionable when disease concepts are applied to behavioral phenomena, as in concepts such as alcoholism or drug dependence. In the traditional view of drug dependence, the factors which hold a drug user to a repeated pattern of behavior have been viewed as located in the organism's body (tissue tolerance, abstinence syndrome, etc.) and/or in the organism's mind (compulsion, loss of control, etc.) (See World Health Organization, 1969, p. 6). Until recently the general presumption has been that a physiological dependence is inherently more compelling and less tractable; if both physiological and psychological dependence seemed to be present, the psychological dependence was usually taken as a symptom of the underlying physiological dependence.

Only in recent years have some clinicians begun to recognize that some of the phenomena covered by the term drug dependence may best be understood as located at aggregate levels. In some cases of drug dependence the factors holding the individual to his behavior seem to be a property of a social situation rather than of the individual, in that the behavior appears and disappears as the individual moves into and out of the situation. There is explicit recognition of this in some of the literature on drug dependence, under such rubrics as "reactive addiction" (Ausubel, 1958, p. 49-54), but it has often not been reflected in general formulations of the nature of drug dependence.

(5) That the phenomena do not occur entirely by the will of the affected individual. That is, of course, the facet of the disease rubric most explicitly and frequently invoked in discussions of alcoholism as a disease: an implication of the involuntary nature of the behavior lies behind each of the terms in Jellinek's list of concepts with which researchers have sought to characterize alcoholism as a disease — "tolerance, craving, habitutation, sensitivity, compulsion, 'habit forming drug,' withdrawal symptoms, 'loss of control' and so forth" (1960b, p. 12). The emphasis is particularly apparent in Jellinek's own formulation, that "anomalous forms of the ingestion of narcotics and alcohol, such as drinking with loss of control and physical dependence, are caused by physiopathological processes and constitute diseases" (1960b, p. 40) — for "loss of control" and "physical dependence" are both terms describing involuntary behavior.

But although the involuntariness associated with diseases is the most attractive aspect of the medical rubric for those seeking to destigmatize a problem area, in their daily practice doctors would certainly recognize an element of will in many of their patient's conditions. The claim of overriding involuntariness for a disease condition often made by moral entrepreneurs to the larger society is most convincing for dramatic life-threatening illnesses — cancer, or a stroke, or tuberculosis; but these are a small part of the average doctor's daily practice. In their advice and warnings to their patients as they set a broken leg from a skiing accident, or treat someone for exhaustion from overwork, or diagnose measles in an unvaccinated child, or treat a case of syphilis, or examine an overweight middle-aged man, doctors will explicitly recognize the element of choice or will in the etiology of the disease. There may indeed have been no specific intent on the part of the patient to incur the particular disease or mishap involved, but risk-taking or negligence or lack of foresight or some other potential culpability will commonly be seen as a factor in the condition. While the physician's professional ethics demand that the condition be treated irrespective of its cause, assumptions about the willfulness of its occurrence are very likely to influence the action model the physician chooses.

These five minimum assumptions involved in calling a set of phenomena a disease are, of course, only preconditions to the decision concerning what kind of disease is involved. In making this diagnosis, the most visible conceptual tools for the physician are the published classifications of diseases which form part of the profession's unofficial wisdom. But in selecting an action model, the physician commonly draws also on official wisdom, transmitted originally by apprenticeship and augmented by his or her clinical experience. The "conceptual packages" with which the clinician organizes his or her experience and practice therefore often cross-cut rather than match the formal classifications of medical nosolgy.

The same clinician may thus apply different action models, as circumstances differ, within the same formal diagnostic category. Sudnow (1967) has documented differences in clinical practice in a hospital emergency room according to the perceived status and demeanor of the patient, and for alcoholism a widely-cited series of papers (Blane et al., 1963; Wolf et al., 1965) demonstrated differences according to social class in whether or not emergency-room doctors acted to assign patients to an experimental alcoholism treatment service. Perhaps even more common is the application of different models in functionally differentiated parts of a particular rubric's system. While an internist and a psychiatrist might agree in classifying a particular client as a "psychiatric case," for the psychiatrist this would imply the need for action, but it has been remarked that in general medicine such a label tends to be regarded as justifying inaction and does not commonly result in a psychiatric referral (Genevieve Knupfer, personal communication). The public VD clinic's action model for its cases, in line with its location in the tradition of public-health epidemic control, is likely to involve much more active case-finding among clients' sexual partners than when the infection is treated by a private physician catering to a respectable clientele.

In this chapter we have started from the conventional wisdom that there are a number of different competing "models" of intractable problems such as alcohol and drug problems. We have argued that there are, in fact, two levels of differentiation between competing models: (a) in terms of the choice of "social rubric" for handling the problems — that is, which institutions and professions shall have custody; and (b) in terms of the specific model for the problems within a particular rubric.

The choices both of social rubric and of specific model influence and are influenced by the social standing of those afflicted with the problems, and also by the structure of interprofessional and interinstitutional relations. We shall return to these issues of "external relations" — matters of broad societal interest in the handling of problems — in the next chapter. In the present chapter, our emphasis has been rather on "internal" matters. For the choices of social rubric and of specific model also carry consequences in terms of the social handling process itself: they define the relevant profession's explicit expectations of the client's behavior, often serving "therapeutic" or "cooling out" or analogous functions; and they relate closely to the relevant profession's implicit conceptual structure — what we have termed its "action models" — for sorting and handling its caseload. In the previous pages, we have explored these aspects of the choice of social rubric and specific model, considering as an exemplar how clinicians, in a process of "differential diagnosis" only partially captured by official nosologies, choose among and apply specific action models. While we shall turn in the next chapter to the question of the negotiation of particular social rubrics and action models in the larger society, the present analysis implies that such negotiations are constrained in their effects by the occupational culture of the professions operating under the chosen rubric. For instance, whatever may have been intended by calling a problem-area "a disease," the denomination necessarily invokes clinicians' understanding of what is meant by a disease, and their occupational culture of relevant specific models for a disease.

Chapter 4. The Negotiation of Characterizations: Governing Images of Alcohol Problems

The particular social arrangements for handling an intractable social problem involve at least as many vested interests, moral and economic, as any other social arrangement. But by definition an intractable problem also has built in an element of instability: whatever "solution" is currently dominant, it can be seen to be not "working," in the sense of wholly eliminating the problem. Intractable problems are thus fertile fields for ideological entrepreneurship: any solution which is not currently in effect is likely to look more hopeful than the currently dominant solution. Thus Bruun has noted with respect to the history of Finnish approaches to alcohol problems that "the consistent frustrations concerning the relative lack of success in fighting alcoholism made us move compulsively from one model to another" (Bruun, 1971).

Gusfield (1967) has described shifts in dominant characterizations of deviance in terms of "moral passage" from one status to another, using as an example the shift of dominant definitions of the drinker from the "repentant drinker" of the moral-persuasion temperance era, to the "enemy drinker" of the later prohibitory phase of the temperance movement, and then to the "sick drinker" of the alcoholism movement of the last 40 years. Gusfield's approach is important in emphasizing the extent to which the public definition of a social problem is the net result of implied negotiation between competing views:

> deviance designations have histories; the public definition of behavior as deviant is itself changeable. It is open to reversals of political power, twists of public opinion, and the development of social movements and moral crusades. What is attacked as criminal today may be seen as sick next year and fought over as possibly legitimate by the next generation (Gusfield, 1967).

But Gusfield's characterization of the history of social handling of alcohol problems, solely in terms of dominant characterizations at the level of what we have termed "social rubrics," offers an oversimplified view of the processes and structure of argumentation involved in the continuous redefinition of intractable problems. Thus Gusfield presents the Temperance movement as antagonistic to the "sick drinker" model of alcohol problems, which he dates as emerging subsequent to Repeal. This traditional interpretation has recently been sharply challenged by Levine (1978), who has shown the continuity between the temperance and alcoholism movements' conceptions of addiction. Levine also remarks on the continuing strength in the temperance movement of mutual-support and moral reform efforts through much of the era of legislative and prohibitory emphasis, and on the cooperative rather than antagonistic relationship of temperance organs to the medically-oriented inebriates asylums established in the late nineteenth century (Levine, 1978).

As this example suggests, processes of change in the social handling of an intractable problem cannot be fully understood at the level of shifts in the dominant social rubrics of the problem. In the first place, attention must also be directed at the specific models for the problem: if the problem is seen in terms of sickness, it is as a contagion, or as a temporary disability, or as a chronic and potentially fatal condition? As we have argued, there are in fact a wide variety of disease models, which along with different models of institutional and professional action imply different moral statuses for the problem in terms of the larger society. Similarly, there are wide variations in the available specific models within a legal rubric. Discussions of drug policy, particularly for marijuana, in the last few years have explicitly recognized the existence of a series of possible legal models, although the alternative legal models have often been embedded in a longer list including also models from other rubrics (e.g., Kaplan, 1970, Chapter IX; National Commission on Marihuana . . . , 1972, Chapter V). Specific legal models vary in terms of the defined gravity of the problem: in the U.S. illegal parking, trespassing, petty theft, manslaughter and murder are usually of different gravity. Relatedly, specific legal models differ in the procedures and processes followed: for instance, such alternatives as mailing in a small fine, technically a default of bail; an automatic appeal to higher courts; a criminal diversion option; the options of county jail or state prison. The variations in defined gravity and in legal procedures are related to the public moral standing of the problem: a parking ticket is not usually a disgrace, and chronic double parking is not thought of as a potential mental disorder like kleptomania.

Secondly, different rubrics and specific models are often adhered to at the same time in a given society, and a characterization only in terms of a dominant rubric ignores the complexities entailed. Favored classes of individuals will often be treated in terms of different action models, even within the same institutional rubric: thus Daniels (1969) notes that long-service men are more likely than short-termers to be acted upon favorably by military psychiatrists. Frequently, as we have noted, different models apply in different institutional frames under the same rubric: the drunk picked up on skid row may be treated in a wing of a jail now relabeled a "hospital," by guards newly reclassified as "alcoholism counselors" (Beauchamp, 1973), while his middle-class counterpart is referred to a private sanitarium.

Thirdly, it must be kept in mind that the coherence and consistency of professional and popular thought about rubrics and specific models can easily be overestimated. Bruun (1971) notes, concerning the "models of drug addiction" and "alcoholism" elucidated by Siegler et al., that "although the models are described as consistent, it is by no means clear that representatives of different views accept the description. In actual operations, there may be mixtures, some may be less successful than a consistent model, some may be more so." One source of mixing of models is the optimistic pragmatism of the clinical perspective noted above: a clinician may with greater or lesser grace find himself using an action model at variance with his overall perspectives on the problem, because the model "works" in one or another sense. Thus the only non-governmental methadone clinic in San Francisco is directed by a clinician who has written extensively against the reliance on psychoactive drugs.

At any given time, then, the practical social arrangements for handling a set of problems are likely to reflect a considerable confusion of social rubrics and specific models. But at the level of the public rhetoric surrounding the problems, Gusfield's picture of starkly contrasting characterizations competing for dominance rings true. Ideological entrepreneurs are in fact often quite selfconscious about the aim of projecting and securing acceptance of a particular characterization of the problems, a characterization which identifies a particular social rubric and often a specific model as the appropriate matrix in which to organize and interpret everyday experiences with the problems. We shall term such characterizations "governing images."

In the following pages, much of our attention will be focused on such governing images as they have been applied to alcohol and drug problems. We will examine such images from several perspectives: in terms of their internal logic, in terms of the social and ideological conditions of their formation and acceptance, in terms of their consequences. In spite of our focus on ideas as actors in history, our analysis is neither entirely materialistic nor entirely idealistic. Governing images are seen as being formed out of a matrix of practical experience as well as from available conceptual materials. Often, indeed, ideological entrepreneurs promoting a particular governing image will base their efforts on a highly-reputed practical success. Thus, as we shall explore in greater detail below, the ideological enterpreneurs of the alcoholism concept in the early 1940s drew on the widely-acclaimed successes of the therapeutic model of Alcoholics Anonymous in the 1930s as validating their claim on the larger society that alcoholism should be treated as a disease. But in the transition from practical experience to social prescription, the governing image will commonly be applied far more broadly than the practical experience would support. Thus, as Robinson noted, in the promulgation of the classical disease concept of alcoholism, "an ever-increasing range of conditions and behavior" have been gathered under the banner of the concept (1972, p. 1038).

Three major governing images may be discerned in current discussions of alcohol policy. Each of these images operates under a disease rubric, but they involve very different action models. In the remainder of this chapter we will offer an overall characterization of each governing image, and some comparisons of their implications. In succeeding chapters we will turn to a closer examination of each governing image's nature, logic, and fit with empirical realities.

One such governing image is of alcohol as an irresistibly attractive but dangerous substance. The imputation of such power to the substance implies the imputation of weakness to the potential users, and the old theme of the drunkard's progress to the gutter and the grave — the *boule de neige* (de Lint and Schmidt, 1968) — tends to be regarded as characteristic of individual drinking histories. The pessimistic view of individual human nature is commonly accompanied by a strong faith in collective human institutions: it is the duty of the state to save people from themselves.

This governing image can be seen in its purest form in much current thinking about heroin — as the title of a book expressed it, "It's So Good, Don't Even Try It Once" (Smith and Gay, 1972). This image points explicitly to limitations on the availability of the substance as the crucial strategy in prevention, and was fundamental to many of the old arguments for the prohibition of alcohol. Since the abandonment of prohibition, discussions of the prevention of alcohol problems governed by this image tend to have focused on control and taxation policies as ways of limiting the damage due to alcohol, by limiting the effective availability of alcohol. The image holds particular attractions for those in the discipline of public-health epidemiology, which derives its basic assumptions from the study of infectious disease epidemics: the concentration on the substance fits neatly as the "agent" into the discipline's basic paradigm of environment-agent-host, and lends itself to contagion models (Ekholm, 1972); the image allows for a concentration on cirrhosis and other unequivocally physiological diseases which are straightforward sequelae of the host's entertainment of the agent; and at least in theory the policy measures it implies can be technocratically applied rather than requiring common consent.

Another governing image is of alcohol problems as being fundamentally a problem of disruptive and/or compulsive behaviors arising out of an ambivalence toward drinking which is seen as characteristic of American culture. This analysis assumes an especially high rate of drinking problems in the United States as compared with other cultures, and blames this essentially on the historical fact of a strong and militant prohibitionist tradition in the United States. This tradition is seen as having so strongly proscribed drinking at all that it offered no guidelines on acceptable drinking behavior, relegating alcohol consumption to the status of a furtive and potentially explosive activity.

This governing image has a history in the alcohol literature dating back over 30 years to Abraham Myerson's seminal essay (1940). The image implies an optimistic, almost Rousseauian, view of human nature; the function of government and other collective agencies is to help rid individuals and the culture at large of some acquired hang-ups. The focus is on an education of the people in general — both in the schools and in mass media campaigns —which aims at the direct influencing of norms and attitudes on drinking. "Teaching responsible drinking" means both a positive encouragement of moderate drinking as a part of everyday life and the establishment of stringent normative limits on amount of drinking and drinking behavior. With the advent of responsible drinking norms, alcohol problems, viewed fundamentally as mental illnesses of disordered or compulsive individual behavior, will wither away.

This image holds strong attractions for both sociologists and social psychiatrists and their cognate disciplines. For sociologists, it offers an etiology of alcohol problems which lies within their competence, at a social level rather than solely in individual minds or bodies. For psychiatrists, the term ambivalence and the implications which accompany it are familiar territory. The image and the measures it points to appeal to the generally libertarian and populist strains in the two disciplines, while the placing of the onus for alcohol problems on the culture in general rather than on those "caught" with the problems appeals to sympathies for the underdog. With its adoption by the Cooperative Commission on Alcohol Problems (Plaut, 1967) and the National Institute on Alcohol Abuse and Alcoholism (1971), the image of cultural ambivalence as the fundamental motor of alcohol problems could now be described as a liberal establishment position.

The third major governing image in contemporary discussions of the prevention of alcohol problems is of the problems as manifestations of a specific disease known as "alcoholism" with an unknown but definite physiological or developmental etiology — an etiology which, in any case, predates the beginning of drinking rather than emerging out of the drinking (cf. Jellinek's "predisposing X factor," 1952). The defining characteristic of the disease is the loss of control over drinking behavior, so that the alcoholic's drinking behavior is essentially unaffected by punishment, threats, persuasion, inducements, or restrictions on the availability of alcohol, at least until he "hits bottom." At that point he becomes amenable to treatment, whether lay or professional, by a combination of therapies notably including moral therapy, and can be stabilized, without current manifestations of an alcohol problem, as a "dry alcoholic." More recently it has been generally felt that the process of "hitting bottom" can be somewhat short circuited, so that partially-developed cases of alcoholism can be successfully treated.

This is, of course, the celebrated "disease concept" of alcoholism, around which the modern alcoholism movement of the last 35 years was organized. The disease concept is undoubtedly the most widely held of the governing images we discuss here. It does not hold any intrinsic implications about human nature, other than a fundamental belief in the potential redemption of every individual. Until recently, the emphasis has been on action to help identified alcoholics by committed individuals and volunteer groups, although the influx of government money is currently professionalizing and bureaucratizing what were previously works of faith.

The disease concept divides the population of drinkers into two classes: "alcoholics" and all other drinkers. The latter class may be subdivided into "normal" or "social drinkers" and "problem drinkers" or some equivalent term, but primary attention is focused on the alcoholics. Since the true alcoholic and the problem drinker are seen as often indistinguishable in their behavior, with the distinction being possible only retroactively (Jellinek, 1960b), the operating presumption is that anyone manifesting alcohol problems is an alcoholic. Preventive efforts other than the treatment effort itself revolve primarily around casefinding for "hidden alcoholics" in the general population, in order to get them into treatment. Traditionally, this activity was carried on fairly passively, for instance by way of lists of "warning signs" of alcoholism or publicity about Alcoholics Anonymous (AA) in the mass media. More active casefinding was discouraged by the concepts of "readiness" and "hitting bottom" among Alcoholics Anonymous members, and of "motivation for treatment" among professionals; and perhaps by an over-supply of candidates for the available treatment resources and by an aversion to intruding into other people's lives without invitation. Recently more active casefinding has become common for a number of reasons, including attacks on the concept of motivation as an excuse for avoiding difficult cases (Sterne and Pittman, 1965), incipient surpluses of newly-expanded treatment resources over the number of volunteer clients, and the transformation of treatment agencies from resources for consultation by the voluntary client into instruments for social control by the state (e.g., as "treatment" in lieu of jail for drink driving).[4] The logic of the disease concept requires that other preventive measures beyond casefinding be seen as utterly irrelevant to the behavior of the alcoholic, since the disease of alcoholism is defined by the individual's complete inability to control his drinking no matter what incentives or deterrents are brought to bear.

As Levine has recently shown (1978), the modern disease concept of alcoholism is a mutated version of conceptualizations of alcohol problems prevalent in the era of the classic temperance movement. The pioneers of the alcoholism movement in the late 1930's and 1940's, however, had a very different perspective. While the events of Prohibition and Repeal had thoroughly discredited the temperance movement, existing social provisions for those with alcohol-related problems were seen as rudimentary and often inhumane. The disease concept of alcoholism, originally primarily a lay conceptualization promulgated by Alcoholics Anonymous, appeared as the logical means to the movement's goals. The disease concept thus served as the rallying-point for a diverse and ad-hoc coalition united only by an interest in improving the public image of the alcoholic and obtaining humane treatment and public services for him. The pioneers of this coalition did not need a Talcott Parsons to see that, in their society, illness was the only legitimated excuse for default on the everyday responsibilities of work, home and public demeanor. The stakes were high, and have become higher: for the alcoholic, not only his responsibility for his actions in law, but also his access to rehabilitation and treatment services, and his entitlement to sick leave, disability payments and medical insurance; for the "alcohologist," not only the prestigious aura of association with medicine (Trice and Roman, 1972, p.14), but also the expanded opportunities that go with budgets for a "major national health problem."

The focus on loss of control as the core of the disease concept fits easily with conceptions of dependence phenomena in psychotherapeutic thought, and has ironically, against the wishes of many in the alcoholism movement, lent itself to the "combined approaches" of the World Health Organization and other agencies, which class alcoholism as a particular form of drug dependence. But the classical disease-concept image is not the particular property of any discipline or profession, tending rather to draw adherents from a variety of disciplines into a common arena of "alcohology." It remains an extraordinarily strong force in American thought on alcoholism, although many treatment programs appear to give it lip service as a polite gesture, while running programs more or less antithetical to its precepts.

Although all three of the governing images we have described identify the object of their characterization as "alcoholism," the meaning of the term differs for each paradigm. De Lint and Schmidt (1971) talk of alcoholism when the proximate object of their concern is cirrhosis; Chafetz (1971) talks of alcoholism when his attention is focused on social damage and casualties due to heavy drinking; and Pittman and Sterne (1967) talk of alcoholism when their focus is on loss of control over drinking. Although all three paradigms thus invoke a social rubric of disease, the specific models of disease involved are quite different: one image draws on contagion and epidemic concepts and centers on physiological consequences of drinking; one draws on social pathology and psychopathology concepts and concentrates on social disruptions due to drinking; and one draws on dependence and neurosis concepts and concentrates on psychic damage due to drinking.

The three images also illustrate the diversity of directions in which disease imagery can direct the social gaze. The focus in the classic alcoholism movement is on the disease itself, and on the therapeutic response to it. For the epidemic and contagion imagery which accompanies the view of alcohol as fatally attractive, the emphasis is on public health interventions to prevent the disease; the nature of alcoholism is of concern primarily as a moral justification of preventive measures and policies. For the tradition of ambivalence imagery, the focus is also shifted away from the nature of alcoholism, in this case emphasizing instead the causal mechanisms involved in the incidence of alcoholism. The different disease conceptualizations thus reflect differences in the policy orientations and concerns of each image's ideological entrepreneurs.

In turn, these differences in policy concerns reflect the different social conditions surrounding alcohol at the different historical periods when the various images came to prominence. Both the ambivalence and the modern epidemic imagery, as applied to alcohol, have flourished in a context where the success of the alcoholism movement had created wide lip-service, at least, to conceptions of alcoholism as a disease. Adherents of the ambivalence concept, in particular, have often more or less accepted the alcoholism movement's definition of the nature of alcoholism, differentiating themselves from it on issues of the causation rather than the nature of alcoholism.

In the next three chapters we will examine in greater detail the internal logic of the three governing images we have identified, before turning to a more detailed examination of the interrelations between governing images and their social and intellectual environment.

Chapter 5. The Classic Disease Concept of Alcoholism

As noted above, for the alcoholism movement of the last 40 years, to proclaim alcoholism as a disease was seen both as therapeutically useful and as the best and most practical way of securing better social handling for those with alcohol problems, in a society where illness is the main legitimizer of unscheduled timeout.

The question of volition is commonly seen as the salient issue in the distinction between the view of alcoholism as a disease and the view of it as a vice or crime: "it should be loss of control which determines whether a skid-row drunkard should be subjected to criminal sanctions or treated for disease," notes a legal review article (Columbia Journal of Law and Social Problems, 1966, p. 114). Certainly the idea of loss of control over drinking has been recognized from the start of the modern alcoholism movement as at the heart of the movement's disease concept. The "first step" in Alcoholics Anonymous' 12-step action model for its members is "We admitted that we were powerless over alcohol — that our lives had become unmanageable".

As Sarbin notes, the humanitarian promotion of a disease model of phenomena to improve social arrangements for those affected is not a new idea —Teresa of Avila was successfully using it against the Inquisition's accusations of witchcraft in the sixteenth century (Sarbin, 1967, p. 448). However, despite its public relations success, the promotion of the disease model of alcoholism does not appear yet to have attained its intended effects of carrying with it the intended corollary that alcoholic behavior is involuntary.[5]

Again, claims on the legal system to hand over custody of alcoholic behavior to the medical system, on the grounds that the behavior is involuntary, have not been fully allowed. Criminal law has a long tradition of careful elaboration of distinctions of degrees and kinds of involuntariness (see, for example, Tao, 1966), into which medically-oriented discussions are not easily integrated. It is worth quoting in this regard at some length from the prevailing opinion in the Supreme Court decision on the punishability of public drunkenness:

> the trial court's 'finding' that [the defendant] 'is afflicted with the disease of chronic alcoholism', which 'destroys the afflicted person's willpower to resist the constant, excessive consumption of alcohol' covers a multitude of sins. [Medical] testimony that appellant suffered from a compulsion which was an 'exceedingly strong influence', but which was 'not completely overpowering' is at least more carefully stated, if no less mystifying. Jellinek insists that conceptual clarity can only be achieved by distinguishing carefully between 'loss of control' once an individual has commenced to drink and 'inability to abstain' from drinking in the first place. Presumably the person would have to display both characteristics in order to make out a constitutional defense [that the behavior is unpunishable], should one be recognized. . . . Moreover, Jellinek asserts that it cannot accurately be said that a person is truly unable to abstain from drinking unless he is suffering the physical symptoms of withdrawal. . . . In attempting to deal with the alcoholic's desire for drink in the absence of withdrawal symptoms, Jellinek is reduced to unintelligible distinctions between a 'compulsion' and an 'impulse' . . . . Other scholars are equally unhelpful in articulating the nature of a 'compulsion' (U.S. Supreme Court, 1968, pp. 1264-5).

The response of those in the alcoholism movement to this legal logic-chopping on the question of volition has been in two directions. One has been increasingly scholastic exegeses on the concept of loss of control over drinking behavior as the core of the movement's disease concept (Keller, 1969, 1972, 1976; Glatt, 1975). The other has been a broadening of the disease claim so that loss of control is only one of a series of alternative criteria. This latter approach is exemplified by the National Council on Alcoholism's "Criteria for the Diagnosis of Alcoholism", adopted by a medical committee, as the prime mover in this effort stated, "in response to a Supreme Court decision [quoted above] in which it was stated that physicians were not agreed as to the manifestations of alcoholism" (Seixas, 1974).

These responses reflect the ambiguity present in the Alcoholics Anonymous concept of loss of control from the start, as exemplified by the AA First Step quoted above: alcoholism was characterized on the one hand by loss of control over drinking behavior, and on the other hand by loss of control over one's life, due to drinking. Thus from the first the "drinking history" derived from AA lore and turned into scholarly form by Jellinek (1946, 1952) included an assortment both of items specifically describing drinking behavior and of life problems — loss of friends, job, spouse — presumed to be a result of drinking behavior. Levine (1978) has argued that in this characteristic AA's disease concept followed temperance movement conceptions of addiction, and reflected the emphasis on the overriding importance of self-control associated with the rise of middle class society in early republican America.

As developed in AA tradition and transmitted to the scholarly literature by Jellinek, the alcoholism movement's disease concept thus included a wide variety of moral, emotional and physical conditions, and adverse life events, as well as drinking behavior. All these items were conceptualized as symptoms of the disease entity, and thus it was natural, in accordance with Sydenhamian tradition, to attempt to relate and order them so as to establish the natural history of the disease. A questionnaire was drawn up and circulated by AA's internal organ, The Grapevine; only after the data had been collected (with a response rate below 10% — Bacon, 1976) was Jellinek, then emerging as the foremost scholar of the movement, called in to analyze the data. Reminiscing about this period, Jellinek's colleagues at the Yale Center for Alcohol Studies have noted the general skepticism there about this enterprise: the study "was originally known as 'Jellinek's doodle', but later was titled 'Phases of alcohol addiction'" (Bacon, 1976, p. 96). But as published in the Quarterly Journal of Studies on Alcohol and separately as a Memoir of the Section of Studies on Alcohol, the study was cloaked in the full scholarly legitimacy of a refereed research report. The study stimulated a substantial tradition of similar studies, some of which are considered later in this chapter.

In tone, Jellinek's 1946 report is properly cautious about the findings. However in the long run the original research report of 1946 was far less influential than a later paper by Jellinek, originally delivered several times as a lecture and then published as an appendix to a WHO report and in the Quarterly Journal of Studies on Alcohol (1952). The cautions and caveats of the earlier report are replaced in this paper by the more straightforward expository style of a lecture. Most importantly, this paper included a "chart of alcohol addiction" which graphically represented the phases and symptoms of alcoholism in their assigned order. This chart, particularly as adapted by Glatt (1970), is probably the most widely diffused artifact of the alcoholism movement's disease concept.

Jellinek's 1946 and 1952 papers together constitute the locus classicus of the disease concept of alcoholism, and will be the focus of our exploration of the assumptions of that concepetualization. Ironically, these papers can be regarded as a detour in the development of Jellinek's thought about alcoholism: in both his early (Haggard and Jellinek, 1942) and in his later (1960a; 1960b) expositions, less rigid and more polymorphous conceptions of alcohol problems are offered. But the 1946 and 1952 papers explicating a unitary disease concept of alcoholism form the major basis for his enshrinement in the pantheon of the alcoholism movement.

The presentations themselves tend to concentrate on the minutiae of time-ordering of behaviors and occurrences, so that the assumptions underlying the particular disease model presented remain implicit. We may describe the assumptions as involving unilinearity, accretionality, and immanence. By unilinearity is meant the assumption that there is a single sequence of stages through which all affected must eventually pass. By accretionality is meant the assumption that each stage builds upon but does not supersede the previous one: each attribute, once acquired, is not lost. Taken together, these two assumptions imply that the sequence is irreversible. By immanence is meant the assumption that each change in the sequence is implicit in the prior nature of the person being changed, even if the proximate cause may appear to be external. The combination of accretionality and immanence tends to impose a teleological perspective, whereby the end product is seen as the "purpose" of the whole process.

It is perhaps in the design and methodology of the various studies in the tradition of Jellinek's pioneering "Grapevine" study (1946) that the effects of these assumptions are most strikingly apparent. The assumption of unilinearity is involved in the fundamental orientation of this research tradition towards the arrangement into a single time-ordering of a whole series of various sorts of behavioral "symptoms." In spite of disclaimers that "not all" of the symptoms "occur necessarily in all addicts," the operating presumption is in fact that "the phases and the sequence of symptoms within the phases are characteristic . . . of the great majority of alcohol addicts and represent what may be called the average trend" (Jellinek, 1952, p. 676). The assumption of accretionality is involved in the odd fact that, while these studies all enquire systematically about the date of first occurrence of each "symptom," none enquire about the date of its latest occurrence. Accretionality is also explicitly invoked in the repeated use of modified Guttman scaling techniques (notably by Jackson and Mulford), by which the extreme point of a scale is defined in terms of more extreme items being added to, rather than substituted for, less extreme items.[6] Irreversibility is asserted in the continuing emphasis on the necessity of "hitting bottom" — completing the disease process — before any "cure" will be effective. The assumption of immanence lies behind such formulations as Jellinek's postulation of a "predisposing X factor in the addictive alcoholics" (1952), and in the continuing enquiries into the relatively unpromising territory of "age at first drink." A teleological perspective underlies the whole design of these studies: the basic method is to ask a population of alcoholic "graduates" of the process how they got that way, and to subsume into the disease model as "symptoms" any attribute or occurrence, no matter how far-fetched.

Taken together, the cluster of assumptions we have outlined might perhaps be described as an ontogenetic model of disease, involving the application to a disease conceptualization of assumptions similar to those which underlie, for example, the theories of social evolution prevalent in the nineteenth century.[7] The application of such models in discussions of human behavior has had a long history in psychoanalytic theories of human behavior — for example, in the postulation of a universal progression through oral, anal, and genital stages —and it is perhaps from these theoretical traditions that the model was imported into alcoholism studies. Certainly the most thorough-going explicit statements of an ontogenetic model can be found in psychiatrically-oriented discussions, such as H. Rotter's description of "the progress of alcoholism in three phases . . . with three subgroups each":

> Careful investigation will show that the phases of alcoholism described here, i.e., the significant symptoms which characterize each phase, can be found in every case of alcoholism; they may last less long in some cases but are never

> skipped. Symptoms acquired in earlier phases persist in all later phases, even if they are no longer in the foreground. It takes a man from five to nine years to go through the middle phase. Certain especially susceptible patients who have a primary intolerance of alcohol often manifest only very brief, hardly recognizable phases; such persons include invalids, persons with brain damage, persons with encephalitis, epileptics and the mentally ill. A considerable number of drinkers, especially psychopathic ones, may stay in phase II for ten to twenty-five years without a noticeable change or increase of symptoms. Phases are not skipped as a result of abstinence, even if it lasts many years. A relapse often takes the form of an abbreviated repetition of previous phases. Usually, however, a relapse is followed by the symptoms of the following phase as signum mali ominis (Rotter, 1962; original in German).

There is, of course, nothing intrinsically invalid in the use of the relatively tight framework of the ontogenetic assumptions as part of a disease model. The question is rather one of usefulness: in the particular case of alcoholism, does an ontogentic disease formulation fit the available data and help us to understand it? How well do the assumptions hold up when we turn them instead into hypotheses to be tested? Looking at the studies in the "Grapevine" tradition in this light, we can in fact tease out of them at least partial answers to these questions, particularly as regards the central assumption of unilinearity. In the three tables below we have gathered and recalculated into comparable form the published findings of nine studies in the "Grapevine" tradition, that is, studies using the AA Drinking History questionnaire, or Jellinek's or their own modification of it, on samples in one way or another identified as "alcoholic."

For unilinearity to remain a useful assumption, we would expect to find a constant and nearly universal prevalence of each symptom in each population of alcoholics studied, and we would expect to find a constant time-ordering of the first occurrence of the symptoms in all the populations. Table 1 shows our testing of the first of these hypotheses, and Tables 2 and 3 show our testing of the second.

Although all the samples in Table 1 consist of people in one way or another labeled "alcoholics," there are remarkably wide and somewhat consistent variations in reported prevalences from one sample to another. Among the U.S. studies, the two purely Alcoholics Anonymous samples generally show the highest prevalences for any item; many items are indeed virtually of universal prevalence among them, and for no item is there less than a majority assenting. The hospitalized samples and mixed groups in general show somewhat lower prevalences, as Trice and Wahl (1958) first showed. It is perhaps not surprising that AA groups show higher prevalences on a list of symptoms originally formulated by and for AA members, but it does cast doubt on the symptoms' universality. Trice and Wahl suggest that the greater prevalences among AA members may signify that the occurrence of the symptoms "causes" AA affiliation: "it seems likely that affiliation with AA is, to some degree, encouraged by having experienced these pronounced symptoms" (p. 646); but in his later work, Jellinek suggested the opposite explanation, in that "AA have naturally created the picture of alcoholism in their own image, although at least 10 to 15 percent of their membership [based on a sample of 2000 AA members] are probably specimens of alpha alcoholism (where the pathology precedes alcoholism) who conform in their language to AA standards" (1960, p. 38). Either way, it seems that reporting the occurrence of Drinking History items is considerably less than universal outside the confines of AA membership.

In general, then, Table 1 does not support an assumption of universality in the prevalence of Drinking History in items in samples of alcoholics. Table 2, which shows the number of years by which the mean age of onset of each item is greater than the mean age of onset of "Loss of Control," raises doubts about the existence of a set of time-ordering of symptoms among those who do report their occurrence. While it is true that Jellinek himself demonstrated the inadequacy of using mean ages to order symptoms (1946, pp. 22-25), mean ages are all we are given in several of the studies, and they do suffice to indicate the likelihood of a time-ordering. The mean ages of Jellinek's two most crucial items, "Loss of Control" and "Benders," for instance, are reversed in order in four of the seven samples including both items. It seems likely that this reversal is at least partly due to instability in reports of "loss of control": thus Glatt's women date their "loss of control" one year after the average age of "abandoning efforts to control." Nevertheless, in the vital middle ground of the chart, no consistent patterns are apparent, although it is clear that by all accounts some items tend to come early (blackouts, surreptitious drinking) and some tend to come late (tremors, hospitalization).

More direct evidence on the relative ordering of some of the symptoms is available in a few of the reports drawn on in Tables 1 and 2, and Table 3 shows such results in terms of the proportion of sample members dating a pair of symptoms at different times who date them in the order specified by Jellinek. Again, as Park concluded after compiling from his data set a more complete set of comparisons, it might be concluded that "the symptoms of addictive alcoholism do not necessarily develop in the order given by Jellinek" (Park, 1967, p. 9). All in all, the tables suggest that there is no single ordered progression of symptoms, to which an overwhelming majority of those labeled as "alcoholics" comply.

Even though the studies in the "Grapevine" tradition were constrained in their research agenda, as we noted above, by the assumptions of the classic disease conception, our reanalysis of their results has shown that they are capable of serving as at least a partial test of the validity and usefulness of the

Table 1

PREVALENCE OF JELLINEK'S 1952 "SYMPTOMS OF ALCOHOL ADDICTION" IN SAMPLES OF ALCOHOLICS

Percentages Reporting Occurrence of Specified Symptom at All*

SYMPTOM, with number assigned in Jellinek (1952):	JELLINEK(1946) U.S. Male, AA	TRICE AND WAHL (1958)		JACKSON (1958) Seattle Male, Mixed Sources	GIBBINS (1962) Toronto Male, Clinic Inpatients	Cantor (1967) Los Angeles Male, Domiciliary	MULFORD-WILSON (1966)		PARK (1962a) Finland Male, Mixed Sources	GLATT(1961) Eng.Mid-Cl. Hospzd.	
		AA	Non-Wisconsin AA-Hos. Male				Iowa and Minn. M&F Hospzd.	Cedar Rapids M&F Domicil.		Male	Female
(N)	(98)	(119)	(133)	(269)	(330)	(150)	(435)	(88)	(806)	(192)	(77)
Increase in tolerance	-	-	-	81	97	-	67	48	-	77	71
1.Blackouts	92	93	72	85	84	80	79	50	86	78	65
2.Surreptitious drkg.	93	-	-	71	86	-	64	26	69	68	70
4.Avid drinking	-	-	-	75	-	-	85	53	-	73	58
7.Freq.Blackouts	-	85	53	77	-	55	-	-	74	61	51
8.Loss of control	100	98	91	-	96	75	79	44	87	86	86
11.Fin.extravagance	82	-	-	82	72	-	-	-	84	74	49
12.Aggres.behavior	61	-	-	43	-	-	-	-	71	47	34
Solitary drkg	89	82	83	60	89	78	-	-	75	75	86
Daytime drunks	87	96	89	82	-	90	72	39	-	75	61
13.Persis.remorse	93	-	-	86	92	-	-	-	88	85	94
14.Wtr.Wag.Abs.	84	-	-	92	88	-	-	-	-	81	70
15.Control attempts	77	-	-	53	78	-	-	-	55	43	56
16.Drop/lose friends	72	-	-	48	-	-	-	-	42	38	27
17.Quit/lose job	58	-	-	64	-	-	-	-	57	51	21
24.Unreas.resentmnts.	71	-	-	58	68	-	-	-	-	64	47
25.Protect alc.supply	80	81	75	61	81	-	64	26	65	55	65
27.1st hospitalizn.	62	-	-	46	-	-	-	-	29	64	62
30.Reg. A.M.drinking	94	96	88	87	94	74	74	28	89	86	83
31."Benders"	91	87	83	87	86	72	67	28	86	71	45
37.Loss of tolerance	-	71	65	68	-	63	-	-	49	60	56
39.Tremors	93	92	80	81	90	89	-	-	89	75	64
43.Rationalizations fail	100	-	-	79	-	-	-	-	80	78	77
Admits defeat/ others	93	-	-	71	-	-	-	-	74	57	71

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* Recalculated where necessary from original figures. Calculated only for reported symptoms which are near equivalents of Jellinek's 1952 symptoms, except that a few symptoms from his 1946 list which have been used in other samples are added.

Table 2

MEAN DIFFERENCE BETWEEN AGE OF FIRST "LOSS OF CONTROL" AND AGE AT ONSET OF SPECIFIED SYMPTOM, IN VARIOUS SAMPLES OF ALCOHOLICS

	Mean Differences in Years*							
	JELLINEK (1946) U.S. Male, AA	TRICE AND WAHL (1958) Wisconsin Male		WELLMAN (1959) U.S. Male, Former Sanatorium patients	GIBBINS (1962) Toronto, Male Clinic Inpatients	PARK (1962a) Finland Male, Mixed Sources	GLATT (1961) England Middle-Class Hospitalized	
SYMPTOM, with number assigned in Jellinek (1952):		AA	Non-AA Hos.				Male	Female
(N)	(98)	(119)	(133)	(554)	(208)	(806)	(192)	(77)
First drink	-	-17	-20	-	(-13)	-12	-16	-22
First drunk	-9	-16	-19	-	-12	-	-14	-11
Increase in tolerance	-	-	-	-	(-2)	-	-3	-4
1.Blackouts	-2	-6	-7	-	0	-2	-4	-4
2.Surreptitious drkg.	-2	-	-	-	-1	-6	-2	-4
4.Avid drinking	-	-	-	-1	-	-	-3	-4
7.Freq.blackouts	-	-2	-3	-	-	0	-1	-4
8.Loss of control	0	0	0	0	0	0	0	0
11.Fin.extravagance	0	-	-	-	0	-4	0	-5
12.Aggressive behavior	4	-	-	-	-	-3	0	-2
Solitary drinking	4	1	0	-	2	-2	0	-3
Daytime drunks	3	0	0	-	-	-	-2	-3
13.Persistent remorse	5	-	-	-	2	3	4	0
14.Water-wagon-Abstainer	3	-	-	-	1	-	2	-2
15.Control attempts	5	-	-	-	4	3	1	4
16.Drop/lose friends	2	-	-	-	-	1	-1	-7
17.Quit/lose jobs	3	-	-	-	-	-1	1	-4
24.Unreas.resentments	6	-	-	-	4	-	2	-2
25.Pro. alcohol supply	5	1	2	6	4	0	3	-2
27.1st Hospitalization	9	-	-	-	-	5	6	1
30.Regular a.m. drkg.	2	-1	-1	3	1	-2	1	-3
31."Benders"	4	-1	-1	0	-1	-1	1	-3
37.Loss of tolerance	-	2	2	8	-	6	4	1
39.Tremors	5	3	2	4	3	1	3	0
43.Rationalizat. fail	11	-	-	9	-	6	7	4
Admits defeat/others	12	-	-	10	-	5	7	3
Present age	16	12	9	-	(c16)	12	11	6
Actual mean age of "Loss of control"	27.6	35.0	37.1	-	31	28.8	34	42

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*See Footnote to Table 1

Table 3

TIME-ORDERING OF CRUCIAL SYMPTOMS, IN FOUR SAMPLES OF ALCOHOLICS

Percentages time-ordering the symptoms in Jellinek's ordering*

	JELLINEK (1946) U.S. Male, AA	TRICE AND WAHL (1958) Wisconsin Male AA | AA | Hospzd.	GIBBINS (1962) Toronto Male Clinic In-Patients with Abstaining Parents	PARK (1967) Finland Male, Mixed Sources
(Approx. N)**	(98)	(252)	(98)	(686)
a. Reporting Listed Item Later than Blackouts:				
Loss of Control	72	77	-	64
Morning Drinking	-	77	-	52
Benders	93***	83	41	-
Tremors	95***	78	-	74
b. Reporting Listed Item Later than Loss of Control:				
Morning Drinking	82***	57	56	35
Benders	90	69	44	59
Tremors	95	78	69	53
c. Reporting Listed Item Later than Morning Drinking:				
Benders	82	43	-	80
Tremors	-	78	-	72
d. Reporting Tremors Later than Benders:				
	61***	73	-	47

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*Recalculated where necessary from the original figures. Base for percentages is those giving a different date of onset for the two items being compared; thus, those not reporting the occurrence of one or both items, and those reporting their onset in the same year, are excluded.

**The base for each percentage is diminished from this figure as specified above.

***The base here also excludes a few cases with what Jellinek terms "rare and anomalous orders."

assumptions of that conception. The results of that reanalysis suggest that the classical presentation of the disease model by Jellinek (1952) would need very substantial loosening and alteration to match empirical realities.

This lack of good fit with the realities experienced by alcoholics themselves, even those involved in Alcoholics Anonymous, raises the question of why the Jellinek phaseology nevertheless became so popular, becoming one of the most widely diffused artifacts of the alcoholism movement. The primary answer to this question is that the phaseology filled a glaring need. The early ideological entrepreneurs of the disease concept as a governing image of alcohol problems (e.g., Anderson, 1942, 1945) had left quite open the issue of what kind of disease alcoholism was, beyond the general statements that the alcoholic could be helped and that alcoholism was, beyond the general statements that the alcoholic could be helped and that alcoholism was a public health concern. Such a "black box" disease concept may have been adequate for general public relations purposes, but begged obvious questions even for sympathetic medical audiences. The claim for disease status had sooner or later to be lent verisimiltude by a description, in as precise and exact terms as possible, by a medically competent authority, of the clinical course of the disease. Jellinek only marginally qualified as a competent authority in medical eyes, although he had previously published on psychiatric nosology (e.g., Jellinek, 1939). But his 1952 description came cloaked with the institutional prestige of a World Health Organization committee. And in terms of circumstantial detail, the phaseology appeared as definitive and conclusive as a description of smallpox or rabies. The relative lack of challenges to its spurious exactitude may have resulted from a combination of prejudices and special interests. Those with direct experience of alcoholism, and thus in a position to challenge the phaseology, were usually more interested in buttressing than undercutting the disease concept. For those on the outsdie, the phaseology's problems, and by the phaseology's family likeness to an older and more familiar ideological artifact, the temperance movement's phaseology of the "drunkard's progress" (Lender and Karchanapee, 1977).

CHAPTER 6. The Epidemic as Governing Image

Governing images of alcohol problems as an epidemic or contagion tend to have been associated in the recent past with discussions of control and prohibition strategies rather than with discussions of the social handling of individual cases. Even in such discussions, the image leads a somewhat evanescent existence, appearing in the language chosen and assumptions made rather than in full explication. No doubt the alcohol literature's skittishness about the epidemic model reflects its "neo-prohibitionist" connotations. It is in the current drug literature that epidemic imagery can be found in an unselfconscious and explicit form. For a detailed consideration of the structure of contemporary epidemic conceptualizations as governing images, therefore, it is necessary to switch attention to contemporary literature and thought on opiate problems. In discussing the social and ideological context of epidemic imagery in a later chapter, we shall return to the alcohol as well as the opiate literature.

The concept of "epidemic" clearly carries with it a whole agenda of assumptions about the nature of the reality it seeks to comprehend, but these assumptions are not often spelled out in the drug literature. The primary exception to this seems to be the work of Jaffe and various associates at Illinois prior to Jaffe's appointment as Nixon's drug "czar". Following his appointment, Jaffe wrote an essay (1973) laying out explicitly the very practical implications of adopting a particular governing image, using the concept of "contagion" as his examplar. In various articles in which Hughes is the first author, the Illinois researchers have described sustained attempts to take seriously and follow out to their logical programmatic conclusions some of the assumptions of the epidemic model (e.g., Hughes, Crawford and Barker, 1971; Hughes and Jaffe, 1971; Hughes, Senay and Parker, 1972; Hughes, Barker, Crawford and Jaffe, 1972; Hughes and Crawford, 1973).

As we have noted, an epidemic model explicitly invokes a disease conceptualization. Thus, it shares with other types of disease models a number of general implications, already noted above, about the nature of the phenomena to be thus characterized. While the epidemic disease model, as we shall discuss, tends to focus attention towards social and ecological patterns and away from individual propensities, it paradoxically tends to run against the implication of most disease models by not carrying a specific exoneration of the "patient."[8] Historically, often there was some feeling of culpability of the affected persons in an epidemic; cholera, for instance, was widely thought in the nineteenth century to be a manifestation of the immoral living habits of the poor (Rosenberg, 1962). At the least, in the great public health campaigns of the past, the question of individual culpability for becoming sick was simply swept aside, and public health laws are still the primary example of laws which can impose very severe de-facto penalties (e.g., quarantine) without the constitutional protections (e.g., against search and seizure) which would be applicable where culpability is at stake. In some more recent campaigns, culpability is in fact assumed. The hero of Ibsen's Ghosts may not have been responsible for his condition; but public health campaigns on venereal disease tend, in spite of a cover of rhetoric, to reflect medical and general attitudes that venereal diseases are an example of poetic justice for willful moral crimes. Venereal disease campaigns are usually seen as the most direct precedent for an epidemic model of drug use, and are cited by Hughes and co-workers as the exemplar on which their efforts are modeled. Unlike disease models in general, then, an epidemic disease model at most side-steps the issue of the "patient's" culpability and, in fact, often carries with it an odium of willful behavior. Particularly when, as for venereal disease and drug addiction, the disease involved is seen as being associated with the voluntary enjoyment of forbidden pleasures, an epidemic model tends to carry with it a justification of the most draconian measures against the moral degenerates harboring the disease, for the protection of the still uncorrupted. In these circumstances, an epidemic model assumes that the balance between the rights of those affected and the rights of all other parties is tilted very heavily against those affected.

Besides implications about the nature of phenomena, disease conceptualizations in general carry implications about the social processing of the phenomena. The most obvious of these is that the phenomena, whatever their nature, fall within the jurisdiction of medical ideologies. Classically, a disease is something to be cured, controlled or prevented, rather than ignored, encouraged, mandated, forbidden or substituted for. A disease is something to be processed by a therapist or therapeutic team with legitimized authority over the processing. Ideologically (although not always practically), the eradication of disease is a moral imperative; calling something a disease is not only labelling it undesirable and abnormal, but also issuing a call for action against it. As we have noted, optimistic — and activistic — pragmatism is the characteristic clinical style. Applying a disease concept to human behavior is thus a classical tactic of "moral entrepreneurs": for instance, calling something a "cancer within the body politic" so automatically invokes this moral imperative that it is unnecessary to add "which must be cut out." As Jock Young implies (1971), clinical perspectives on human behavior slide very easily into a stance of moral and social absolutism. The very idea of tolerating or accepting something which is viewed as a disease is shocking.

Besides these general implications of any disease model, an "epidemic" or "contagion" model also carries implications specific to the model, which are often in contrast with alternative disease models. To start with, when applied in the drug field, "epidemic" and "contagion" are characterizations of change in a set of human behaviors, specifically in the use of particular drugs. The terms are used to refer to particular kinds of change: to increase rather than decrease in use, and to increase in the form of initiation of new users rather than to increased use or other changes in use by old users. The terms are, of course, explicitly placing the behaviors referred to under the rubric of disease entities, which in clinical thought tend to be something you have or don't have, rather than a dimension which you have more or less of (see Chapter 3 above). So, when we speak of an epidemic, we are usually speaking of a pattern of occurrences rather than a pattern of intensification or modifications.[9] Applying "epidemic" or "contagion" to a pattern of increasing use, then, concentrates attention on the question and process of initiation into use (see Hughes and Crawford, 1973 and de Alarcon, 1969), more or less to the exclusion of consideration of other kinds of changes in use — intensification, modification, diminution, cessation — and of stability of use. Epidemic models are not normally applied to phenomena which are seen as relatively stable in their overall rates — like alcohol problems — even if the stable overall rate conceals a great deal of initiation and remission at the individual level.

Hughes, Jaffe and coworkers have recognized quite explicitly the contrasting views of the nature of drug-using behavior implied by a mental illness versus a contagion model:

> The evidence presented in this paper suggests that the incidence of heroin addiction can follow the course of contagious diseases, fluctuating from periods of epidemic spread on the one hand to relatively quiescent periods on the other. The application of a contagious disease framework to the study of heroin addiction suggests . . . a need to shift emphasis from

> the psychological characteristics of "diseased" individuals to the specific mechanisms of spread. . . . Planners appear to treat mental illness as an epidemic disorder with fairly stable incidence and prevalence rates for a given community over time. . . . The incidence and prevalence of a contagious disease, on the other hand, may vary greatly from community to community and from year to year in the same community. . . . Community mental health programs are not expected to control mental illness. While the mental health system does detain emotionally disturbed individuals who disrupt the community, it does not seek out the mentally ill and coerce them into treatment. Contagious disease programs, however, have a clear mandate for disease control. Protection of the general public from exposure to and infection from actively diseased individuals requires that they be coerced into treatment should they refuse help voluntarily. This notion of coercive treatment is alien to the tradition of community mental health workers (Hughes, Barker, Crawford and Jaffe, 1972, p. 1000).

The epidemic model is traditionally applied in situations of great urgency and gravity. The quotation above accurately conveys the spirit of this heroic tradition of epidemiological intervention efforts. What is missing, however, is any recognition of the fact that the efforts are not equally heroic for all infectious diseases. The degree of heroism in the efforts, in fact, seems to vary according to a regular calculus of the risks involved in catching the disease, including: (a) the probability of death or irreversible and debilitating damage; (b) the probability of chronic impairment; and (c) the probable span of time affected by an ill-effect (so that child's death is more shocking than an old person's).

Medical ideology, and particularly epidemiological ideology, tends to be avowedly activist and oriented to the heroic: every epidemiologist carries in his or her knapsack the handle to the Broadstreet pump; the moral imperative to prevention is so strong that the fact that there are differentiations in our commitment of energies between preventing rabies and preventing warts is often not noticed. But, in fact, public health efforts to combat syphilis were less strenuous in the heyday of penicillin than either before that time, or since the increase in resistant strains.[10] It is clear, as the Marihuana Commission points out, that differentially severe contagions receive and merit different kinds of prevention action (National Commission on Marihuana . . ., 1973, pp. 271-2).

As the quotation from Hughes et al. emphasized, a contagion model is implicitly in contrast with other disease models of drug use, notably the "mental illness" model of psychological dependence currently in the ascendant in the drug literature. Dependence notions emphasize chronicity, and focus on characteristics of the individual and on the psychological loading to be put on behavior. The process of transmission — the effective accessibility of the drug — is taken for granted; the research question concerns individual differences in susceptibility.

Contagion notions emphasize change, and focus on behavior itself and the ecological and sociometric patternings of behavior. Individual susceptibility is taken for granted ("It's so good, don't even try it once" — Smith and Gay, 1972); the process of transmission is the focus of interest. For contagion models, the drug-using behavior itself tends to be regarded as the "seat" of diseases; for dependence models, the behavior is at most an indicator of an entity "seated" in the individual's will. Other disease "seatings" are also available, though currently out of fashion for the opiates. Long-term physiological consequences may be regarded as the "disease" to be prevented, as with cigarette smoking; or long-term social consequences, as is often the case with the homeless alcoholic on skid row. Each of these disease models has a different set of interpretations to bring to bear on the data; as also, of course, do the various alternative non-disease models.

The emphasis of the contagion model on the transmission process brings it into the arms of several subdisciplines of sociology. The diagrams of Hughes and Crawford (1973) and of de Alarcon (1969) are essentially a variety of sociometric chart. Discussions of social contagion processes traverse the same territory as differential association theory. Classical diffusion research in sociology (Rogers, 1962) tended to make the assumption that all innovations studied were universally desirable and took as its problem overcoming the recalcitrance of the potential adopters. This is now matched by a style of research in diffusion of drug use that assumes the universal undesirability of the innovation and takes as its problem negating the susceptibility of the potential adopters. By directing attention to transmission processes and to factors external to the affected individual's self, the epidemic model focuses upon essentially sociological data. But though they share a conceptual territory, the sociologist and the clinically-trained epidemiologist are likely to have small patience with each other's disciplinary paradigms, and radically different approaches to the data and interpretations of its meaning are likely to result.

As we noted, governing images of drug use like the epidemic model are more frequently invoked than examined; the models are usually seen as setting the agenda for research rather than as forming part of the substance of the research. It is still rare to find the various alternative models for the same field of behavior defined explicitly in contrast to one another, and even rarer to find their relative predictive strength subjected to empirical testing. Yet clearly the different images cannot all be equally faithful to reality all the time, and to the extent they can be operationalized, the models can and should be tested for their relative goodness of fit to various kinds of empirical data. Hirschi's landmark study, Causes of Delinquency (1972), provides a precedent in its testing of the evidence for three different sociological models of delinquent behavior.

The testing of an epidemic model on empirical data is hampered by the fact that the model does not specify expectations for many aspects of the data. Is it an epidemic of drug use in general or of use of a particular drug (or a particular mode of administration — O'Donnell & Jones, 1968) that is to be tested for? Does an epidemic end in return to previous patterns or can it include a pattern of a permanent rise in usage? If there is a fall in rates, is this to be attributed, as Hughes et al. do, to a "delayed community response," or to the epidemic's burning itself out?[11] There are many historical examples of tendencies to self-limitation in hazardous or impulsive human behavior. Since the "seriousness" of the behavior, either in its own right or in its implications for the future, seems to be an important part of the epidemic model, to what extent can we operationalize and test for the seriousness of particular patterns of behavior?

Even when the problems of measurement can be solved, the empirical evidence will not, of course, conclusively settle which governing image, if any, best fits any particular circumstances and behaviors. The evidence will still be subject to varying interpretations, and will be viewed by conflicting ideological parties as a weapon for their dispute rather than as an Occam's razor for determining the truth. But we must at least hope that, in the long run, the piling up of relevant empirical data will have its effect on the governing images with which we view alcohol and other drug use.

CHAPTER 7: Ambivalence as a Governing Image of Alcohol Problems

The Problem to be Explained

It has long been recognized that there are cultural differences in rates of alcohol problems. The exact standing of particular societies is often a matter of dispute (Room, 1972a), and the cultural differences often vary according to the particular alcohol problem examined (Walsh and Walsh, 1973), but the existence of cultural differences is an undoubted "social fact." A wide diversity of explanations of cultural differences has been offered. In fact the explanations often have outrun the available data: at least six different theoretical explanations have been based on essentially the same worldwide compilation of ethnographic data (Stull, 1975). Explanations of data from industrialized societies have been less codified into a single tradition, but are no less diverse: even climatic theories can be found in the current literature (Lynn, 1971).

Although on such indicators as per-capita alcohol consumption and cirrhosis mortality the U.S. falls in the middle range of reporting countries, cultural explanations of alcohol problems in American alcohol sociology tend to have been oriented around the assumption that the problems of alcohol are especially severe in the U.S. In this tradition, the presumed especial severity of American alcohol problems then becomes the problem to be explained. The explanation offered has been in terms of norms: something is wrong with American norms about drinking, and this defect produces the alcohol problems. With considerable consistency, the defect that has been identified in the norms has been their "ambivalence." In this chapter, we shall examine the function of ambivalence as a governing image in the alcohol sociology literature and in the parallel case of Parsons' theory of deviance, and consider the possible meanings of the term and its potential empirical measurement, while questioning its usefulness as a general-purpose explanatory concept.

The argument that American drinking norms explain a presumed high rate of drinking problems is by now effectively an establishment position in "alcohology," having appeared in publications deriving from the influential Cooperative Commission on the Study of Alcoholism (Plaut, 1967; Wilkinson, 1970), and having been argued repeatedly and with considerable emphasis by the former director of the federal alcoholism agency (the National Institute on Alcohol Abuse and Alcoholism), Dr. Morris Chafetz (Chafetz and Demone, 1962; Chafetz, Demone and Solomon, 1962; Chafetz, 1967; Chafetz, 1970a). A formal submission by Chafetz to Congress can serve as a useful summary of the general line of argument:

> The rate of alcoholism . . . has been shown to be low in groups whose drinking-related customs, values, and sanctions are widely known, established, and congruent with other cultural values. On the other hand, alcoholism rates are higher in those populations where ambivalence about alcoholism is marked. Apparently, the cultures which use alcohol but have a low incidence of alcoholism, people drink in a definite pattern. The beverage is sipped slowly, consumed with food, taken in the company of others—all in relaxing, comfortable circumstances. Drinking is taken for granted. No emotional rewards are reaped by the man who shows prowess of consumption. Intoxication is abhorred. Other cultures with a high incidence of alcohol-related problems usually assign a special significance to drinking. Alcohol use is surrounded with attitudes of ambivalence and guilt. Maladaptive drinking, drinking without food and intoxication are common . . . . Ours is a Nation that is ambivalent about its alcohol use. This confusion has deterred us from creating a National climate that encourages responsible attitudes toward drinking for those who choose to drink (Chafetz, 1971, pp. 3-4).

The adoption of this position is a rare example of the direct — if unacknowledged — influence of sociological thought on public policy. Chafetz' statement should be compared with the hypothesis advanced by Albert Ullman over a decade earlier:

> . . . in any group or society in which the drinking customs, values, and sanctions — together with the attitudes of all segments of the group or society — are well established, known to and agreed upon by all, and are consistent with the rest of the culture, the rate of alcoholism will be low. Conformity to the drinking standards is supported by the total culture. However, under conditions in which the individual drinker does not know what is expected or when the expectation in one situation differs from that in another, it can be assumed that he will have ambivalent feelings about drinking. Thus ambivalence is the psychological product of unintegrated drinking customs (Ullman, 1958, p. 50).

In stating his hypothesis, Ullman in turn explicitly drew upon the work of a number of sociologists including, besides Ullman himself, Bales (1946), Straus and Bacon (1953), Snyder (1958) and Skolnick (1958). The studies where norms were an explicit part of the analytical agenda revolved around case studies of prototypical cultural patterns of alcohol use, conceived partly with the programmatic objective of shedding light on the sociocultural etiology of alcoholism in the United States. Rather as Ruth Benedict (1934) had done in Patterns of Culture, clear-cut cultural prototypes were chosen in these studies — the Jews as the prototype of moderate drinking with little alcoholism (Bales, 1946; Snyder, 1958), the Irish as the prototype of a high-alcoholism group (Bales, 1946), the Mormons as the prototype of an abstinent group (Straus and Bacon, 1953), the Methodists as a traditionally abstinent group whose traditions were increasingly honored in the breach (Skolnick, 1958).

As Riesman et al. found in discussing Patterns of Culture with students (1950, p. 260-271), coherently-organized cultural descriptions are indeed very suggestive for characterizations of the large polymorphous society which is the half-hidden element in the analytical agenda — but they can suggest somewhat different characterizations to different people. A comparative perspective is only fully effective against ethnocentric assumptions when both sides of the comparison are based upon careful and detailed analysis. But while descriptions of American drinking practices are by now a well-established tradition, general characterizations of U.S. norms concerning drinking have been relatively rare, and descriptive and analytical studies even rarer (Room, 1975). Ullman was indeed avowedly tentative: "the amount of information available to us in the field is much less than necessary for validation of theories of causes of alcoholism. What has been described in this article represents a beginning in a kind of research that looks most promising" (Ullman, 1958, p. 54). To fill in the missing ideal type, the general American population, he was forced back, in the absence of supportive empirical data, on a characterization by Bacon, in Bacon's own words "clearly oversimplified and often without sufficient data," of "the United States American of the northeast quarter of the nation — Protestant, middle-class, urban, white, from Anglo-Saxon background of three or more generations in this country":

> The social functions of drinking are rather vaguely and somewhat defensively described; they concern drawing people, both family members and also complete strangers, together, often for purposes of 'fun,' often to allow relaxation from (rather than as [for Orthodox Jews] closer adherence to) moral norms. There is only an archaic symbolism for drawing man closer to deity and this refers to such a specialized situation that it is not even considered to be 'drinking.' The rules and procedures are on occasion rather specific, but also show enormous variability so that a given individual may follow one set of rules with his family, another with business or professional associates, and a third on holiday occasions and show even different patterns when away from the home town.

> Sanctions for violations are extremely irregular, ranging from accepting laughter to violent physical attack. Parents, employers, priests, physicians, and other agencies of sanction are most uncertain sources, both in formal statement and in actual behavior, many of them avoiding the issue whenever possible. The custom shows marked variations by segments and subsocieties of the group; again adults, men, and wealthy persons tend to drink more frequently. Some, however, do not drink at all, use of alcohol by women and children is suspect, and certain occupations are ordered not to drink at all (although acceptance of this sort of rule is surely irregular).
>
> The custom is generally learned between the ages of 15 and 20 and accompanies the time of the troublous diminution of parental controls (as contrasted to [learning from infancy among Orthodox Jews]). Sometimes the learning stems not from parents, ministers, physicians, elders, and teachers but from other adolescents, sometimes on trains, in cars, or in commercial places. The custom is not significantly entwined with family and religious institutions, although there may be one set of drinking practices related to the family. There is great emotional feeling about the problem on the mass level as well as by individuals, feeling that has run rampant for generations. Activating the custom, especially by the young, is often attended with feelings of guilt, hostility, and exhibitionism and may occur as a secretive practice insofar as parents or employers or elders are concerned (Bacon, 1957. See also Bacon, 1943, pp. 414-429).

Bacon's characterization is a perceptive and thought-provoking statement, containing sufficient implied hypotheses for a generation of research. It is not, however, backed with any particular empirical research — of the four ideal-type characterizations in Bacon's article, it is the only one without a footnote.

In Ullman's article, the greater part of the Bacon characterization we have reprinted was quoted, although Ullman omitted some of the details on variation in customs, so that the sense of indeterminancy of norms is somewhat heightened.

But the omissions were immaterial in Ullman's argument, since Bacon's characterization served Ullman simply as his exemplar of "unintegrated drinking customs."

In Ullman's argument, then, the master theme was cultural integration, and specifically integration of drinking customs, as the crucial cultural factor in the etiology of alcoholism. The theme of general cultural integration linked the argument to the grand tradition of arcadian social thought, adding alcoholism to the long list of social problems which have been viewed as disorders of a complex industrial society. The best-known application of this theme to alcoholism in the sociological literature remains Selden Bacon's "Alcohol and Complex Society " (1945), but the motif continues to the present (see Snyder, 1964 and Stivers, 1971, pp. 322-326). The implications for meliorist social policymaking of this generalized arcadian theme are, of course, pessimistic, and this more general theme in Ullman's discussion has notably not been picked up by Chafetz and other policy-oriented discussions. It is the emphasis on integration of drinking norms which has found resonances outside the sociological literature, and which concerns us here.

The Convergence in Explanation

If we examine the incidental characterizations of U.S. drinking norms which can be found scattered through the sociological literature on alcohol, we find that Ullman's rubric of lack of integration of drinking norms does indeed describe a broad area of agreement. On the exact nature of the lack of integration there is considerably less agreement, but there is a curious convergence on the terms chosen to describe it — pre-eminently, the word used is "ambivalence," although in some discussions "confusion," "inconsistency" and "conflict" appear by its side or in its stead.

The very wide range of interpretations in which ambivalence has been invoked can perhaps best be conveyed by some selected quotations. We have already quoted Ullman's identification of ambivalence as the product in the individual psyche of a lack of norms or segmentalization of norms on drinking behavior. Lemert also saw ambivalence as existing in the individual psyche, but interpreted it as lying in the individual's double interpretations of behavior while drinking:

> A marked ambivalence [of] attitude and opinion concerning the proper place of alcohol in social life . . . in part . . . stems from an awareness that satisfactions brought by imbibing alcohol not infrequently have a spurious quality. What seemed to be love to the intoxicated maiden turns out in sober retrospect to have been sex exploitation. The comradeship of the college reunion in afterthought is seen realistically as largely inspired by the martinis rather than by common interest long gone. A more important ingredient of this ambivalence towards alcohol comes from the perception of its previously mentioned function as a behavior modifier. Modifications in human behavior brought by intoxication are socially and personally destructive as well as socially integrative (Lemert, 1962, pp. 554-5).

Other writers have located the ambivalence rather at institutional and cultural levels. Thus Stivers presents the ambivalence as lying in the contradictions between the specialized institutions of an industrial society:

> Modern society fosters a profound ambivalence toward drinking, especially hard drinking. As a technique of leisure and integration it is tolerated if not encouraged. However, insofar as hard drinking thwarts the end of technology — efficiency — it must be discouraged. Advertising on behalf of the liquor industry incites people to drink heavily while public information representing the interests of agencies for alcohol control dissuades the mass from drinking. To the extent that the liquor industry falls under government control, the state is both advocating and discouraging hard drinking (Stivers, 1971, p. 323).

Among discussions of ambivalence as a cultural factor, a common motif has been the association of the ambivalence especially with the rise of the temperance movement. This was explicitly stated by Abraham Myerson, who in 1940 most notably introduced the term into the alcohol literature. Myerson saw the ambivalence as residing in the existence of conflicting cultural trends, one of them — hedonism — innate and biologically determined, and the other —asceticism — "at least on the surface" unnatural, whose rise was an "extraordinary" historical phenomenon: "these two trends — hedonism and asceticism — create an ambivalence of human attitude and opinion of extraordinary importance for the social historian and the social psychologist and are particularly relevant to the understanding of the controversies that rage around sex and alcohol" (Myerson, 1940, p. 13). Thorner (1953, p. 171) viewed the ambivalence as occurring rather in the mind of the individual "ascetic Protestant" in the prohibitionist tradition, caught between "Protestant inhibitions and personality ideals" and the attraction of "social drinking" with its "ease and informality of personal relations implicit in friendship." "Even to contemplate violation of [sobriety] norms is simultaneously a temptation and a stimulus to moral reproach." While Straus and Bacon also saw temperance sentiments as the source of "confusion" and "inconsistency," their interpretation was more in terms of a cultural lag between old norms and new behavior:

> At the present time American drinking practices and attitudes — and the philosophies and programs for meeting the problems associated with drinking — can still be summed up in one word: confusion. Drinking practices themselves have been undergoing marked change for a century. However, social responses to them have continued to be based on philosophies stemming from practices and problems common to the period 1700 to 1840. . . . For the majority of

> Americans at this mid-point in the century there is still a great deal of inconsistency, unreality, and both moral and intellectual uncertainty connected with drinking (Straus and Bacon, 1953, pp. 34, 35).

For Pittman, on the other hand, ambivalence reflects not historical survivals, but still lively value conflicts; in

> Ambivalent Cultures . . . there is conflict between co-existing value structures. . . . Probably in the American society one finds the prototype of the ambivalent culture. The American cultural attitudes toward drinking are far from being uniform and 'social ambivalence' is reinforced by the conflict between the drinking and abstinent sentiments co-existing in many communities (1967a, p. 8).

The virtual unanimity in the use of the term ambivalence in characterizing American drinking norms seems to be arrived at independently rather than the result of a cumulative tradition. Explicit discussions of the term elsewhere in sociology, such as that by Merton and Barber (1963), are nowhere referenced, the usage of the term varies from one author to another, and the few cross-references for the term within the sociological alcohol literature are invariably to the original Myerson article (Verden, 1968) and often involve drastic reinterpretation (Lemert, 1962, p. 554) or outright misinterpretation of it (Pittman, 1967a, p. 9). A variety of other terms are available to cover the rather varied territory this term has been used to cover — conflict, dissonance, dilemma, inconsistency, incongruity, disjunction, contradiction, are but a few of the possibilities. The convergence on the use of the term seems, then, to be due neither to cumulation nor to accident, but rather to the exigencies of particular analytical perspectives of American sociologists, sharing a common hidden agenda of explanatory strategy.

Ambivalence as a Logical Necessity

As we noted at the outset, the term appears in a context assuming that there is an especially severe or widespread alcoholism problem to be explained. The sociological literature reinterpreted the problems of alcoholism as forms of deviance from social norms, but by and large accepted the clinical perspective of alcoholism as a phenomenon — a disease — defined at the individual level and without a normative order of its own. At least with reference to American society, the possibility of the existence of positive norms of approval for heavy drinking has not been contemplated in the literature (Stivers, 1971 for a recent exception concerning Ireland), except perhaps for the tight little enclave of Skid Row. The perspective on norms has been essentially Hobbesian — norms are the sanctions which constrain the inherent impulses of the individual and prevent the war of each on each. Thus, though Mizruchi and Perrucci (1962) and Larsen and Abu-Laban (1968) explicitly set up the category of "prescriptive norms," what they mean by this is the "Jewish" pattern of prescribing light drinking but proscribing heavy drinking.

Given this perspective on norms as acting only to hold down potentially disruptive behavior, there are essentially two choices for an explanation of deviance in terms of general cultural norms: either the norms do not exist at all, or for some reason they fail to "work." The theme of the absence of norms as an explanation of alcoholism rates has a lengthy history in sociological studies of alcoholism, stretching back almost to Durkheim (Snyder, 1964). In Bales' typology of functions for drinking, the problematic type — "utilitarian drinking" — is the type where an absence of social constraints allows free play to individualistic desires. "There is little reason to doubt that the utilitarian attitude toward drinking, if commonly held, is the one of the four types which is most likely to lead to widespread compulsive drinking. There is no counter anxiety attached to the process of drinking in this case, and there is every suggestion for the individual to adopt drinking as the means of dealing with his particular maladjustment. The prevalence of this attitude in the culture of the Irish, along with widespread inner tensions, seems adequately to explain their high rate of alcoholism" (Bales, 1946, pp. 275-276). In line with Bales' analysis, there has been a consistent tendency in surveys of drinking to tag "individualistic," "personal effects" reasons for drinking as problematic, and to assume that social reasons for drinking are not (see Riley, Marden and Lifshitz, 1948; Mulford and Miller, 1960; Knupfer et al., 1963; Cahalan, Cisin and Crossley, 1969; Jessor et al., 1968). The same implicit reasoning underlies Mizruchi and Perrucci's discussion of "permissiveness" (1970, pp. 248-250), and Larsen and Abu-Laban's invention of "nonscriptive norms" (Larsen and Abu-Laban, 1968; Abu-Laban and Larsen, 1968).

As this lively tradition shows, the absence of norms is at least a viable mode of explanation of deviance in terms of the limited social milieux of particular individuals or small aggregates. But at the level of "social facts," explanations in terms of an absence of norms raise some awkward problems. One problem is the fundamental question of whether an absence of norms is a logical possibility in continuing social interaction, or whether it is a negation of the definition of norms. Suicide was perhaps a unique territory of deviance for the doctrine of anomie, since the act itself broke off the possibility of future continuing interaction, and thus neutralized the effectiveness of any sanctions. Another problem is that, with a Hobbesian perspective, the history of a society with no drinking norms should presumably be nasty, drunk and above all short. It is presumably with this problem in mind that Pittman noted that his typological category of the "Over-Permissive Culture," "permissive toward drinking, to behaviors which occur when intoxicated, and to drinking pathologies," "is a polar type of cultural attitude which exists only in part, never in entirety" (Pittman, 1967a, pp. 5, 10).

In addition, any explanation of alcoholism in America which focusses on an absence of norms fits rather awkwardly with obtrusive social facts. It is hard to conceive of a society in which about one-third of all arrests are for drunkenness as having abandoned social controls over drinking. The existence of social constraints on drinking in America is likely to become obvious to anyone who has tried to get a drink in a bar on Sunday, to carry a bottle onto a schoolyard, to show up drunk as a track-and field contestant, or to take a drink while acting as a teller in a bank. Further, an explanation of American drinking problems in terms of lack of norms would tend directly to imply one or another form of temperance perspective. Given their period in American history, in the aftermath of the repeal of Prohibition, and given their social background and status, modern American sociologists have consistently regarded such perspectives as anathema; in explanations of a special American drinking problem, then, the temperance tradition had to be regarded more as a special cause of problems than as a potential cure. But apart from their generally civil libertarian and wet proclivities, sociologists have shared in the conventional post-Repeal interpretation of the temperance movement, and Prohibition in particular, as an excrescence on the American body politic, an unnatural "noble experiment" confirming sociology's wise Sumnerian saws. By the most generous sociological interpretations, the Prohibitionists were sadly out of tune with their times (Bacon, 1967), or engaged in symbolic rather than pragmatic politics (Gusfield, 1963).

By the logic of their assumptions and the experience of their epoch, then, sociologists of the last thirty years who sought to explain American drinking problems in terms of characteristics of the culture as a whole were impelled to an explanation not in terms of normlessness but in terms of norms which didn't work. Normative man, like economic man in economic analyses, acts rationally in ordinary circumstances. Thus he responds with compliance to the sanctions implicit in norms unless something special enters the situation to disturb it. For a norm not to "work," then, something must "go wrong" either with him or with the normative situation. This kind of thinking impelled Keller to view the occurrence of social sanctions against an individual's drinking as an indicator of alcohol addiction — if the threat of the sanctions had not worked, something must have destroyed the individual's rationality, made him "lose control" of his drinking (Keller, 1962, p. 316).

Explanations at a national or cultural level of high rates of drinking problems in terms of genetic or biological factors are not in much favor these days, particularly with sociologists. Therefore, sociological explanations were bound to focus on factors which interfered with the working of the "natural" normative situation. Since the drunkard's career as a drunkard is considerably longer than the suicide's as a suicide, the explanation had to be in terms of a long-term and continuous interference: the continuance of the deviance had to be explained, as well as its genesis.

To this set of explanatory requirements, the term ambivalence presents an attractive solution. First, the term draws attention away from the content of norms or values and places the emphasis on the fact of a conflict of values. The onus for the existence of the resulting problems is implicitly placed on whichever side of the conflict is seen as a disturbance of the natural state. This implication can be seen in Myerson's discussion. Thus the existence of temperance sentiments are to some degree held responsible for the severity of alcoholism problems in the United States. This implication has fueled a search for an especially high rate of drinking problems among temperance groups in the U.S. (Skolnick, 1958; Seifert, 1972; Cahalan and Room, 1974), a search which is usually represented as successful although the rates on the total group —when abstainers are included in the base — have invariably been lower than in other groups (see discussion in Cahalan and Room, 1974, Chapter 8 and Makela, 1975). The focus away from the content of the norms means that the problems can even be seen as arising from the conflict of two sets of constraining norms.

Secondly, the term "ambivalence" carries a connotation not of momentary or occasional occurrence, but of continuation in time. Freud originally popularized the term in connection with conditions rather than events — taboos, obsessional neuroses, and conscience (Freud, 1950, pp. 29, 35, 68-68). In the social psychological literature, the term has primarily been used in the context of relationships where there is an extraneous "glue" holding the ego and alter together — such as leader and follower in a totalitarian movement (Gibb, 1954, pp. 906-907) or master and apprentice (Merton and Barber, 1963, pp. 92-93). Thus Merton and Barber note that "the norm prescribing a continued relationship" between a professional and a client "provides a basis for the accumulation of ambivalence" (p. 110).

In the third place, the term carries a connotative freight, deriving from the psychotherapeutic literature, of an especially excited and potentially explosive state, where irrational behavior is to be expected.[12] Thus Freud speaks of the "immense expenditure of mental energy" arising from ambivalence (1950, p. 66), and Gibb notes that the "conception of ambivalence suggests the explosiveness of the leader-follower relation" (Gibb, 1954, p. 907).

These three connotations of the term all contribute to its attraction to sociocultural explanations of the existence and continuation of alcoholism, viewed as an individualistic deviant phenomenon. The irrationality explains why the constraining norms don't "work," the continuity explains why there are deviant careers — why an initial negative sanction does not bring the deviant into line — and the de-emphasis of the content of norms tends to turn temperance sentiments into part of the problem rather than a potential part of the solution.

In essence, then, our argument is that, given a societal model with only two levels, the individual and the whole system, and given an assumption that norms operate only to constrain individual deviant behavior, an explanation of the occurrence and continuation of deviance which is not completely individualistic — i.e., in terms of an inherently defective deviant individual — must be made in terms of a repeated defective social interaction involving the norm — an explanation for which ambivalence provides a convenient and apparently supraindividual and explanatory rubric.

A Parallel Case: Ambivalence in Parsons' Theory of Deviance

This argument can be elucidated by an examination of an analogous but apparently independent analytical situation, Talcott Parsons' analysis of the genesis and maintenance of deviance from the "stably established interactive process" in the microsocial system of ego and alter (Parsons, 1951). Parsons' analysis has the virtue of laying out explicitly the assumptions and analytical perspectives which are left hidden in the literature we have been examining — of spelling out, as Alexander Pope might have put it, "what oft was thought but ne'er so nakedly expressed."

Parsons' starting situation is a system with two levels of aggregation, ego and alter as individuals, and a system of norms between the two, operating to constrain both ego and alter's behavior — "they are sensitive to each other's attitudes, i.e., attitudes are fundamental as sanctions" (p. 252) — so that both are in "conformity" (p. 254). The desired mode of explanation of deviance is in terms of social interaction rather than of internal psychology: "Our primary interest is not in the internal integration of the personality but in ego's adjustment to social objects and to normative patterns" (p. 253). To make such an explanation, Parsons needs to posit that an initial "disturbance is introduced into the system" so that established norms fail to operate (p. 225). "This failure . . . places a 'strain' on [ego], that is, [it] presents him with a problem of 'adjustment'" (p. 252). Parsons notes that one possible result is a "successful learning process" whereby ego "learns to inhibit [sic] his need-disposition," breaks off relations with alter, or "extinguishes or alters" the violated value-pattern (p. 252). The possible result of "alter abandoning his changed behavior" is also mentioned. Perhaps since these results are not very helpful as a paradigm for explaining the occurrence and continuance of deviance in a stable society, they are mentioned and then essentially dropped from the argument. Parsons continues: "but another outcome is possible, and in many cases very likely. That is that a 'compromise' should be reached. . . . Ego must have some reaction to the frustration which alter has imposed upon him, some resentment or hostility. In other words the cathectic orientation acquires an ambivalent character, there is still the need to love or admire alter, but there is also the product of his frustration in the form of negative and in some sense hostile attitudes toward alter. . . . Ego is put in an emotional conflict in his relation to alter. Similarly, . . . ego may develop an ambivalent attitude-structure, at the same time adhering to the normative pattern and resenting the 'cost' of this adherence" (p. 253).

Parsons goes on to describe "two fundamental alternatives" in "handling the strains inherent in such an ambivalent motivational structure" (p. 253). One, mentioned in passing, is for ego to "find a way to gratify both sides of his ambivalent motivation" (p. 253), an avenue of analysis to which we shall return. The other, on which Parsons concentrates his attention, is, "repression of one side of the ambivalent structure so that only the other side receives overt expression" (p. 253). Depending on which side is repressed, the result is "compulsive conformity" or "compulsive alienation." "The psychological reasons for using these terms are not far to seek. The essential point is that ego is subject not only to a strain in his relations with alter, but to an internal conflict in his own need-disposition system." With compulsive conformity, "he must 'defend himself' against his need to express his negative feelings"; with compulsive alienation, he must "be doubly sure that the conformative element does not again gain the upper hand. . . . This defense against the repressed component is in both cases the primary basis of resistance against the abandonment of 'symptoms,' even though they involve ego in serious negative sanctions in his social relationships" (pp. 254-5).

These quotations from Parsons illustrate the extent to which the term ambivalence serves as a false social-interactional front on what is an analysis rooted essentially inside the individual mind. Ambivalence may indeed be a product of social interaction, but it is a property of the individual mind, and a description of its qualities quickly resorts to the language of psychopathology. Underneath the ambivalent motivational structure we find the mad actor tearing at the social walls:

> It is well-established that, if the relevant need-disposition has not been fully extinguished, it will tend to find some outlet, however indirect . . . . Normally a considerable instability in the object-cathexes and motivational imputations [is] involved. This seems to be the most important basis for the existence of what is often called 'free-floating' affect. . . . The common feature is the fluidity and instability of the cathexis. In turn the urgency of the need for cathexis may lead to a compulsive intensity of

> the cathexis once achieved, the very intensity of which, however, is a symptom of its instability. . . . In general it comprises the cases where the affective intensity can be shown to be 'overdetermined' relative to any intrinsic significance of the object (p. 266).

Parsons' analysis of the cumulation of an initial deviance into a deviant career — what he calls "the well-known vicious circle in the genesis of deviant behavior patterns, whether they be neurotic or psychosomatic illness, criminality or others" (p. 255) — is in terms of "the interaction of complementary ambivalences in the motivational systems of ego and alter" (p. 256). This analysis imparts a further social interactional flavor to the analysis, but it is difficult to see, in the light of the description of the ambivalent state quoted above, why just one ambivalence-crazed actor would not suffice.

In Parsons' analysis of the genesis of deviance, then, we contend that the term ambivalence is called into play by the same logical problems which faced the alcohol literature: the need for a normative explanation — one appearing to be at the social level — of deviance as a continuing and thus eventually "expected" state in an analysis which does not contemplate the existence of countervailing, directly deviance-encouraging norms. Ambivalence functions in the arguments as a kind of end-point in the regression of causes: since it is by its nature a state which fosters irrational action, we need not seek any further for a rational or functionalist explanation of the deviant's behavior. For both the alcohol sociologists and Parsons, the term ambivalence had the further virtue of putting an implied onus on the disturbing factor in what is assumed to be the natural situation — if there were no temperance movement in one case, if there were no "alienative need-disposition" in the other, there could not be any ambivalence, and presumably all would be sweetness and light.

Logical Necessity versus Empirical Reality

The burden of our argument concerning the general characterizations of American drinking norms, then, is that their nature was dictated by the structure of ideological assumptions within which the characterizations were made.[13] As essentially ideological statements, the characterizations did not really invite empirical testing; while there have been a number of empirical studies of American drinking practices and problems, there have been no large-scale studies specifically directed at American drinking norms. As Mendelson commented, "most reports of drinking practices in relationship to sociocultural factors are anecdotal or reportorial in nature with little or no real assessment of the phenomena which are deemed crucial. It is, therefore, premature to amalgamate some global generalities of drinking practices of a given cultural or ethnic group with inferences of attitudes about drinking practices of the same group and conclude that the two are causally related." (Mendelson, 1970, p. 369).

Perhaps the clearest example of the imperviousness of the general characterizations to empirical testing can be found in Straus and Bacon's classic and seminal empirical study of Drinking in College. On the basis of the kind of argument reproduced from that book above, the authors clearly indicate they had expected to find "confusion" in the attitudes of their sample of students (p. 171). Just as clearly, they recognize that they failed in general to find what they expected. Instead of facing the possibility that their earlier general characterization might need some modifications, however, the authors back off into a series of post-hoc explanations of why their empirical results need not be taken seriously:

> In the various measures of opinion and attitude which we have examined there appears to be a fairly high degree of consistency between the student's own drinking behavior and his interpretation of the degree of drinking which he would

> prescribe for others. . . . The findings do not reveal the expected degree of confusion between overt practice and attitude which has been described as common to drinking behavior in American society. . . . It is possible that students, either because of a higher than average intelligence level or because as a generation they escaped the full force of the conflict about national Prohibition, are better able than some to evaluate behavior and attitudes in this area realistically. Furthermore, they have not yet been subjected to the highly emotional impact of adult responsibilities. They are not for the most part parents or church leaders. They do not occupy positions of responsibility in the community. In short, they do not fill certain types of roles which would be apt to conflict morally with their personal drinking practices. And it should be remembered that while there is a surprising consistency of behavior and attitudes of college students on the intellectual level, this consistency does not always extend to those aspects of the custom which are most highly charged with emotion (Straus and Bacon, 1953, pp. 184-5).

Pscyhological Ambivalence as an Explanation of Action

Our attention has been focussed so far on the internal logic of a general line of sociological argument, directed at showing the near inevitability of a term like ambivalence being brought into play once a particular set of assumptions had been made. In the light of this, it is worth considering what empirical evidence could reasonably be considered as indicative of social ambivalence, and what would be the explanatory significance of such a finding.

The denotative meaning of ambivalence is, of course, quite straightforward — Merton and Barber define it as "the experienced tendency of individuals to be pulled in psychologically opposed directions, as love and hate for the same persons, acceptance and rejection, affirmation and denial" (Merton and Barber, 1963, p. 94). As we have already noted, however, there are a wealth of alternative terms which cover this straightforward denotative meaning, and it is in its connotations that the distinctive qualities of ambivalence as a term are to be found. We have already noted the connotations of a continuing state rather than a momentary occurrence and of an especial excitation and potential explosiveness. These connotations, we would contend, arise out of the special and limited range of circumstances in which the term was generally used in the psychotherapeutically-derived literature; and it is not permissible to assume that these connotations are carried with the denotative meaning if the term's range of coverage is extended beyond that original type of social interaction and its analogues.

The primary use of the term has been for a particular class of interpersonal relationships: those where there is a very strong "glue" holding ego to alter, e.g., strong primary "needs" are gratified by alter; and where the power in the relationship, including the power to constrain ego's mode of expression, is all with alter. Within the relationship, the emphasis in discussions of ambivalence is on the workings of the mind of the powerless one. Thus the prototype of ambivalence is the slave's feelings towards a kindly master; the archetypal relationship in the psychotherapeutic discussions of ambivalence is the child's feelings towards the parent in a strongly hierarchical nuclear family. Freud proposed, concerning the origins of "emotional ambivalence," that it "was acquired by the human race in connection with their father-complex, precisely where the psycho-analytic examination of modern individuals still finds it revealed at its strongest" (1950, p. 157). As classically described, then, ambivalence does not arise in the reciprocal relationship described in Parson's discussion, and is not the result of a disturbance entering into the relationship, but rather is a consequence of the particular nature of the relationship. Ambivalence is not a property of both members of the relationship but specifically of the powerless member. Ambivalence, as actually used, might be more exactly defined as opposed feelings toward the powerful in the powerless member of a relationship, when the powerlessness is legitimated and internalized, and includes constraint of the expression of negative feelings.

Although the term does not appear in its index, then, Miller and Swanson's Inner Conflict and Defense is predominantly concerned with the classical territory of ambivalence, in its emphasis on "inner conflict" in children's minds and their parents' child-rearing methods. The perspective of this testing of Freudian-derived theory with the methodology of sociological surveys helps shed some light on the notion that a showing of ambivalence is a final explanation of deviance. In the first place, the authors start from an assumption diametrically opposed to those in the literature we have been considering: "each of us experiences inner conflict many times a day" (1960, p. 3). In line with this perspective, ambivalence is a starting point for the research effort, rather than a final explanation: "because conflict is ubiquitous and decisions can be so important, each man develops his own characteristic method of defining the alternatives and of choosing among them. Even casual observations readily reveal considerable variations in individual reactions to incompatible impulses" (p. 3). Rather than being a unitary black-box explainer of what is otherwise inexplicable, ambivalence thus results in a typological series of alternative "defense mechanisms" and "expressive styles," which are subjected to explanation in terms of sociological variables such as social status and characteristics of the parents' interactions with and controls over their children. Implicit in this analysis is the idea that manifestations of ambivalence vary greatly and are at least partly socially determined, and that, while according to a given universalistic criterion they may appear irrational, they do not lack an internal and situationally-defined logic.

In our view, then, even in the classical territory of ambivalence as we have described it, Talcott Parson's characterization of its results, quoted above, begs rather than answers questions. The lurid light which the term ambivalence is taken as casting on proceedings is even more in question if the term is extended, as it commonly has been in the sociological literature we have been quoting, to cover any conflict of ideas or feelings, including, for instance, the description in Merton and Barber of the alternation between affective neutrality and compassion in the demeanor of the doctor towards the patient. If ambivalence is used to cover any conflict in feelings, values, or ideas, then — as in the original formulation by Bleuler (1911, pp. 43-44, 305-306)[14] — it becomes merely a descriptive and not in any sense an explanatory term. An explanatory power derived from psychotherapeutic connotations in a restricted class of relationships cannot legitimately be attributed to the extended usage. Yet both Parsons and the alcohol literature we have been examining use the word ambivalence in the extended meaning, but assume the relevance of the explanatory tradition based on the restricted meaning. Thus Ullman's usage, in the hypothesis we quoted at the start of this discussion, is explicitly in the extended meaning — ambivalence is seen as the "psychological product" of "conditions in which the individual drinker does not know what is expected or when the expectation in one situation differs from that in another." Yet the hypothesis is based on the presumption that such an ambivalence is a necessary and sufficient explanation — or at least the invariable symptom of a necessary and sufficient explanation — of a high rate of alcoholism.[15]

With a lack of any clear set of restrictions on the usage of the term, ambivalence became essentially a conceptual cover for modern variations on the ancient classicist theme of unity and the integrated life, a perennial asthetic ideal with aristocratic and academic audiences, but also in the last two centuries associated with left utopian thought. In line with this ideal, behind the doctrine of ambivalence lies the idea that all conflict of ideas, values, or feelings is strain-producing,[16] that is, that it tends, if there is no strong "glue," toward a change to a univalent resolution. This is, of course, the basic starting-point of Festinger's theory of cognitive dissonance: "in the presence of an inconsistency there is psychological discomfort. . . . Cognitive dissonance can be seen as an antecedent condition which leads to activity oriented toward dissonance reduction just as hunger leads to activity oriented toward hunger reduction" (Festinger, 1967, pp. 347-8). Now there is some room for doubt whether Festinger's hypothesis can be regarded as a human universal. Irony and complexity are alternative aesthetic criteria to the ideal of classic simplicity in Western art, and in Jungian expositions of the persona and Goffman's master image of life as the self-conscious playing of roles, we see intimations of double levels of action as an everyday reality. Certainly in the literature of skid row alcoholics one finds intimations of their "failure" being a failure at the normal juggling-act of competing roles (Park, 1962b; Connor, 1962). Beyond this, the concern with consistency may be a Western, and particularly an American theme.

Furthermore, as Osgood points out, "Festinger's theory fails to give explicit recognition to the fact that if cognitive elements are to interact, they must be brought into some relations with one another. . . . We have varying attitudes toward myriad people, things, and events, many of them potentially incongruent, imbalanced, or dissonant as one's theory would have it, but these cognitions are not continuously interacting — only when they are brought together in some way" (Osgood, 1960, p. 362). The strain is defined by the mind of the ambivalent one, not by the definition of the observer. In survey data, a majority of San Francisco males thought it was OK for themselves to get at least high in a bar with some friends, but not OK for them to have more than one or two drinks as a father playing with his children (Room and Roizen, 1973). By Ullman's standard this would constitute ambivalence ("when the expectation in one situation differs from that in another"), but there is room for doubt that the respondents would consider it so, and the amount of strain holding the two standards at once puts upon their minds may well be minimal.

Even if we accept Festinger's starting hypothesis, however, that conflicts of ideas, values and feelings will produce a strain toward resolution except to the extent there is a resistance to the resolution, the existence of strain cannot in itself be taken as constituting a prediction of the exact form of the resolution. Festinger notes that resolutions can include changing one's own behavior, changing one's environment, and erecting a rationalization — "adding new cognitive elements" — that reduces the felt ambivalence (pp. 353-4). We might add, that the ambivalence may be reduced or neutralized by effective role segregation — or, in psychotherapeutic language, by a variety of mechanisms such as projection, sublimnation, etc. Hamlet reminds us that ambivalence has traditionally been regarded as a cause of paralysis perhaps more than as a spur to action.

It is our contention, then, that the extended meaning of ambivalence can be useful as description if properly specified, but does not of itself explain anything about human behavior, including deviance. To some minds, incongruity may appear more "natural" than congruity. Even if congruity is the "natural" state of mind an incongruity implies strain only to the extent that the incongruous elements are brought together to interact, and are subjectively — rather than in the opinion of an observer — incongruous. Even if the incongruity does produce strain, there are many methods of handling the strain — including a process of rationalization that by some means reconciles the two formerly incongruous but still unchanged elements.

In its extended meaning, then, ambivalence is directed at the question of the interaction of ideas, values or feelings when simultaneously held by the same person. If we turn the assumptions of the ambivalence literature into hypotheses, dimensions which would demand empirical exploration for any given pair of potentially incongruous attitudes in any given subject would include:

—the actual extent of incongruity experienced by the subject;
—the potential for experienced incongruity under specified changes in circumstances for a given subject;
—the subject's tolerance of (or preference for) incongruity of the given type;
—the subject's characteristic mechanisms for dealing with incongruity of the given type;
—situational factors influencing incongruity of the given type.

Only with answers to such questions would we be in a position to hazard a prediction of degree and nature of a motivation to action resulting from the simultaneous adherence to two apparently incongruous attitudes. This is, of course, a large analytical agenda; pending its completion, it is worth keeping in mind the lively possibility that direct motivations at the individual and social level are more important in explaining deviance or problems than the interplay between conflicting motivations.

Ambivalence at Aggregate Levels

So far we have been considering only "psychological ambivalence," that is, ambivalence rooted explicitly in the individual mind. The alcohol literature raises implicitly the question of the relation between ambivalence at the individual level and ambivalence at aggregate levels: "ours is a Nation that is ambivalent about its alcohol use," as Chafetz stated it in the initial quotation in this paper. What does it mean to talk about ambivalence at the aggregate level, and what is the relationship between individual and aggregate level ambivalence?

The sociological literature is no help in answering these questions. Merton and Barber expend considerable energy in erecting a "sociological theory of ambivalence" which "refers to the social structure, not to the personality": in their view, sociological ambivalence refers to "incompatible normative expectations" in an individual's status-set or role-set (1963, pp. 94, 95). "Sociological ambivalence . . . is in the social definition of roles and statuses, not in the feeling-state of one or another type of personality" (p. 95). Yet it is clear that what is sociological about Merton and Barber's analysis is the emphasis on the social etiology of ambivalence: however ambivalence is caused, they still regard it as fundamentally a property of the individual mind. The clearest indication of this is in their exposition of "a fourth kind of sociological ambivalence," which discusses "contradictory cultural values held by members of a society." "As long as these value premises are widely held and not organized into sets of norms for one or another role in particular, they can be regarded as cases of cultural conflict" (p. 98). It is only when the values "are so organized" into sets of role-norms that Merton and Barber are willing to attach the label of "sociological ambivalence."

Both Parsons and Merton and Barber regard role and status conflict for an individual as the primary social factor in psychological ambivalence, although Parsons has no analogue to Merton and Barber's term, "sociological ambivalence":

> Sociological ambivalence is one major source of psychological ambivalence. Individuals in a

> status or status-set that has a large measure of incompatibility in its social definition will tend to develop personal tendencies toward contradictory feelings, beliefs, and behavior (Merton and Barber, 1963, p. 95).

> Exposure to role conflict is an obvious source of strain and frustration. . . . What, on the interaction level if not the fully developed social role level, is exposure to conflicting expectations of some kind may be presumed to be the generic situation underlying the development of ambivalent motivational structures with their expression in neuroses, in deviant behavior or otherwise (Parsons, 1951, p. 282).

Though these are certainly plausible hypotheses concerning psychological ambivalence in its extended meaning of double-perception, their relevance to the core psychiatric type of psychological ambivalence as organizer of action is dubious. Ambivalence toward the parent in the young child does not seem to require alternative role-sets to flourish; indeed, it could be argued that the very lack of alternate legitimated roles for the child is one of the sources of the explosive qualities attributed to this type of ambivalence. Unlike Merton and Barber, Parsons recognizes a distinction along these lines between ambivalence and role conflict:

> When, however, the element of conflict is present on the level of institutionalized role-expectations, a further element is introduced which can be of great significance. The fact that both sides of the conflicting expectations are institutionalized means that there is the basis for a claim to legitimacy for both patterns. As distinguished then from alienative need-dispositions which are clearly stigmatized by the moral sentiments common to ego and alter, and later, hence, are the foci of feelings of guilt and shame, there is the possibility of the justification of the alienative as well as the originally conformative motivation (p. 282).

However, he regards this "as a factor in the intensification of internal conflict," calling "for greater pressure to resort to defensive and adjustive mechanisms"

(p. 282). While this is a testable proposition, it seems a rather unlikely one: if the conventional response of segregation of roles and audiences is for the moment unavailable, the sequel seems more likely to be vague unease and embarrassment rather than explosion, since there are by definition socially acceptable courses of action available in a situation of role conflict.

"Sociological ambivalence," as defined by Merton and Barber, then, raises questions about the social patterning and determination of ambivalence as a property of the individual mind, but does not explicitly contemplate the possibility and meaning of ambivalence at supraindividual levels. The nearest approach to such a conceptualization is the discussion of their "fifth type of sociological ambivalence," which subsumes into the ambit of sociological ambivalence Merton's famous conceptualization of anomie and the attendant literature: the type "is found in the disjunction between culturally prescribed aspirations and socially structured avenues for realizing these aspirations. It is neither cultural conflict nor social conflict, but a conflict between the cultural structure and the social structure. It turns up when cultural values are internalized by those whose position in the social structure does not give them access to act in accord with the values they have been taught to prize" (p. 98). Since this passage is somewhat ambiguous about the level of aggregation at which the ambivalence is "seated," we must examine Merton's discussions of anomie for elucidation. A consideration of the anomie literature will also be useful to our present purpose since it has been a major arena for sociological attempts to face the problems of level of aggregation.

Before doing so, it may be helpful to state more systematically the nature of the distinction we are concerned with. As Selvin and Hagstrom (1963) and other discussions of the relation between classes of data and levels of aggregation indicate, there are two fundamental types of possible characteristics of an aggregate: a characteristic which is a parameter of characteristics of the units composing the aggregate, and a characteristic which is intrinsically a property of the aggregate, and not defined by the characteristics of the member units. A state law, a zoning classification, a family income, are inherently properties of a collectivity and not of the individuals composing the collectivity, although of course the individual's membership in the collectivity and the fact of the group characteristic's application to him as a member are related properties of the individual.

Anomie or ambivalence as collective "facts" — properties of a collectivity — may therefore be defined two ways: as a parameter of the distribution of some trait of individual "anomia" or ambivalence, or as a property of the collectivity which bears no necessary relation to the existence of traits in the individual members of the collectivity. As an example, suppose we define group anomie as a disruption of normative expectations in social interactions so that "nothing is taken for granted" — all social interaction is held to a minimum, and the necessary minimum is conducted literally or figuratively at gunpoint. This is, then, a supraindividual property which can be measured in a "population" of social interactions in, say, a given city block as our collectivity of interest. Now it is clear that a condition of anomie so defined could vary directly with the proportion of individuals on the block with an equivalent individualistic "anomia" — an individual trait disposing them towards violent exploitativeness in social interactions. But it is also clear that the condition of anomie could arise without *any* such anomic individuals being on the block — a rumor, for instance, that a putatively insane murderer was coming into the neighborhood might produce the same effect of collective anomie.

Conversely, it is possible to conceive of situations in which all the individuals might usefully be defined as exhibiting individual "anomia," without an equivalent anomie as a property of the collective. In short, by this viewpoint, the relationship between a property of the collective defined at the collective level and a property of the collective defined as a parameter of the individual members becomes a matter for useful research rather than for assumption.

It is clear that Merton fundamentally conceived of anomie as he defined it as a property of the social system, but defined as a parameter of individual anomias. Defending himself from the charge by Albert Cohen that his theory was basically "atomistic and individualistic," Merton quotes from his own writings several passages in which the process of the genesis of anomie is considered in terms that do not treat the individual as shut off "in a box by himself," but rather envision a kind of snowball or contagion effect as a result of social interaction. However, Merton's outline of the process involved leaves it clear that for him a rise in the degree of anomie is defined by the cumulation of anomic individuals:

> The men most vulnerable to the stresses resulting from contradictions between their socially induced aspirations and poor access to the opportunity structure are the first to become alienated. Some of them turn to established alternatives (Cloward's illegitimate opportunity-structure) that both violate the abandoned norms and prove effective in achieving their immediate objectives. A few others actually innovate for themselves to develop new alternatives. The successful rogues — successful as this is measured by the criteria in their significant reference groups — become prototypes for others in their environment who, initially less vulnerable and less alienated, now no longer keep to the rules they once regarded as legitimate. This, in turn, creates a more acutely anomic context for still others in the local social system. In this way, anomie, anomia, and mounting rates of deviant behavior become mutually reinforcing unless counteracting mechanisms of social control are called into play (Merton, 1965, p. 235).

In line with this perspective, Merton's exposition of the form of prototypical empirical analysis of the relation of anomie and deviant behavior introduces characteristics defined at an interactional level only in the form of differential association, which is seen only as having "mediated" "the pressures of [the] collectivity" (p. 238), and preserves throughout as a measure of the collectivity's "anomie" the percentage of anomic individuals. "Measures of anomia for individuals in a given social unit . . . can of course be aggregated to find out the rate or proportion having a designated degree of anomia. This aggregated figure would then constitute an index of anomie for the given social unit" (p. 229).

Apparently, then, in Merton's view anomie is as much a parameter of a phenomenon seated at the individual level as are the other types of ambivalence with which he and Barber classed it. In our view, on the other hand, anomie and cognate concepts can usefully be defined as a collective phenomenon in terms of "seating" at several different levels of aggregation—for instance, in terms of the proportion of anomic individuals, of the proportion of anomic social interactions, of the existence of anomic subgroups within the larger collectivity, and of anomic characteristics of the collectivity per se. We do not contemplate a one-to-one relationship between anomics defined in terms of these different levels of aggregation, even though all are characteristic of the whole collectivity; the relationship between them is a matter for empirical testing.

Conceptualizing ambivalence at aggregate levels is a more complicated matter than conceptualizing an aggregate anomie. For Durkheim, at least, anomie is marked simply by the absence of a normative order, while ambivalence requires the simultaneous presence of two normative orders experienced as conflicting. The possibility arises that the level of aggregation in which the orders are experienced as conflicting may differ from the level of aggregation of the normative orders. Thus some discussions of American ambivalence toward alcohol identify as the conflicting normative orders the temperance movement and the "wets," both of which are subaggregates of the total society, and neither of which are necessarily seen as themselves ambivalent. The ambivalence resulting from the conflicting normative orders is seen by some writers (e.g. Pittman, 1967a) as a property of the society as a whole.[17] Others view it instead as a property of the individual minds of the large subaggregate of the population who are not committed to either the wet or the dry viewpoint—who are, as Dwight Anderson put it, "sitting in the bleachers" (1945, p. 357). Thus Verden settles on an interpretation of Myerson's "social ambivalence" as meaning "that simply the mutual presence of opposing views on the subject within American society creates a potential ambivalent condition for those members of society who remain uncommitted to one side or the other" (1968, p. 253). For Ullman, ambivalence appears instead as the manifestation in the individual mind, presumably of all members of the culture, of a "lack of integration of drinking customs" at the societal level. Further plausible conceptualizations of ambivalence at aggregate levels could be propounded without much difficulty; for instance: ambivalence in the legal order: A state-imposed levy of one cent per gallon on wine until recently supported the efforts of the California Wine Marketing Board, while the state at the same time imposed restrictions on the hours, places and price of sale of wine; ambivalence as an inconsistency between the collective "official morality" and personal sentiments: as in Warriner's classic account of the Kansas community in which people "vote dry and drink wet" (Warriner, 1958).

Even more than for psychological ambivalence, then, ambivalence at the aggregate level as an explanatory concept tends to raise more issues than it resolves. At least until a basic groundwork of conceptualization and data is laid, it might be well to adopt the solution Verden contemplated, that "the phrase 'social ambivalence concerning alcohol' should be discarded on the growing pile of worn cliches" (1968, p. 252). For by the time the researcher has made the specifications and conditions we would argue are necessary before ambivalence is useful as an explanatory concept, the theory will be sufficiently well articulated to dispense with the concept of ambivalence altogether.

CHAPTER 8 : The Social and Ideological Environment of Governing Images

In the preceding chapters we have presented and critically examined three particular governing images of alcohol and drug problems. Examining their assumptions and implications has underlined the diversity of possible and actual action models within the overall rubric of disease, while shedding light on the logical structure of argument of particular positions on the handling of intractable problems. But, to avoid a static and overly idealistic analysis, consideration of the internal structure of particular governing images must be matched by an attention to their interaction with the social realities which they seek to organize. However arbitrary they may appear, governing images are not arbitrarily formed — they represent a response to particular social facts interacting with the historical experience of their advocates and adherents. To the extent a governing image is successful in organizing the handling of an intractable problem, it also has real and independent effects on the social facts.

As seen here, thus, a governing image is formed out of preexisting experience and assumptions, but comes to have an independent effect on subsequent events. The nature and structure of the governing image chosen in a particular situation is to a large extent determined by the historical circumstances and the position of the chooser. The clearest exemplification of this is the recurrence of particular governing images in separate but similar historical circumstances. Thus Christopher Hill has traced the recurrence of various forms of the myth of the "Norman Yoke," as an appeal against the pretensions of the English crown and nobility to the ancient liberties and rights of an Anglo-Saxon golden age, in every significant upswelling of English radicalism for six centuries:

> The theory of the Norman Yoke can be traced from the [thirteenth century] London burgher's Mirror of Justices — the first timid protest

> from "the underworld of largely unrecorded thinking" — till the days of Gladstone and beyond. Its life roughly coincided with the rise and expansion of capitalist society. It originated to criticize the institutions of medieval society. It was a rallying cry in the English Revolution. When the battle for parliamentary reform began again in the late eighteenth century, the Normal Yoke once again did service. It declined when the Third Estate was no longer united, Chartism and socialism ultimately taking its place. Its last whimper,appropriately, comes at the most radical moment [1911] of the last liberal government' (Hill, 1964, pp. 121-122).

As often in such circumstances, it is not always clear whether a particular proponent was aware of earlier versions of the theory or was engaging in an independent invention; but in either case, the theory was used as a governing image of the nature and legitimacy of state power which fitted the logic of argument of a particular position in particular historical situations.

Ambivalence as a Governing Image of Alcohol Problems

In the preceding chapter, we have already suggested some of the historical and ideological circumstances for which the governing image of ambivalence was a logical solution.

(1) The invocation of the image depended in the first place on a perception that alcohol problems in the U.S. and other cultures identified as "ambivalent" were especially severe. As Bacon stated it, "it would appear eminently safe to assert . . . that the United States in the twentieth century is among the nations exhibiting more problems related to alcoholic beverages than would a mythical average country. There is some evidence to suggest that this country is one of the most severely affected" (Bacon, 1952). The perception in turn depended on the dominance of an image of alcohol problems in terms other than straightforward consumption or cirrhosis mortality levels — for in international

comparisons based on these available indices the U.S. made only a mediocre showing. Thus the ambivalence image tended to presuppose a social-disruption or an addiction model of alcohol problems. The assumption that U.S. alcohol problems were especially severe also drew on the tradition of arcadian argument that alcohol problems are especially severe in a "complex society" such as the U.S. — an argument made persuasively by Selden Bacon in a widely-distributed lecture (Bacon, 1945).

The assumption of an especial severity for U.S. alcohol problems made the ambivalence argument especially attractive in the context of official agency rhetoric. "Problem enhancement" — the presentation of the intractable problems over which a social agency has charge in the most dramatic and wide-ranging terms — is commonly seen by agency officials as a political necessity to justify current budgets and to compete for future allocations. A governing image which assumes problems are severe and, as we have argued, tends to cast them in a lurid light, fits congenially in a context of problem enhancement. Thus the presentation of the ambivalence image in the "Introduction" to the 1971 NIAAA Report to Congress follows a variety of problem-enhancing statements: of alcoholism as an "iceberg problem," with only "3 to 5 percent" of those suffering from it in the "visible population . . . on skid row"; of a "price of $10 billion" in industrial losses each year from alcoholism; of a "highway carnage" from alcohol-involved auto accidents which "has snuffed out 28,000 lives in 1 year" (National Institute. . . , 1971). In the report of the Liaison Task Panel on Alcohol-Related Problems to the President's Commission on Mental Health (1978), the ambivalence image is again invoked, partly in the classical form presented in the preceding chapter, and partly as an explanation of why there has been a presumptively insufficient societal response to the "enormity" of U.S. alcohol-related problems as they are enumerated in the report.

(2) The image assumes the natural "wetness" of mankind, and identifies the temperance movement as the disturbing condition which resulted in an especial severity of alcohol problems. Identification of the temperance movement as bearing a responsibility for American alcohol problems reflects general currents of libertarian and academic thought in the 1940's and 1950's: the temperance movement was regarded as discredited in the wake of Repeal, and characterized in the sociological literature as fanatic, regressive, simplistic and racist (Lee, 1944).

An imagery which tended to blame the temperance movement for alcohol problems may also have had an especial appeal for the alcohol sociologists at the Yale Center for Alcohol Studies. The Center saw itself as self-consciously pursuing a "scientific approach to the alcohol problem" (Jellinek, 1945a). The rubric of science had also been a stock-in-trade of temperance movement rhetoric, and the new Center found itself in the somewhat uncomfortable position of being embraced by the temperance movement: the majority of students at the Center's initial Summer School of Alcohol Studies, in 1943, were temperance workers, and the Center's most important publication, Alcohol, Science and Society, was widely distributed gratis by temperance organizations.[18]

In the following years, the Yale Center moved in a number of directions antagonistic to the temperance movement, including a study critical of temperance movement domination of alcohol education in the schools (Roe, 1943); a study of drinking in college proposing that colleges can aid "our society to achieve a . . . better integrated morality concerning drinking and its related problems" (Straus and Bacon, 1953); and a study asserting the irrelevance of alcohol control systems to alcohol problems and alcohol consumption (Bacon and Jones, 1963). By the late 1940's and 1950's, the work of the Center was being hailed by a scientific writer close to the distilleries' public-relations organization[19] (Hirsh, 1949) and attacked by temperance organs (see Jellinek, 1960, pp. 174-178, for a quotation and exegesis on a 1958 temperance attack). In the postwar political and academic environment, a theory of the genesis of alcohol problems which tended to place the onus on the "drys" rather than the "wets" was politically wise as well as congenial to libertarian sympathies.

In its public career, notably during Morris Chafetz' five-year tenure as Director of the National Institute on Alcohol Abuse and Alcoholism, the ambivalence image has been clearly associated with a "wet" alcohol policy, as expressed in the campaign for "responsible drinking." Under Chafetz' successor, Ernest Noble, the adoption of a drier line was signalled by the shift to the slogan, "responsible decisions about drinking," intended to include as a possible choice the decision not to drink.

(3) As noted in the last chapter, the ambivalence image assumes that alcohol problems are a result of deviance in the individual rather than at collective levels. The emergence of the ambivalence image in sociological thought about alcohol coincided with a general retreat from structural interpretations of alcohol problems in American society, and in particular with turning a sociological blind eye to institutional and cultural supports for heavy drinking.

In the heyday of the Temperance Movement scholarly analysis of alcohol problems had paid considerable attention to systemic factors maintaining alcohol problems. In its emphasis on legislative action, on the saloon as a fount of social evil and on the machinations of "liquor trusts," the Temperance Movement itself had for many decades promoted a systemic view of alcohol problems. Under the impetus of temperance agenda-setting, but with a clear divergence in viewpoint, sociologists and other social scientists employed by the brahmin Committee of 50 to Investigate the Liquor Problem had made careful observational studies of the social functions and problems associated with the saloon (Calkins, 1901; Moore, 1897; Melendy, 1900; 1901) and detailed studies of alcohol's role in social problems (Koren, 1899). Social scientists were prominent in the flurry of scholarly studies of alcohol policy surrounding the Repeal of Prohibition (e.g., Feldman, 1927; Warburton, 1932; see Levine and Smith, 1977). In his comprehensive initial approach to sociological studies of alcohol, Selden Bacon (1943), the premier sociologist of the "new scientific approach," took a quite structural view of drinking patterns and problems, although apparently at that time with little contact with earlier sociological work.[20] Reflecting the earlier, structurally-inclined tradition, Lee and Lee's (1949) textbook on Social Problems in America included four readings on alcohol problems, all couched in terms of policy and cultural factors.

Despite these landmarks, sociological studies of drinking behavior and problems were relatively rare prior to the 1950's. In the 1950's a number of studies were published, many of them by students of Bacon, and a Committee on Alcoholism of the Society for the Study of Social Problems was established.[20] The most prominent landmark of this flurry of activity is the still unsurpassed compendium of alcohol sociology, Society, Culture and Drinking Patterns (Pittman and Snyder, 1962). Included within this volume were a number of studies which implied a supra-individual source for alcohol problems, notably including Simmons' anthropological report (1962) on high ambivalence about alcohol in a culture with well-integrated drinking behavior and widespread drunkenness, explicitly presented as a partial challenge to Ullman's ambivalence hypothesis. Both Clinard's (1962) and Bruun's (1962) papers in this volume discuss group factors in the promotion or maintenance of heavy drinking or alcoholism.

Nevertheless, in this period the dominant sociological view on alcohol problems shifted decisively to a perspective in terms of individual deviance — in contrast, say, to the delinquency literature of the period, which was focussing on gang, subculture and class as well as societal factors. The trend can be seen clearly in social problems textbooks of the period. In Bredemeier and Toby's Social Problems in America (1960), for instance, "alcoholism" appears under the classification, "The costs of an acquisitive society: the acceptance of defeat: withdrawal," with a selection describing two skid-row professional blood donors, and a textual characterization of alcoholism as "a condition wherein the individual becomes slavishly dependent on liquor. . . . The alcoholic finds that his mode of adjustment to his problems — problems that may originally have been no worse than average — multiplies his difficulties" (p. 156).

In the later 1960's and 1970's, as social problems textbooks shifted their approach to more structural views, alcohol problems sometimes dropped out of view altogether: thus in Becker's Social Problems: A Modern Approach (1966), "alcohol use and alcohol problems" are covered only in a paragraph in the introductory material as an exemplification of "multiple definitions of social problems" (pp. 10-11).

In view of the broader range of orientations displayed in the original research literature, as in Pittman and Snyder (1962), how did it come about that a perspective in terms of individual deviance, and specifically the alcoholism movement's disease concept, "colored the thinking of much social science research bearing upon alcoholism" (Snyder and Pittman, 1968)? Part of the answer is perhaps the absence of any competing organizing perspective. As one of the editors of Society, Culture and Drinking Patterns later noted, the volume was "illustrative of the relevant literature, rather than systematic in its coverage," exemplifying "pretty nearly the gamut of styles and types" of social science alcohol studies (Snyder and Horned, 1964). Within this "gamut," a distinction was maintained between studies of drinking attitudes or behavior and studies of alcoholism, with few linkages between the two. The definition and description of alcoholism was left to non-sociologists (Keller, 1962; Jellinek, 1962); the sociologist's task was to describe its patterning, primarily in terms of individual variation. Alcohol problems were primarily covered under the rubric of "alcoholism." The emphasis on alcoholism as the premier alcohol problem thus tended to sever any linkage between structural and subcultural analyses of drinking and analyses of drinking problems.

Furthermore, the newly emerging sociological literature was largely inductive and atheoretical. In line with this perspective, an abortive attempt was undertaken to compile a "propositional inventory on drinking behavior" to give some form to "a diverse and widely scattered literature" (Snyder and Horned, 1964). The authors of this attempt note the lack of theoretical direction evident in meetings of the Committee on Drinking Behavior to plan a national drinking survey:

> Considerable heated discussion centered around the notion that such a survey should be designed to test theories and hypotheses suggested by the extant literature — yet when it came to the difficult task of specifying concretely just what propositions were to be tested, most of us who had argued so fervently for this approach beat a hasty retreat and became, not surprisingly, preoccupied with other matters (Snyder and Horned, 1964, p.42).

Besides the lack of competing sociological images, we may suspect that the sociologists, like the medical literature reviewers before them, "capitulated" (Keller, 1972) to the success and "lay wisdom" of Alcoholics Anonymous. Many of the rising generation of alcohol sociologists spent some time employed in or associated with clinical settings; populist proclivities may also have contributed to at least partial acceptance of the lay wisdom.

The ambivalence image thus emerged in a context where alcoholism movement conceptions of alcohol problems in terms of defects in the individual drinker had already focussed attention on individual deviance. The ambivalence image, however, differed from the alcoholism image in allowing for a more widely defined and polymorphous dependent variable of "alcohol problems." The generally atheoretical cast of the alcohol sociology of the time did not focus attention on group factors in maintaining alcohol problems, and provided a receptive environment for what came to be seen as a full-blown theory of alcoholism, the "Ullman-Blacker hypothesis" (Whitehead and Harvey, 1974).

Epidemic Images of Alcohol and Drug Problems

The use of an epidemic image of problems implies a number of characteristics of the situation: (1) that the population at risk is seen as highly susceptible; (2) that the problem is conceived of in terms of all-or-nothing (e.g., use vs. non-use, rather than as a matter of degree; (3) that the problem be seen as having rapidly increased in magnitude. Because of the first two characteristics, epidemic imagery is particularly likely to be used concerning youthful alcohol or drug problems: youth tends to be seen as a particularly susceptible population; every youth who uses has passed at some point from being a nonuser; and the fact of use of any drug by youth is in the modern era seen as a problem in itself. That the problem must be seen as having rapidly increased in magnitude has constrained the application of epidemic imagery to alcohol problems. In the early eighteenth century London of Hogarth's "Gin Lane," epidemic imagery can be found:

> With regard to the female sex, we find the contagion has spread even among them, and that to a degree hardly possible to be conceived. Unhappy mothers habituate themselves to these distilled liquors. . . . Others again daily give it to their children. . . and learn them even before they can go, to taste and approve this certain destroyer. (Report of a committee of the Middlesex Sessions, 1735, quoted in George, 1925, p. 34.)

The Temperance Movement, at least at the end of the nineteenth century, tended to put greater emphasis on transmission by heredity than by contagion. For instance, one medical writer noted "the vast amount of alcoholic disease that is transmitted by heredity. If the hereditary form could be extinguished, there can hardly be a doubt about the result for the future; and the crusade against intemperance would easily prove victorious. As it is, the alcoholist may hand the disease down to even the fourth generation" (Usher, 1892, pp. vi-vii). Epidemic imagery can be found in temperance discussions of the effects of alcohol or the saloon at a local level. Thus, at the great town temperance meeting which closes T.S. Arthur's novel, Ten Nights in a Bar-Room, a speaker asks,

> What is the root of this great evil [which has befallen the town]? Where lies the fearful secret? Who understands the disease? A direful pestilence is in the air — it walketh in darkness, and wasteth at noonday. (Arthur, n.d., p. 173).

And another speaker responds,

> There is but one remedy, . . . the accursed traffic must cease among us. You must cut off the fountain, if you would dry up the stream. . . . Evil is strong, wily, fierce, and active in the pursuit of its ends. The young, the weak, and the innocent can no more resist its assaults, than the lamb can resist the wolf. (Arthus, n.d., p. 173).

But, as these quotations suggest, epidemic imagery was often mixed with other imagery of disease or evil. Alcohol and the saloon were not mere passive agents of transmission but active destroyers. Even in more scholarly discussions the disease imagery was often mixed:

> The statistics of poverty, crime, prostitution, and domestic disorder, all point to the saloon as the chief source of infection. The American people have determined that this cancerous growth shall be cut out before it incurably taints the body politic (Peabody, 1919, p. xxx).

In the current alcohol literature, epidemic imagery has again made an appearance, but not in terms of a contagion of use but rather of a contagious effect on amount of use among users. The imagery was carried into English from the work of the French scholar, Sully Ledermann (1956, 1964, 1965). Collecting evidence that the distribution of alcohol consumption in a population always approximated a lognormal curve, Ledermann noted that "probably the phenomenon [of a regularity in the distribution of consumption] could be grasped with greater precision through a probability model suitable for the phenomena of contagion or epidemics. . . . The curve of consumption frequencies involves as a mechanism a certain contagious process." Ledermann proposed that disseminating information on alcohol could provide a countercontagion: "information unceasingly diffused among the public through important media gradually starts an antagonistic contagious process" (Ledermann, 1965, p. 3, 9).

Ledermann's choice of relatively vivid imagery was in keeping with the general tone of modern French writing on alcohol, which frequently has the minatory tone of a prophet crying in the wilderness, speaking in terms of the "struggle against alcoholism" and of France as an "alcoholized" country. As originally carried into the general English-language scholarly literature, the imagery was shifted to an emphasis on progression in the career of the drinking individual:

> Ledermann attributes the particular shape of the curve to the "snowball" effect of alcohol use, which states that in the confrontation with alcohol an individual gravitates toward increasing consumption as a result of social pressures and the pleasurable aspects of alcohol use. Every person enters the drinking population at a point near zero, and it presumably takes some time to acquire the various drinking habits present in a given society. (de Lint and Schmidt, 1968, p. 973).

Commenting on related work by researchers at the Addiction Research Foundation of Ontario, Ekholm noted the lack of any "sociological theory that would explain why the lognormal distribution is a reasonable hypothesis. . . . The general implication in the writings around the lognormal distribution in the alcohol field seems to be that there is some kind of contagion effect. . . . We should need a derivation of the lognormal distribution based on the contagion effect" (Ekholm, 1972, p. 512). More recently, Skog has picked up Ekholm's challenge, proposing a theory of mutual influence on drinking behavior at first in terms of a generalized scenario (Bruun, et al., 1975, p. 39), and more recently as a statistical model of mutual influence in social networks (Skog, 1977).

In Skog's hands, the epidemic imagery has been transformed into a somewhat esoteric problem in statistical aggregation. As originally presented in English, however, the imagery was associated with a deliberate and sustained attempt to influence policy on the part of researchers. As Addiction Research Foundation staff members have recently noted,

> In defense of ourselves . . . let us recall again the climate of ideas which prevailed some ten years ago. The dominant view found 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. . . . But to a few of us — researchers with an epidemiological perspective — it was apparent that there were large and important discrepancies between the assumptions underlying the approach and events in the real world. . . . We [also] became aware of the rapid rise in alcohol consumption which was occurring during this period and has continued since, and of the pandemic character of the trend. . . . We may be justly accused of some overstatement and oversimplification. . . . To a degree this was due to a deliberate strategy to secure a hearing for a point of view which ran counter to the prevailing sentiment. (Schmidt and Popham, 1978, pp. 414-415).

As implied in this passage, the Addiction Research Foundation staff members primarily identified with what they refer to as the "distribution of consumption hypothesis" adopted the identification of epidemiology as their disciplinary approach, although their professional training was in anthropology and law. In Canada and several other countries, social science alcohol researchers found themselves with greater or lesser reluctance in the period after 1968 drawn into the role of moral entrepreneurs attempting to raise the sensitivity of the polity to the hazards of increased alcohol consumption. Christie has noted that this development came in the wake of the "paralysis of the social organizations created to control . . . alcohol problems" — the temperance movement. In Christie's view, researchers found themselves to be the only potential "counterforce" to the alcohol beverage industry:

> being apart from the producers, but with unusual interests in the field of alcohol, researchers are forced to take the empty seat and use considerable energy as advocates for interference at the general social level. Alcohol researchers are needed as functional equivalents to teetotalers. If researchers do not take this role, the field remains completely open to the producers. . . . I cannot see that this role of the alcohol researcher deviates from well-established and generally approved roles within other areas of research. The role of scientists within the field of general nutrition represents the

> easiest example. . . . Of course [the nutritionist] is acting in the role as a moralist. All of us are, when we are striving towards changing other people's behavior in the direction we think is good for them. (Christie, 1976).

Commenting on Christie's remarks about "the absence of counter forces other than academicians or alcohol researchers," Jan de Lint, one of the Addiction Research Foundation staff members, implicitly accepted Christie's analysis. De Lint felt "sure there are other counterforces to be found if one knew where to look for them; but perhaps we researchers have made some of the objections more explicit or crystallized them" (Room and Sheffield, 1976, p. 38).

As social scientists took on this role of moral entrepreneurship, they repeatedly put on the mantle of public health, and often spcificially of epidemiology, as the most powerful available rhetoric for influencing public policy. Two of the Canadian researchers wrote a paper on "Consumption Averages and Alcoholism Prevalence: A Brief Review of Epidemiological Investigations" (de Lint and Schmidt, 1971); an American political scientist wrote a paper on "Exploring New Ethics for Public Health: Developing a Fair Alcohol Policy" (Beauchamp, 1976); a British team led by a sociologist issued a critique on public health grounds of proposed liberalizations of English licensing laws (Robinson et al., 1973); a group of primarily social-science researchers from Finland, Norway, Canada, England and the U.S., operating under World Health Organization auspices, produced an influential report on Alcohol Control Policies in Public Health Perspective (Bruun et al., 1975).

The mantle of epidemiology had a dual attraction for social scientists in these discussions. On the one hand, in its extended meaning of studies of the distribution of health problems in the population, it was clearly applicable to much social science research; as Knupfer remarked, "what the public health researcher does is not vastly different from what the pollster does, even though one is producing epidemiology and the other is producing survey research" (Knupfer, 1967). On the other hand, epidemiology as a public health discipline derived its name and analytical tools from the study of epidemics, was equipped with an honored history of policymaking activism, and offered a ready paradigm to those wishing to focus some attention on alcohol per se as a "disease agent . . . which causes" a wide variety of conditions (Terris, 1968). Thus, although the social scientists often steered clear of the imagery of contagion and epidemic spread, the mantle of epidemiology and traditional public concerns allowed them to invoke a general action-model for disease developed in response to contagious and serious diseases.

It might be noted that the public health establishment did not initially welcome the application of epidemiological imagery to alcohol problems. Milton Terris, a physician epidemiologist, presented a paper at the American Public Health Association meetings of 1966 assembling evidence for the close empirical association of per capita alcohol consumption and cirrhosis mortality, and arguing in guarded terms for the significance of recognizing that "governmental fiscal and regulatory measures can be effective in reducing alcohol consumption and lowering mortality from cirrhosis of the liver" (Terris, 1967). All the papers presented at the same session as Terris' were printed in the June, 1967 American Journal of Public Health — except for Terris'. This resulted in the curious situation of the prepared discussion of the session papers, over half of which focussed on the Terris paper, appearing without a paper on which it was commenting (Elinson, 1967). This discussion manifested considerable unease over Terris' "provocative analysis." In addition to citing various pieces of counter-evidence, the discussant joked about "having a drink or two" at lunchtime "before some impulsive local government is led by Dr. Terris' skillful presentation" to alter control laws, and suggested that, as with a possible association of cervical cancer with frequency of intercourse, there might be knowledge better left unknown: "the implications for prevention — if this were a factor — [might be] just too horrible to endure. I think most of us have a similar feeling about alcohol" (Elinson, 1967).

An extraordinary editorial footnote to this discussion, in giving the reference to Terris' presentation, further dissociated the official organs of public health from any policy implications of Terris' paper:

> A summary of Terris' paper appeared in the APHA 1966 conference report issue of "Public Health Reports," March, 1967, vol. 32, No. 3. The summary in "Public Health Reports" carries the headline, "Restrict Alcohol Availability to Reduce Liver Cirrhosis," and refers to a paragraph toward the end of Terris' mimeographed paper — a paragraph which was not read at the meeting, although the full mimeographed paper, which included this paragraph, was distributed to the press. (footnote to Elinson, 1967).

Terris' paper, apparently including the offending paragraph, was finally printed in the American Journal of Public Health six issues later (Terris, 1967). Its publication may have been aided by the fact that Terris was by then president of the American Public Health Association. In more recent years, public health journals have shown a greater receptivity to papers in the tradition of Terris' (Brenner, 1975) — including a social scientist's challenge that public health's disinterest in alcohol controls has resulted from a philosophy of "accommodation with the prevailing ethical paradigm" of "market justice" (Beauchamp, 1975).

As noted in Chapter 6 above, the governing image of the epidemic disease has been used much more widely and explicitly in recent years concerning drugs, and particularly heroin addiction, than concerning alcohol. The relationship and appeal of the epidemic image to policymaking discussions can perhaps best be gauged by the subsequent careers of its major proponents: Jerome Jaffe shortly was named head of the federal Special Action Office for Drug Abuse Prevention; Patrick Hughes became chief of the World Health Organization drug dependence staff; and Robert DuPont, who had published on heroin using epidemic imagery as early as 1971 (DuPont, 1971), became Director of the National Institute on Drug Abuse as well as succeeding Jaffe for the remainder of SAODAP's existence.

The public health establishment showed far less qualms about accepting an epidemiological and agent-oriented model for heroin than for alcohol, going so far as to publish a special supplement of the American Journal of Public Health on "The Epidemiology of Drug Abuse," edited by two SAODAP staffers, in which several articles self-consciously applied public health communicable disease methodologies (Greene and DuPont, 1974a). As the lead article makes the case,

> heroin use is a process with a known agent, host, reservoir, and vector; it has a predilection for a highly selected subset within the general population, spreads by sequential person to person contact in the setting of adolescent peer groups, and is associated with a characteristic pattern of morbidity and mortality. In these ways, it closely resembles the more classical communicable diseases. The change in rates of use over time support the validity of applying the term "epidemic" to this process (Greene, 1974).

Perhaps reacting to critical comments, the "Foreword" is somewhat more gingerly about the article's theme, describing it in terms of "the hypothesis that heroin use can be analyzed in the same way as acute communicable diseases. This is intended as an analogy only, not as direct equivalence. As with any analogy, extended far enough it is doomed to failure. However, there are several important lessons to be learned prior to reaching that point" (Greene and DuPont, 1974b).

It is notable that physicians predominate in using the epidemic governing image for heroin, while social scientists predominate for alcohol. This presumably reflects different political proclivities and sympathies, and perhaps a greater awareness by social scientists of the symbolic power of governing images — Greene argues, perhaps ingenuously, concerning the epidemic model that while "this notion may be misunderstood by the politician or the man in the streets, . . . it is incumbent upon those workers involved in the use of such techniques to insure that the method is not abused" (Greene, 1974). Whatever the cause, the division results, as we have seen, in a considerable difference in the rhetoric of invocation of the image -- forthright and detailed in the heroin literature, but sidelong and skeletal in the alcohol literature.

The Alcoholism Movement's Disease Concept as a Governing Image

In a recent paper, Levine (1978) has traced the inception of the disease concept of alcoholism to the beginnings of temperance thought in the late eighteenth and early nineteenth centuries, and has remarked on the continuities between the temperance and the alcoholism movement conceptions of alcohol addiction. Levine links the rise of the addiction concept in the early nineteenth century to the new middle-class views of madness which emerged in this era (Foucault, 1975) and which focussed on self-control and self-discipline. Both for the temperance movement and for Alcoholics Anonymous, drinking made lives "unmanageable."

But, as Jellinek notes, when the disease concept was revived in the 1930's the older tradition "was forgotten by all except the older temperance workers. The work of the 'Founding Fathers' was swallowed up in a collective blackout. When the idea of 'alcoholism' as an illness was revived it was hailed as 'the new approach'" (1960b, p. 4). In Jellinek's view, there was one tenuous connection between the nineteenth century tradition and the new professional interest of the 1930's: "while the . . . old . . . slogan, 'inebriety is a disease', was practically forgotten in America, it remained alive in Europe, although not prominently, and it floated back to America to be developed and elaborated here by psychiatrists" (1960b, p. 8).

Jellinek identifies nineteenth-century American disease conceptualizations with the American Medical Association for the Study of Inebriety and Narcotics and its Journal of Inebriety. While he recognized that this "Society and its Journal were rather close to the temperance views on alcohol," he maintains that "the temperance and prohibition movements regarded the Society as inimical to temperance goals" (1960b, p. 6). Levine (1978) has collected substantial evidence that Jellinek is doubly wrong; that important Temperance organizations and leaders supported the establishment of special asylums for inebriates by those around the Journal of Inebriety, and more generally that the temperance movement itself had a disease concept of alcohol problems — "the idea that habitual drunkards are alcohol addicts" was "at the heart of Temperance ideology during the nineteenth century" (1978, p. 158).

Jellinek's mistaken view of the nineteenth century temperance movement may well represent a projection back into an earlier era of his contemporary experience. Jellinek had an antiquarian interest in history, but undertook no systematic study of the temperance era. As we have noted, the scholars of the Yale Center of Alcohol Studies, including Jellinek, were concerned to differentiate themselves from the temperance movement, in an era when support from temperance sources was a political liability. Selden Bacon identified "Dry organizations" as a potential threat to the establishment and survival of alcoholism programs:

> adherents of such organizations are likely to minimize the efforts of a rehabilitation program, are reluctant to see that prevention emerges from rehabilitation and allied education, may feel that such a program urges

> moderation or a temperance to which they are unalterably opposed. . . . Since they believe that drinking is the cause of alcoholism, they feel that working with alcoholics is largely a waste of time. . . . The social, religious, educational, financial and political influence of these groups should not be underestimated (Bacon, 1949, p. 15).

Likewise, Jellinek contended that "in the view of most American temperance societies, the idea that alcoholism is an illness is a threat to their educational efforts" (1960b, p. 174). But the extracts he presents from contemporary temperance critiques (pp. 175-178) do not dispute a disease concept of alcoholism, but rather the accompanying "tie-in sales," as one quoted pamphlet put it — that is, the penumbra of assumptions and implications invoked by the specific governing image of the alcoholism movement. Already writing with some hindsight, Jellinek admitted the justice of some temperance critiques: "it must be admitted that in America, the scientific literature and the public and private agencies concerned with 'alcoholism' have concentrated to such a degree on the true alcohol addict and the problem drinker that other important problems arising from the use of alcoholic beverages have been neglected. . . . The man versus bottle idea is the weakest link in the armor of the alcoholism programs and it is little consolation that many concepts in the propaganda of the temperance movement are even more spurious" (1960b, pp. 174-176).

Jellinek offers some speculations about reasons for the lack of success of the inebriates-home movement of the 40 years prior to the First World War. He mentions the controversy and chaos which dogged the history of many of the asylums, the vagueness of the disease concepts of the time, the lack of standards and prestige in the Journal of Inebriety, and the hostility of the temperance movement. The adequacy of these explanations may be disputed, although in the absence of detailed historical work on the inebriates-home movement alternative explanations can only be outlined. After all, the vagueness of disease concepts of alcoholism is not a problem only of the nineteenth century — and indeed Christie and Bruun (1969) have argued for the functionality of vagueness in a situation where maximum consensus is a goal. The Journal of Inebriety's lack of prestige may have had more to do with its subject-matter than its standards of scholarship — again a phenomenon well-known in Jellinek's time. The emphasis in the temperance movement of the day on what would today in public health terms be called "primary prevention" undoubtedly weakened the inebriateshome movement; thus when national Prohibition finally came, most alcohol-specific treatment institutions closed in the belief that there was no further need for their existence (Corwin and Cunningham, 1944). We may suspect that the national emergency of the First World War may also have contributed to the demise of inebriates asylums: national emergencies create a demand for the labor of the inmates and drain off the social supports of marginal institutions.

If we compare the inebriates-home movement with its earlier analogue, the mental-asylum movement, we can surmise that the inebriates-home movement was less permanently successful because it did not succeed in creating an economic base and a constituency of support. Like the early superintendents of mental asylums, the superintendents of inebriates' asylums were primarily medical men imbued with a missionary spirit concerning their own work, but they lacked the movement of popular and intellectual support which established mental asylums as a state responsibility. The recurrent controversies and scandals around inebriates' homes, mentioned by Jellinek, are primarily a reflection of the lack of an assured basis of state support. Mental asylums succeeded as institutions (at the price of their original optimism and orientation) by becoming the vehicles for transferring the expense of maintaining many of those unable to support themselves from traditional institutions supported by local taxes to the new mental hospitals supported by the state (Grob, 1966). Inebriates' homes apparently never succeeded in carving out such a niche, where a political interest such as local government officials had a strong economic reason to support their continued existence.

The modern alcoholism movement can only be said to have coalesced as a social movement in the 1940's. But the major institutions of the movement's early years trace their origins to shortly after the Repeal of Prohibition. Alcoholics Anonymous dates its founding to 1935 (Alcoholics Anonymous, 1957). In the same year, researchers at Bellevue Hospital in New York conceived of "a grand research project" with "a multidisciplinary approach" (Keller, 1975, pp. 136-7) which would extend research there from the nutritional diseases of alcoholism to studying the alcoholism itself.

In their early history, both institutions apparently independently turned to the Rockefeller family for potential financial support. In this they were following longstanding precedents.[22] But both appeals were unsuccessful. As Bill W., cofounder of Alcoholics Anonymous, later put it concerning AA's approach to Rockefeller in 1937, "ideas of comfortable and well-paid jobs, chains of AA hospitals, and tons of free literature for suffering alkies seized our imagination. But Mr. Rockefeller had other ideas. He said, 'I think money will spoil this'" (Alcoholics Anonymous, 1957, p. 111). As an organization, Alcoholics Anonymous eventually committed itself to self-support, although the subsequent growth of state, federal and private alcoholism programs now provides employment for many AA members. In 1941, AA became a nationwide organization "overnight" as a result of the enthusiastic response to a Saturday Evening Post article (Alcoholics Anonymous, 1957, pp. 190-192).

Out of the unsuccessful application of the Bellevue Hospital researchers emerged a prestigious Research Council on Problems of Alcohol "with the special aim to seek funds to support research on alcohol problems" (Keller, 1975, p. 137). Though the Council was never very successful in this aim, it did secure a grant to the Bellevue Hospital group from the Carnegie Corporation for a review of the biological literature on alcohol, on the strength of which Jellinek was brought into the field. In 1941, Jellinek and eventually others of the staff of the literature review project were invited to come to Yale, where Howard Haggard, a member of the Research Council, the previous year had initiated the Quarterly Journal of Studies on Alcohol. Eventually the project became the Yale Center of Alcohol Studies (later the Rutgers Center of Alcohol Studies).

The Research Council continued to exist until 1949 (see Hirsh, 1949, pp. 158-164; Anderson, 1950, pp. 200-206). In 1942 its Scientific Committee adopted as policy an "Outline of Basic Policies for a Research Program on Problems of Alcohol" prepared by Jellinek (Jellinek, 1942). Jellinek's Outline committed the Council to giving systematic priority to studies of "the origin of addiction and excessive drinking," over studies of "the effects of inebriety." Concerning this priority, he commented:

> At first thought it may seem unreasonable to assign secondary importance to such subjects as the relation of inebriety to divorce, family life, pauperism, delinquency, community life, etc. Investigations of these subjects may be of real use to the administrator, the penologist, and so forth. But as far as the Council is concerned these subjects do not contribute to the understanding of inebriety and only in small measure to its prevention. On the other hand, such studies serve to characterize the magnitude of the problem of alcohol. Insofar as it may be necessary to educate the public on the magnitude of the problem in order to obtain its support, the fostering of such studies is justified. It is also justified from the viewpoint that the Council will be performing an expected public service by supporting such projects. When these motives are absent, however, these projects can be considered only as secondary interests of the Council (Jellinek, 1942, p. 111).

However, the Research Council never succeeded in attracting substantial funding for research of any kind, and eventually "reoriented its policy to place the accent on action — measures to treat and prevent alcoholism as well as a stepped-up educational campaign" (Anderson, 1950, p. 203). Even so, its primary funding after the grants of its initial period 1937-1939 came to be small grants from liquor industry sources. Eventually, in part because "to the public . . . it looked suspiciously as though the liquor interests were using the Council to front a drive against prohibition" (Anderson, 1950, p. 205), the Council was disbanded in 1949. But "long before the dissolution of the Research Council Yale University had taken the ball and had run away with it" (Anderson, 1950, p. 207).

Until the move to Yale, the researchers working on the Bellevue Hospital literature review project had functioned in relative isolation from other developments in the alcohol field. Mark Keller, who had started working at Bellevue in a junior position even prior to 1935, was unaware of the flurry of scholarly work appearing at that time on liquor control issues (see Levine and Smith, 1977; Mark Keller, personal communication). There had been only casual contacts in the 1930's between the research project and Alcoholics Anonymous (Keller, personal communication).

The newly established Yale Center took on a number of new functions besides research and documentation, and for a number of years became the organizational center of the nascent alcoholism movement. The Center's Summer School of Alcohol Studies, initiated in 1943, sought to introduce opinion leaders and relevant professionals to the "scientific study of the problems of alcohol" (Jellinek, 1945a, p. 1), both in the actual curriculum and through the widely-distributed compilation of the School's lectures. In 1944, the National Committee for Education on Alcoholism was formed at the Center, with an Alcoholics

Anonymous member as its director. Retitled the National Council on Alcoholism, this organization became the major public education and action group on alcoholism — "to arouse public opinion and mobilize it for action" (Mann, 1958, p. 189). In the view of its founding director, "it could be said that NCA grew out of the needs of A.A., . . . and that NCA was designed to do those things for alcoholism which A.A. could not, and did not wish to do. . . . There is a close working relationship between the loosely knit fellowship of A.A. and the formal organization of NCA" (Mann; 1958, pp. 192-3).

Also in 1944, the Center established the Yale Plan Clinic "as a pilot out-patient community facility for the treatment of alcoholism" (Henderson and Straus, 1952). In the following year, the Connecticut Commission on Alcoholism was established as a state agency sharing a medical director with the Yale Plan Clinic and extending the Clinic model throughout the state. The clinical and organizational models developed in Connecticut were repeatedly diffused to other states in the succeeding few years, so that by 1952 a review of the status of the movement by Yale Center staff members could state that "following the pioneering efforts of the Connecticut Commission on Alcoholism in the fields of treatment, education and research, 38 states (and the District of Columbia) have passed laws recognizing alcoholism as a public health problem and creating boards or commissions to establish programs" (Henderson and Straus, 1952). In his dual role of chairman of the Connecticut Commission on Alcoholism and sociologist on the Yale Center staff, Selden Bacon wrote a number of programmatic papers spelling out practical considerations in organizing state and community alcoholism programs (e.g., Bacon, 1947; 1949).

The explosion of alcoholism movement activity in the 1940's was remarkable in a society at war for part of the period. In part, the activities sought a larger social justification, as rehabilitative — that they would restore men (predominately) to active functioning in society, and specifically until 1945 to the war effort. There is no doubt that in its early years the Yale Center drew together an extraordinary collection of academic visionaries and promoters, undeterred by frustrations and failures in fund raising. The period of expansion of the Center's functions came to an end eventually around 1950 with the abandonment of an elaborate scheme to establish a Yale Institute of Alcohol Studies in the Southwest, financed by Texas oil money and located at several Texas sites. Following the demise of this scheme, Jellinek was forced to leave the Center to pursue wider-ranging but less ambitious activities at the World Health Organization (Keller, personal communication).

By the early 1950's, the disease concept of alcoholism was fully established as the governing image of a rapidly growing social movement which eventually institutionalized itself in federal as well as state and local programs. The best-known scholarly artifact of the movement is certainly Jellinek's much-reproduced "Phases of Alcohol Addiction" (1952), drawing on his earlier study (1946) undertaken at the behest of Alcoholics Anonymous. Although the fact that scholars are more likely than others to publish records of their activities makes it easy to overestimate the role of the Yale Center in the movement, it is clear that the Yale Center played a central role and certainly established itself as the intellectual cadre of the movement.

If one examines the earlier writings of the Center's leaders, it is by no means clear that this would be the outcome a few years later. In the early 1940's Jellinek habitually wrote of "inebriety" rather than "alcoholism"; as late as 1944, he was using "compulsive drinkers" to refer to "drinkers who, although they wish to stop drinking, are irresistibly driven to it through an unconquerable fear that without alcohol they will not be able to exist," and distinguishing such drinkers from "chronic alcoholics," who were "persons who, in consequence of prolonged excessive drinking, have developed a bodily disease or a mental disorder" (Jellinek, 1945b, p. 23). In his monumental first contribution, on "Sociology and the Problems of Alcohol," Selden Bacon also speaks of "inebriety," and of "psychotic," "neurotic" and "abnormal" drinkers, emphasizing instead the importance of the sociological study of normal drinking: "the exotic and the pathologic are useful fields of scientific inquiry, but they have their limits. . . . This sort of erroneous or perhaps naive approach has appeared in studies of drinking, . . . almost all of which have concerned themselves with wealthy alcoholics, psychotic alcoholics, or alcoholic felons. Inebriates, however, are but a minor percentage of drinkers" (Bacon, 1943, p. 409). As we have noted above, by the end of the decade, Bacon was writing papers of advice on the administration of alcoholism programs. In 1957 he was writing in a medical journal on "the sociological approach to alcoholism," listing a set of 16 Jellinekian symptoms as "some of the typical signs of the present-day alcoholic among white, Protestant males of northern European cultural orientation living in urban areas of the northern quarter of the United States" (Bacon, 1957, p. 178). In their later thought, both Jellinek and Bacon retreated somewhat from their identification with the alcoholism movement. In his late writings on alcoholism, Jellinek (1960a, 1960b) abandoned the alcoholism movement's restriction of the term to those with loss of control over drinking, and defined it instead as including any tangible alcohol-related problem: "any use of alcoholic beverages that causes any damage to the individual or society or both" (Jellinek, 1960b, p. 35). Somewhat paradoxically, noting that "this is admittedly an arbitrary distinction," he then proposed to limit the term "alcoholic" to five named "varieties of alcoholism," while regarding only two and possibly three of these varieties as constituting diseases (1960b, pp. 40-41).

Even in his period of identification with the alcoholism movement, Bacon maintained, in the college drinking study, a tangible commitment to studying normal as well as abnormal drinking (Straus and Bacon, 1953). In recent years, he has returned with great vigor to his earlier theme of the importance of a "phenomenological" rather than a "problem" orientation (1976), and has commented ruefully on his role in the alcoholism movement. Speaking in 1977 of the "alcoholism cult of the last 27 to 34 years," he noted that "I was one of the builders until I got thrown out for saying that wasn't quite what I meant," and that the "cult became so powerful in the period 1960-1972 that it took over all alcohol problems," including such areas as traffic casualties.[23]

It seems clear, then, that both Jellinek and Bacon, the leading luminaries of the Yale Center, were perturbed from their natural orbits of thought in the course of the connection with the alcoholism movement, roughly in the period of 10 or 15 years after 1944. The sweeping perspective comprehending all of drinking phenomena evinced by Jellinek in the design of the Yale Summer School (Jellinek, 1945a) and in the scope of the early issues of the Quarterly Journal of Studies on Alcohol, and by Bacon in the paper on "Sociology and the Problems of Alcohol," narrowed down in a very short time to a relatively single-minded focus on the objectives of the alcoholism movement. While there remained some differences in perspective between Jellinek and Bacon, both men took on the role of academic functionaries and promoters of the movement.

There are several possible explanations of this constriction of perspective. Some in the Temperance Movement proposed a materialist explanation: the Yale researchers were in league with the alcoholic beverage industries, if not paid by them. In 1946, Ernest Gordon, an elder statesman of the Temperance Movement with a wide international knowledge of alcohol politics, published an 87-page aleatory attack on the Yale Center and associated organizations, Alcohol

Reaction at Yale. Gordon's attack was couched in nativist populist terms: he describes the New York Times as an "organ of reactionary capitalism," and notes "the interlocking of general capital with the alcohol capital" (p. 23). Part of the problem with the Center from his perspective was its location at Yale.

> The presidents of the great eastern universities are intimates of Wall St. whence come their endowments. They reflect Wall St. wetness. . . . "Wall St." is painted all over Yale. . . . In view of this general atmosphere, . . . one questions whether a school for alcohol studies would be countenanced at Yale save within understood limitations" (pp. 23-24).

Gordon's scattershot approach details a substantial amount of interlocking relations and "intimacies" between the distillers' public-relations organization and the Research Council and Yale Center, and notes the financial support of the Research Council by the distillers. But his argument tends to the view that the Yale researchers are dupes rather than agents of the liquor interests. He notes that Jellinek "protested repeatedly" the Research Council's acceptance of liquor-industry support — "yet he remained Vice President of the Research Council's Scientific Committee." He allows that "Dr. Jellinek is unquestionably a savant in alcohol studies; also a man of polyglot and international training," and is thus "astounded" that he is not prohibitionist like earlier savants. Bacon he dismisses as a "fatalist who says 'the problem of inebriety, as of poverty, is ever with us' and presumably ever will be" (pp. 17, 19, 20). In Gordon's view, the Yale researchers engage in "minimizing alcohology," discounting alcohol's bad effects. In line with this, they promote the acceptability of moderate drinking. Gordon quotes a 1949 statement from the Brewers' Journal that "there is a growing tendency among church leaders to encourage temperance and the moderate use of alcohol. . . . This tendency . . . has, without doubt, been partly stimulated by research being done in Yale University" (Gordon, 1946, p. 22). On the other hand, the Yale researchers are unacceptably fatalist about the prevention of alcohol problems.

> "Let us hear the conclusions of the whole matter." "The Outlook" is the title of the last chapter of Alcohol Explored [Haggard and Jellinek, 1942]. It is an outlook of eternal repair and despair. "Hospitals and farms for inebriates must be equipped to classify the various types of inebriates according to the causes of their condition". . . . Meanwhile German brewers and the Jewish whisky trust are to continue to work ruin in this our fair land. (Gordon, 1946, p. 84).

In his 1960 work on The Disease Concept of Alcoholism, Jellinek recognizes Temperance arguments that "the propagation of the illness conception of alcoholism may favor the interests of the alcoholic-beverage industry and, as a matter of fact, it has been intimated that the disease conception was triggered and has been fostered by those interests" (1960b, pp. 174-5). He does not directly answer these charges: agreeing that "no doubt, 'alcoholism as an illness' is pleasing to the beverage industry," he argues that "their pleasure concerning the illness conception of 'alcoholism' cannot form a basis for its rejection if that conception should turn out to be valid." There is no question that the alcoholic beverage industry, and particularly the distillers, recognized early in the history of the alcoholism movement its potential utility in diverting attention from "the bottle" to "the man." The early 1940's were a particularly worrisome time for the industry, since they faced the threat of what was seen at the time as a "new Prohibition drive" (Lee, 1944). Industry public-relations staff have been involved in the organs of the movement from the start, and still sit on the board of the National Council on Alcoholism and on the Coalition for Adequate Alcoholism Programs. But the industry was probably not interested in too large an alcoholism movement, and there are intimations it may have been involved in a general refusal of philanthropic foundations to get involved in alcohol research or programs (see Straus and Bacon, 1953, p. 43, concerning this refusal). Certainly, the industry's own record over the years has been of an ostentatious but minimal commitment to supporting alcoholism research, treatment or prevention programs. A leading alcoholism movement figure once commented to me facetiously that he was willing to consider being bought, but not so cheaply.

The industry thus benefited and perceived itself as benefiting from the alcoholism movement, and played a role in the movement's organs. Beyond this, it may have contributed to structuring the funding environment which directed researchers on "soft" money with ambitious plans toward particular research questions. But its influence is certainly not a sufficient explanation of the zeroing in on the disease concept of alcoholism which occurred among the Yale researchers in the mid-1940's.

An alternative explanation has been offered by Keller (1972) — that the researchers "capitulated" to Alcoholics Anonymous' governing image because it "worked."

> At first glance it may seem surprising that much of the contemporary understanding of a disease, with which medical and allied therapeutic professionals are heavily engaged, should derive from a fellowship of laymen. Especially so when, if one re-examines the exhaustive review of the psychiatric literature published in 1941 by Karl M. Bowman and E.M. Jellinek, it is obvious what a vast amount of observation, study, theorizing and writing had been done in the effort to understand alcoholism. Why, then, in spite of all the sophisticated syntheses that came out of that review, did the medical and paramedical world, and Jellinek himself, soon after capitulate, as it were, to the lay wisdom of Alcoholics Anonymous? This problem merits a deeper consideration than I can give it in the present aside, but I would like to suggest that it was a very practical and understandable capitulation. For all the wisdom of the older

> medical-psychiatric writings, in the beautifully organized Bowman-and-Jellinek synthesis, made good sense in theory, but offered small help in practice. That is, in medical practice, in the practical business of successful treatment. On the other hand, at the time when that review was published, Alcoholics Anonymous began to become famous, the story of its success was then for the first time widely publicized. The medical world had to look, at first with surprise, and finally with conviction, at a way of dealing with alcoholism that worked.

Support for this explanation certainly can be found in the writings of the time: the air of ostentatious hopefulness in them certainly does not fit Gordon's accusations of fatalism: "the Alcoholics Anonymous method has helped 45,000 alcoholics to date. . . . People . . . have come out, have strengthened their lives, and have become assets to the community and the family and the job, have become leaders instead of parasites. . . . Many seem to have gained in stature from their experience with this disease" (Bacon, 1947, p. 483).

But there are aspects to the relationship between the Yale Center and Alcoholics Anonymous that do not fit Keller's explanation. Certainly it appears that the influence was primarily in one direction: Alcoholics Anonymous was already well established before the Yale Center began its expanded programs. In the twenty-first anniversary volume (Alcoholics Anonymous, 1957), there are tributes to and indeed pictures of a variety of important non-alcoholics in A.A.'s history — but there is no mention of the Yale Center or of any of its staff. Although written about the Research Council on Alcohol problems, Dwight Anderson's comments may indicate a general attitude of those close to Alcoholics Anonymous to academic alcohol studies at the time — roughly speaking, a tugboat's attitude to a heavily-laden but rudderless ocean liner:

> 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 and that it seemed perhaps more interested in measures of liquor control and the curbing of drunken driving than in attacking the fundamental problem of what causes 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 (Anderson, 1950, 201-2).

The Yale researchers were undoubtedly influenced by their interactions with Alcoholics Anonymous members. But, however well the A.A. action model was seen as working, it was not the model the Yale researchers followed as they moved into programmatic work. When the Yale Plan clinics were set up, they were organized as traditional hierarchically-organized outpatient clinics staffed by psychiatrists and social workers. Where A.A. insisted on the principle of voluntary attendance, the clinics quickly accepted criminal-diversion cases (Anderson, 1950, pp. 200-211). The Yale Plan clinic was seen at the time as an alternative to Alcoholics Anonymous, not as an application of the same model: Bacon's assertions about the success of A.A., quoted above, are followed by similar claims for other methods: "A few psychiatrists can show similar results. The Yale Plan Clinic can show similar results" (Bacon, 1947, p. 483).

In the following years, the Yale Center moved beyond these first wartime experiments in state-supported alcohol clinics to bring about the establishment of a Connecticut Commission on Alcoholism, and eventually to serve as a kind of support center and clearinghouse for the movement to establish state alcoholism agencies. Alcoholics Anonymous members played key roles in this movement. But the operating assumptions and model of Alcoholics Anonymous were antithetical to a movement built around clinics, professionals and bureaucracies. In view of A.A.'s soul-searching in its early years about internal professionalization (Alcoholics Anonymous, 1957, pp. 139-220), it is ironic that the main concern of recovered alcoholics as state and federal treatment agencies became established was to preserve a position in the agencies for the recovered alcoholic "paraprofessional."

What the Yale researchers absorbed from A.A., then, was not an action model for the treatment of alcoholism as a disease, but rather the energies and ideas of specific A.A. members. It is no accident that the most prominent of these alliances were in the area of publicity and public relations. Anderson (1950, pp. 214-217) chronicles Yale's lightning moves to take on sponsorship of Marty Mann, then a New York fashion publicity director, and her plan for what eventually became the National Council on Alcoholism. Anderson himself, a lawyer who was 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, appears to have played a key role in arguing for the importance of the disease concept as a means of influencing popular sentiment and public policy — and of securing support for research establishments.

> The chief obstacle to progress in the scientific solution of programs 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. . . .

> What are the ideas of the least common denominator concerning alcohol which can be most easily established and which will serve to gather around them those apparently disparate but basically related impulses which at present are loosely integrated in other groups? 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 made explicit and must be inculcated into public opinion. Sickness implied 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 (Anderson, 1942).

Jellinek thought enough of the argument to invite Anderson to repeat it at both the 1943 and 1944 Yale Summer Schools (see Anderson, 1945, pp. 367-368). Haggard, then the editor of the Quarterly Journal of Studies on Alcohol, persuaded Anderson to raise money to circulate reprints of the 1942 article (Anderson, 1950, pp. 72-73). Anderson's "four-point program" — "first, that the problem drinker is a sick man, exceptionally reactive to alcohol; second, that he can be helped; third, that he is worth helping; fourth, that the problem is therefore the responsibility of the healing profession, as well as the established health authorities, and the public generally" — became the credo of the alcoholism movement of the succeeding years.

The Yale researchers thus do not appear to have adhered to the alcoholism movement and its disease concept because of either the pressure of the alcoholic beverage industry or the compelling power of the Alcoholics Anonymous model. There is no denying that both these factors were influential in pointing towards and promoting a concentration on alcoholism rather than on alcohol studies and problems in general. But the prime motivating factors in the Yale Center's involvement in the alcoholism movement appear to have been a self-sustained mixture of altruistic and material interests. In what was basically a "soft money" (self-funding) situation, the Yale Center seems to have assembled an unusually ambitious consortium of academic entrepreneurs. Haggard, its director, was in fact persuaded to use his gifts as Yale University's chief fundraiser for two years in the late 1940s.[24] Work on wartime alcohol problems with Connecticut communities and state agencies, and on public information with recovered alcoholics in the National Committee for Education on Alcoholism, pointed the way to practical usefulness in society, to securing a basis of data and support for research work, and to leadership positions in a social movement fueled with the energies of recovered alcoholics as its footsoldiers. The change in tone and emphasis in Jellinek's and Bacon's writings reflects a shift from the uncertainties and indulgence of curiosity of independent scholarship to the certainties and modulated responsibility of the public functionary of a social movement. If the researchers can be said to have sold out to anything, it was to their own institutional ambitions and altruistic aspirations.

Governing Images and Men and Women of Knowledge

The movement of ideas is responsive both to empirical findings and to political necessities. As Galileo and many others might testify, those whose profession is knowledge often find themselves caught between conflicting impulses from their data and from the politics of their situation. Because of their expertise in ideas, men and women of knowledge often play crucial roles in the construction and propagation of governing images. On the other hand, since governing images are specifically political constructs, aiming to structure the social handling of problems, the pressure is quite strong for knowledge related to them to "come out right." In the present chapter we have examined the working out of such conflicts in the writings and actions of scholars associated with each of the three major contemporary governing images of alcohol problems.

The politics of thought about alcohol in our time have been dominated by two major vectors. One of these is the discrediting of temperance thought in the 1920's and 1930's. Although the necessity to differentiate oneself from "neo-Prohibitionist" thinking has diminished over time, it is still a powerful impulse, particularly since there are strong and vigilant economic interests on the "wet" side. The other major force is the historic swing towards the management of a variety of intractable problems through health institutions. This general swing also seems to be losing momentum, as in the rise of the "new criminology," but its influence is still paramount in the alcohol and drug field. Scholarly writers supported this shift in large part out of a commitment to securing a more humane society, and a perception that a health rubric was the most expedient means to that end. The fact that alcohol research has been primarily funded through the federal public health agency has also tended to tilt scholarship toward a frame of reference in terms of a health rubric.

The intellectual history of each governing image we have examined reflects the operation of these two main vectors. Each governing image has been couched in terms of health institutions and clinical professions as the social rubric with custody of alcohol and drug problems. As we have seen, the specific form of the alcoholism movement's disease concept of alcoholism directed attention to "the man" rather than "the bottle," and tended to present "alcoholic drinking" as separate from and unrelated to "social" or "normal drinking." In contrast with temperance thought, this conceptualization dissociated alcohol problems from alcohol consumption and thus was compatible with a "wet" political position. While these ideas originally arose as part of the internal therapeutic action model of Alcoholics Anonymous, they played a politically crucial role in securing wide acceptance of the governing image as the alcoholism movement coalesced and turned in the 1940's to political action.

In the previous pages, we have seen that the researchers of the Yale Center, as they assumed leadership positions in the nascent alcoholism movement, became for a time voices for this governing image, even though, judging from their earlier and later work, it diverged in important respects from their native bent. As the movement secured footholds of power and resources first in state governments and then at the federal level, the scholars were pushed aside, and eventually took public stances implicitly (Jellinek) or avowedly (Bacon) critical of some aspects of the movement's governing image.

In the field of alcohol problems, the success of the alcoholism movement and growing dominance of its governing image made it by the 1950's a third major vector in the field of forces of public alcohol thought. As originally propounded by sociologists in the 1950's, the ambivalence conception of alcohol problems reflected this dominance. The ambivalence governing image accepted the alcoholism movement's conception of alcohol problems in terms of a disease rooted in individual predispositions, but sought to recapture a role for sociological variables in the explanation of alcoholism's etiology. Temperance era thinkers a half century or century before had solved a similar problem by focussing on what in sociological terms might be called differential associational, subcultural, social-structural, or economic-interest explanations of the occurrence of alcohol problems. And sociological analyses of opiate use in the 1950's and 1960's moved in similar directions. But the repulsion from explaining alcohol problems in such "dry-oriented" terms pushed alcohol sociologists in other directions. Drawing on the increasingly prestigious imagery of psychoanalytic thought, the ambivalence image provided an explanation of alcoholism at an apparently supraindividual level and in a manner that specifically implicated American "dry" traditions in the etiology of alcoholism. In the late 1960's, the ambivalence imagery was picked up from the sociological literature, first by quasi-official organs (the Cooperative Commission on Alcohol Problems) and then by governmental spokesmen (National Institute on Alcohol Abuse and Alcoholism). Again, the imagery filled a need for a rhetoric concerning alcohol problems that was not "dry" and yet focussed on alcohol problems at a societal level. Since the ambivalence concept did not conceptually depend on any specific disease model of alcohol problems, the imagery also proved adaptable to the quiet retreat from a singleminded perspective on "alcoholism" as the condition to be explained that accompanied institutionalization of a federal alcohol problems agency.

The ideological hegemony of the alcoholism movement directed scholarly attention in the 1950's and early 1960's away from alcohol consumption as itself problematic. The re-emergence of concern with consumption and associated problems in the late 1960's and 1970's was an early sign of the waning of the alcoholism image's hegemony. Although the new line of thought implicitly diverged from an alcoholism perspective, it remained within the overall framework of the health rubric and in fact specifically embraced a public-health perspective.

But although its proponents were attacked as "neo-Prohibitionist" and certainly alluded to contagion formulations, they refrained from wholehearted presentation of a governing image in terms of epidemic or contagion. In contrast, researchers in an analogous situation in the opiate literature showed no such compunctions, but built public careers on their adoption of the epidemic image. While the difference may reflect personality and professional divergences between two groups of researchers, the political unacceptability of an openly dry perspective in alcohol thought may also have played a part.

CHAPTER 9: The Application and Appropriation of Governing Images: The Case of Public Drunkenness and the Detoxification Center

As the quotations from Anderson in the previous chapter imply, the major public policy aims of the disease concept of alcoholism of the 1940's as a governing image were to establish a climate of hope about the treatment of alcohol problems, and to legitimate claims on the health system and professions for treatment of alcohol problems. These aims complemented the earlier purposes of AA and fellow-traveling physicians in adopting the disease conceptualization as a particular action model for therapeutic purposes. Initially, the "new" disease concept was not seen as antithetical to the handling of alcohol-related problems in the criminal law system: special Alcoholics Anonymous groups in prisons, first formed in 1942 and reaching 335 prisons by 1957, found a congenial environment in the rehabilitative philosophy of progressive correctional thought of the time (Alcoholics Anonymous, 1957, pp. 6, 89), and workers in various parts of the correctional system published articles in the Quarterly Journal of Studies on Alcohol in the 1940's and 1950's on the handling of the alcoholic in the system.

In the early years of the alcoholism movement, thus, the disease conception was not seen as making a jurisdictional claim against the legal system for the handling of alcohol problems; rather, alcoholism movement groups and enthusiasts moved within the correctional system as well as within other custodial institutions — the state mental hospital, the workhouse, the welfare system — to provide special rehabilitative services for alcoholics.

Apparently the first program to conceptualize alcoholism treatment as an alternative to rather than an adjunct to the correctional system was set up in 1950 (Brunner-Orme, Iddings and Rodrigues, 1951). This program was explicitly a criminal-diversion program where, as a rule, the court suspended sentence on condition that an offender attend the clinic. In succeeding years, a number of such programs arose in various localities, often under the impetus of sympathetic judges. Although these programs were alternatives to rather than situated within the orthodox correctional system, overall authority remained within the rubric of criminal law rather than the rubric of medical therapy. It was not until the 1960's that claims began to arise for transferring overall jurisdiction over some alcohol-related problems from the correctional system to a therapeutic system. A prerequisite for this was a shift in applicable legal doctrines. The Supreme Court's decision, in Robinson vs. California (1962), that it was unconstitutional to use the criminal laws to punish someone in the condition of being addicted to narcotics, was quickly recognized as opening up the possibility that social handling at least for the condition of being a "common drunkard" might be removed from the rubric of criminal law (Deitrick, 1963).

The succeeding years saw the development of a sustained campaign to shift the police-court inebriate from a legal to a medical rubric, eventually crystallizing around the Uniform Alcoholism and Intoxication and Treatment Act, adopted in 1971 as a model for the states by the National Conference of Commissioners on Uniform State Laws, and urged on the states with fiscal incentives as a matter of federal policy.

In the late 1960's and early 1970's, thus, the police-court inebriate — roughly speaking, the Skid Row drunk — somewhat unexpectedly became a major public policy focus for the application as a governing image of the alcoholism movement's disease concept. In the present chapter, we shall consider the background, events and results of this development as a case study in the application of a governing image to an intractable social problem. Such a study extends our analysis of the operation of governing images beyond the limits of the preceding chapter. In that chapter, we discussed the material and ideological contexts which formed and interacted with particular governing images. In the present case study, we examine the interaction of a governing image, and the movement which supported it, with other material and ideological interests in the redefinition of social policy on an intractable problem.

Our analysis is in part a critique of an earlier analysis of the same events by Kurtz and Regier (1975). Kurtz and Regier saw the adoption of the Uniform Alcoholism and Intoxication Treatment Act as a "compromising process" between two main interest groups: on the one hand, "alcohologists," an all-purpose term that appears to encompass both the alcoholism movement and others with an interest in alcohol issues, and on the other hand, law enforcers, with appeals courts forming a third group helping to set the framework of the compromise. Our analysis does not dispute the unworkability of the Uniform Act as a permanent solution to the problem of public intoxication; but, as the general discussion of the social handling of intractable problems above (Chapter 4) would indicate, we do not share the utopian rationalist faith of Kurtz and Regier that there _is_ an attractive and permanent solution to the problem of public drunkenness.[25] Additionally, the present analysis differs from Kurtz and Regier in the listing and characterization of interests involved in the policymaking.

What's the Problem?

A discussion of policy formulation concerning intractable problems might well start from a consideration of the nature of the problem itself. Discussions of public drunkenness conventionally focus on the legislative history of enactments concerning drunkenness. Our focus here is rather on the substantive problems and interests that underlie the enactments.

There is no single answer to the question, what is the problem represented by the public drunkenness offender? Certainly one element in our concern is the risk of serious harm to the drunken individual if he is not "protected" --

whether from the weather, from traffic or other casualties, from crimes against him, from the short-term or cumulative effects of alcohol, or "from himself." As David Pittman expressed it, "in Alaska during the winter, if there are bodies in the middle of the street, do you leave them there? . . . We should start with fundamental humanitarian values. People should not be allowed to freeze in the street" ("Public Health Services. . .," 1974-75, pp. 6, 9).

But clearly concern for the drunken individual does not exhaust society's concerns. Perhaps the most insistent and urgent problem, in the form of complaints to and pressure on the police and civic authorities, is the problem of the drunk on the merchant's doorstep; in a policeman's words, "primarily, the reason you pick up drunks in the daytime is the merchants" (Thompson, 1975a). More generally, there is a concern with the possession and control of "public" territory, and with the definition of appropriate behavior and demeanor in that territory. The late-afternoon patrol wagon round-up of drunks in San Francisco served the purpose, as a police sergeant put it, of "cleaning up the streets and getting the potential troublemakers off the streets before people start going home from work" (Klein, 1964). When San Francisco street drinkers in recent years started using the seats in newly-constructed Hallidie Plaza, a centrally-located sunken plaza protected from the wind, even the more liberal local columnists approved the police rousting out what were jocularly referred to as the "skidrowgues." Such actions illustrate the informal societal policies of hemming in and enclaving disreputable behavior (Room, 1975) which traditionally helped maintain such "vice districts" as "tenderloins" and skid rows as identifiable areas in American cities.

During the last thirty years, these chronic skirmishes over the control of territory which are part of the "problem of the chronic drunkenness offender" escalated into a full-scale attack on the offender's home territory, private as well as public. The chronic drunkenness offender, and in particular the skid row inhabitant, came to be seen as occupying and by his presence turning into commercially "dead land" (Sigal, 1967) what was potentially immensely valuable property. In the age of cheap gasoline and multiplying freeways, with the core city dying from the flight to the suburbs of those with assets and automobiles, skid row inhabitants, without political clout or moral legitimacy, served as handy scapegoats to be sacrificed to the profitable processes of "urban renewal" (Vander Kooi, 1973). The relocation and other services provided under the federal urban renewal program, particularly in its later years as it came under increasing attack, employed many humane and thoughtful professionals and tried many imaginative solutions, but always within the constraints of an overall policy of obliteration: "the Skid Row way of life is a dangerous and unhealthy one, and Skid Row localities are unfit for human habitation" (Blumberg, et al., 1973, p. 204). In Philadelphia, for instance, the professional's role on skid row was to suggest "what to do before skid row is demolished" (Rubington, 1958); solutions to the problems of skid row should not offer the possibility of regrouping and re-forming: "the facility should be sufficiently far away from the action of the city to pose some difficulties in getting to any skid row area that may continue to exist or recur"; "rather than concentrating the rooming houses in one section of the city (provide them with a community of their own), these should be located in various parts of the city" (Blumberg et al., 1973, pp. 209-211). In some places, traditional police measures also played their role in the tactics of the war of attrition with urban renewal, so that the problem of the chronic drunkenness offender as manifested in police arrest statistics peaked during the urban renewal program. For instance, in Sacramento, California arrests for drunkenness in 1960, at the height of the redevelopment program, were more than twice as numerous as in 1950 or in 1970 (Lockhart and Desrys, 1975, pp. 81-83).

Besides the concern for the chronic drunkenness offender's wellbeing and the various concerns over territory and demeanor, the problem of the chronic drunkenness offender can be seen as a part, filtered through the specific rubric of alcohol, of the larger social concern with what used to be called the "disreputable poor" — "the people," as Matza defines them, "who remain unemployed, or casually and irregularly employed, even during periods approaching full employment and prosperity" (Matza, 1966, p. 289). Matza notes that "skidders are the pathetic and dramatic symbols of the ultimate in disreputable poverty," both in their "tone of neuroticism and flagrant degradation," and in the presence among them of "men and women who have fallen from higher social standing," which offers "visible evidence of the flimsy foundations of success and standing in society" (pp. 295,296). Kurtz and Regier write of the "public threat" of skid row, but the threat is neither as real nor as strongly perceived in the public mind as, for instance, the threat of the drunk driver (Cahalan, Roizen and Room, 1976, Tables 8-10), but is rather a symbolic threat to societal values, corporeal evidence of "the meanness of social life, and the whimsy of destiny" (Matza, 1966, p. 296). The symbolic nature of the threat is illustrated by the criminal offense of begging, which forms part of the stereotype of skid row (Weiner and Weaver, 1974). The difference between the solicitor for charity or the sidewalk newspaper seller and the panhandler does not reside in differences in behavior but rather in the discomfort even many political liberal persons feel when solicited about the panhandler's blatant affront to such values as work and thrift. Bahr and Caplow argue that the homelessness and lack of social affiliations of the skid row inhabitant are also an important part of the symbolic threat. "The presence of a homeless population often arouses a degree of hostility in a settled population that seems entirely disproportionate. . . . Being homeless or vagrant became a felony in England in the fourteenth century and a capital crime under the Tudors; it is still treated as a criminal offense in many American and European cities" (Bahr and Caplow, 1973, p. 6).

Even apart from drinking, then, the skid row way of life is both a reproach and an affront to general social values in its very existence. It has often been pointed out that not all skid row inhabitants drink, and probably only a minority are currently heavy drinkers (Bahr and Caplow, 1973, pp. 246-250); and it has also been pointed out that people on skid row are sometimes arrested for drunkenness without having had a drink (Stern, 1976, p. 150). Clearly the disreputability of skid row is not simply a matter of drinking habits, and clearly drunkenness arrests are often a handy tool in the police's pursuit of other purposes. Nevertheless, the loss of self-control in public demeanor implied by public drunkenness is obviously itself a salient element in the disgrace of the chronic drunkenness offender.

Each of these problems of public drunkenness are longstanding, although the battles over the territory of Skid Row have been particularly acute in the last thirty years. The traditional solution, of course, has been the exercise, with greater or lesser vigor, of police powers to sweep the streets and lock up offenders. There remained always the problem of what to do next: to release the offenders, in which case they were likely to repeat the offense, or to remove them from circulation for a longer time. A lengthy sentence tended to fill the jails, and, as prisoners were gradually removed from the labor market, placed an increasing charge on public finances. With the rise of therapeutic ideals in the nineteenth century, a variety of alternative arrangements were proposed and tried, including the Scandinavian temperance boards studied by Christie (1965). One impetus behind the inebriates' home movement of the late nineteenth century was to provide a solution to problems of public drunkenness. Thus in the annual report of a nineteenth century prison superintendent can be found a complaint and a proposal with a quite modern ring:

> The manner in which drunkards are dealt with is generally admitted to be unsatisfactory. Men and women afflicted with the disease of habitual drunkenness are ignorantly dealt with as criminals, and the abortive treatment to which they are in consequence subjected is neither deterrent nor reformative. Scores of these poor creatures spend years of their unhappy lives in moving backwards and forwards between the public-house and the prison. . . . No possible good is done by their incarceration. Their sentence of two, or seven, or fourteen days, or whatever it may be simply patches them up in preparation for another bout of drink, and so the miserable game proceeds, costing much money and doing no good. . . . It is no uncommon thing to find over fifty convictions recorded against one of these unfortunates. Could anything show more plainly the uselessness of the present system? Indeed, it is generally admitted; but, although reform is much talked about, it has been found impossible to get beyond the talking stage. . . . It is not easy to hit upon remedial measures which are free from objections of some kind. It is no doubt due to this difficulty that the present system owes its continuance. To deal effectively with the matter, new ground will have to be broken, and some purely experimental steps undertaken. Objections will no doubt be raised, but they should not be allowed to obstruct reform. The first thing should be to take habitual drunkenness out of the category of crime, and class it as a disease requiring medical rather than prison treatment (Neitenstein, 1896).

The general sentiments of this proposal can be found in numerous reports in various countries over the ensuing eighty years. And, indeed, a variety of institutions were set up in various times and places to offer rehabilitation to the flow of police-court inebriates. Uniformly, these institutions failed to diminish or even to cope with the whole flow, and most of them eventually disappeared. The reformers of the 1950's and 1960's were thus largely unaware of this previous history, and tended to assume that any alternative to police-court handling of public drunkenness was a substantial innovation.

What was new about the solution eventually embodied in the Uniform Alcoholism and Intoxication Treatment Act was the ostensible commitment to handling all or nearly all public drunkenness outside the court system, and the emphasis on detoxification as separate from the treatment of inebriety. The Uniform Act's approach was thus broader in its coverage but narrower in its proximate aims than previous waves of reform efforts concerning public drunkenness. In the following sections we will consider the interplay of ideological and material interests, including the alcoholism movement, in the adoption of this policy solution.

The Interplay of Interests in the Adopting of the Uniform Act

In their analysis of the "process of social policy formation," Kurtz and Regier (1975) portray the Uniform Act as resulting from the interplay of three sets of players — the "alcohologists," the law enforcers, and the jurists. In my view, these players have been in some respects miscast, and important other players in the action have been omitted.

The "Alcohologists": This term is listed as "rare" in 1968 (Keller and McCormick), and would not have been a recognizable self-identification in the 1940's or 1950's. We might better speak of an "alcoholism movement," recognizing that the coalition of interests in the movement were united only in allegiance to a "disease concept of alcoholism," without full agreement on what this meant, and that to a considerable extent lay thought in the movement led professional thought, rather than the reverse. Alcohol researchers were in the 1940's and 1950's a tiny band. Their acceptance of the disease concept was doubtless mixed in its motivations, but it smacks a little of the "enormous condescension of posterity" (Thompson, 1966, p. 12) to attribute a primacy to a "struggle for respectability" for themselves. Quite clearly, an improved status for the client, the alcoholic, was a primary motivation; and a disease conceptualization of alcoholism was in any case quite in tune with the tendency of the day to conceptualize social problems in terms of pathology or disease.

The relation of the alcoholism movement to the problems of skid row is tinged with paradox. Straus has noted that "in the early 1940's, prevailing studies of alcoholism were limited to the then visible and captive populations of alcoholics. These included, primarily, studies of the habitues of mental hospitals, jails, and some impressionistic reports from skid row" (1975). He attributes the emergence of the "more respectable alcoholic . . . out of hiding" to two factors": Alcoholics Anonymous, which "had then, and has continued to have, its greatest appeal and success with alcoholics who have some remnants of community or family stability and some employability," and the development of the "prototype Yale Plan Clinics of 1944" which developed "an immediate and major clientele from among the more stable elements of society." Ironically, Straus notes, although such clinics had "often justified their original funding by promising to reduce the public investment in jails and mental hospitals, they actually had little impact on such populations" (Straus, 1973).

As Kurtz and Regier pointed out, the argument that skid row alcoholics are a tiny minority of the alcoholism problem has proved enduringly popular, and has usually been quite explicitly presented as an argument for the respectability of the alcoholic — "there is a wide belief that alcoholics are mainly bums. . . . This is one of the damaging misconceptions about alcoholism. . . . The alcoholic can be anyone, rich, poor, brillant, stupid. Many are successful people, business-wise. Many are very intelligent, sensitive men and women" (Blakeslee, 1952). Bacon's early estimate that 20% of alcoholics were on skid row (Blakeslee, 1952, p. 4) was gradually eroded by common tendencies to inflate policy-relevant figures and the expansion of the meaning of "alcoholic" until the current figure of "probably less than 4 percent" was reached (NIAAA, 1972, p.

9). Although the original research report on which the argument is based was by two sociologists (Straus and Bacon, 1951), the argument soon became primarily the property of clinically-oriented policy advocates, and left the realm of research.

Meanwhile, sociologists and social workers became the sole custodians of a renewed research interest in skid row per se — a research tradition that had a rich past (Bahr, 1970) and that fed into and was often supported by federally-funded urban renewal programs, but which did not have much impact on other alcohol literature, at least until recent years. Curiously, in view of the rhetoric about the equation of the alcoholic with the skid row bum, the identifiably skid-row drinker is conspicuous in the early research literature of the alcoholism movement by his absence. His first appearance as the topic of an article in the Quarterly Journal of Studies on Alcohol is in Volume 7, in the guise of the "homeless man" (Straus, 1946). The first Quarterly Journal article with skid row (actually "Skid Road") in the title appeared in 1953; its opening remarks were that "it is common knowledge that the Skid Road of any major American city has a large population of alcoholics. Yet few articles which take cognizance of this concentration are to be found in the literature on alcoholism" (Jackson and Connor, 1953).

How is this statement to be reconciled with such concurrent statements as, "traditionally, the inebriate has been characterized either as a deteriorated derelict who must be punished in jails or relegated to a Bowery type of existence, or as a person with a mental illness warranting institutionalization?" (Straus and McCarthy, 1951). The answer is perhaps to be found in the strongly clinical orientation of all the early and much of the subsequent research of the alcoholism movement. The early clinical researchers were indeed looking at a largely skid-row population — what became the Yale/Rutgers Center of Alcohol Studies was originally located at New York's Bellevue Psychiatric Hospital — but they did not identify it as such. The clinician looks at the patient who comes in the door, and not at the environment outside the door from which the patient came. In fact, paying attention to the social background of the patient is often seen as likely to prejudice the clinician in his actions (Blane et al., 1963; Wolf et al., 1965). The "revolving door," in this case the door of the clinic, was an early experience of the alcohol researchers, but the clinician looked at it pathologically rather than ecologically: Jolliffe is quoted as saying in the mid-1930's, "you know, I must be doing the wrong thing. I send these people out cured [of nutritional diseases]; and the same ones keep coming back in. . . . Why are they drinking that way? That's the real question. It's the alcoholism we should be studying." (Keller, 1975, p. 136).

The tendency to ignore the ecology of the alcoholic has remained a characteristic of much of the clinical literature to the present day, and has been reinforced by the rhetoric about the unrepresentativeness of the skid-row drinker and the vast army of respectable "hidden alcoholics." However, despite both this rhetoric and the large increase in federal funding of alcoholism treatment centers, most public agency programs for alcoholism continue to have a clientele with more in common with skid row than with the socially stable and occupationally integrated client of the Yale Plan clinics: in the 41 NIAAA-funded alcoholism treatment centers in 1972, only 35% of clients were currently married and 46% of the clients in the labor force were employed at intake (Towle et al., 1973, pp. 139-140), and the centers were considered to show a "wide rejection of all but the public inebriate model" ("NIAAA's 46 . . . Centers", 1973).

The skid-row drinker, then, continues as a major presence in alcoholism treatment services and the attendant literature, but his presence is largely unacknowledged and seen as cause for embarrassment. Kurtz and Regier portray the alcoholism movement as somewhat cynically using skid row as a "threatening image" to secure public financing of alcoholism programs. But, throughout the period leading to the Uniform Act, I believe that most involved in the alcoholism movement continued to regard the "public inebriate" as a millstone, discussed as a "special problem" in carefully segregated sections of comprehensive reports (e.g., Plaut, 1967, pp. 110-116). Thus, when the Washington Area Council on Alcoholism, an NCA affiliate led by civil-liberties-oriented lawyers (Beauchamp, 1973, p. 266), became actively involved in several court cases seeking to decriminalize public drunkenness, Marty Mann and other national NCA leaders became very concerned that the publicity in the cases might damage the image of the alcoholic, and even took steps to terminate the affiliation of the Washington group (Johnson, 1973, pp. 366, 371). The national NCA's amicus curiae brief on the Supreme Court decriminalization case, Powell vs. Texas, did not support the Washington group's "alcoholism defense" of the unpunishability of public drunkenness, resorting instead to an argument that did not invoke the alcoholism concept (Johnson, 1973, p. 372).

Those concerned with the "public inebriate" tended to constitute a special constituency in the movement, oriented around urban renewal programs or the halfway house movement. The Uniform Act, directed at state legislatures, was far less crucial to the movement and far less important in securing financial support than legislation at the federal level. The alcoholism movement was in fact a relatively passive participant in events leading to the Act. It provided the conceptual basis for the constitutional lawyers' arguments, and organs of the movement joined in some of the test cases, but the primary initiative lay elsewhere.

The law enforcers: Kurtz and Regier remark on the interest of police and correctional authorities in dignifying their work by ridding themselves of the public inebriate. It is, again, an old concern, perhaps expressed more honestly in earlier times:

> The constant stream of drunkards flowing into the gaols is at once most inconvenient and expensive. Their presence is embarrassing and interferes considerably with the arrangements for properly accommodating the more legitimate prisoners. . . . A huge army of drunkards and vagrants, owing to drink, march into prison, many of them in a filthy, diseased, and verminous condition, forming at once a danger to the cleanliness, order, and usefulness of the gaol (Neitenstein, 1896).

Echoes of these sentiments can be found in the current literature: "the general attitude expressed toward the public inebriate by the police officer can be summed up in the comment of one administrative officer when he said, 'The public inebriate is a social and medical problem and not a criminal justice problem, he's just a nuisance and the police end up having to handle him.'" (Lockhart and Desrys, 1975, p. 102). The police in one San Francisco station complained that they ended up having to deal with public inebriates that a new civilian Mobile Assistance Patrol refused because they were "'too dirty' for them to handle" (Winslow, 1975, p. 34).

For the correctional officer, the inebriate offender is often indispensible in running the jail. Giffen (1966) has commented on the functional and in some ways privileged position in jails of the skid row "regulars" who "fill most of work roles in the internal economy." In the Sacramento County Correctional Center in California, public inebriates are set apart from other prisoners by wearing red shirts. An officer commented, "when the tower guard sees an inmate in a red shirt in a questionable area, he figures the guy just wandered too far or is lost — but if he sees someone in a yellow shirt it's a different matter" (Thompson, 1975a, p. 20). In this jail, as in many others, "the public inebriate is viewed as a model prisoner. Most are docile in custody and, if health permits, are willing to work. The inebriate has long been regarded as the backbone of the inmate work force. 'The inebriate makes our operation click. He is in a sense a model inmate. In the downtown area the drunk is a problem, out here he does the work.' The recent decline in the Correctional Center's inebriate population . . . has resulted in a need to hire people to do the Center's work" (Thompson, 1975a, p. 19). Similarly, the city jail in Oakland, California had to increase its staff by about one-quarter — adding 9 cooks and kitchen helpers, and 9 janitors — when a local judge ruled drunkenness arrests illegal.[26] Cost/benefit analyses of the decriminalization of public drunkenness conventionally ignore the fact that removing the public inebriate from the jail often increases rather than decreases the costs of administration of the correctional system.

Thus although there is a general police and correctional interest in concentrating resources on "serious" crimes, associated with the more "heroic and newsworthy" investigative aspects of police work (Stinchcombe, 1963), this concern runs counter to other concerns of those engaged in day-to-day police and correctional work, and is likely to be strongly manifested only by those with policy and administrative responsibilities. To the extent that there was a law-enforcement contribution to the Uniform Act, it was at these higher levels, and was not necessarily responsive to the concerns of the policeman on the beat.

The jurists: Conversely, in the judicial system, much of the pressure for change came from below. All over the United States, municipal court judges had demonstrated increasingly over the years that they were tired of their role as the doormen of the "revolving door." Often the judges felt that only they truly comprehended the impossibility of the situation:

> We, Judges, are prone to approach the problem of the drunk docket with a peculiar pessimism which only we can understand. . . . We have been driven to extreme frustration. . . . On the one hand, we are cast in the role of the bully trampling down and further degrading those within our society who are already the weakest and most inadequate among us, which grates on our sense of fairness; but, on the other side, we also find ourselves frustrated by the realization that neither do we protect society by the prevention of law violations in this regard. . . . Little wonder we find ourselves gathering in groups such as this with the hope of reorienting ourselves in gathering a fresh approach (Burnett, 1964).

Judges in different localities tried various strategies for changing the situation. Starting in the 1950's these strategies often involved "court honor classes" and other judicially-initiated diversions of chronic offenders. Even prosecutors became involved in these efforts (Daly, 1952). But occasionally the judges adopted strategies aimed at destroying the drunk-court system itself.

New York City provides an early example of the strategy of the judicial sitdown strike. A New York magistrate started systematically dismissing charges of public intoxication in 1935, and five years later his ruling was given general effect in the city by the simple expedient of the Chief Magistrate ordering the destruction of all court forms dealing with public intoxication -- although the law on public intoxication was not changed until 1962 (Murtagh, 1967). The strategy of simply refusing further convictions has since been adopted elsewhere -- e.g., in Oakland, California. District of Columbia judges used a variant of this approach in refusing to commit alcoholics for treatment when public officials sought to comply with the Easter decision in form but not in substance by changing "the sign over part of the local workhouse to read 'Hospital' rather than 'Jail'" (Hutt, 1967, p. 113).

Another strategy adopted in the 1960's was the encouragement and cultivation by local judges of test cases, in hopes that higher court rulings would overturn the system. In the Easter case, after the prosecutor, tipped off by a sudden appearance in court of an attorney and several expert witnesses, declined to porsecute four earlier defendants selected to be test cases, the court's presiding judge tricked the prosecutor into starting the prosecution and then refused to allow the prosecutor to withdraw the case. The judge then took four further actions to set up the test case: he permitted the presentation of nearly a full day of defense testimony; he ruled against the alcoholism defense so that the appellate court would have to fact the issue; he imposed a sufficient sentence to guarantee a right of appeal; and he suspended the sentence so the case would not become moot (Merrill, 1968, pp. 1141-1142).

Although the test-case strategy did not fully succeed in outlawing arrests of alcoholics for drunkenness, it did focus attention on the issue of public drunkenness arrests and their disposition. In the atmosphere created by the Easter and Driver test cases, two presidential crime commissions — one for the District of Columbia and one national in its scope — faced up to the problem of public drunkenness and recommended decriminalization. In many communities the precedents of Easter and Driver and the expectation that Powell would finally outlaw the arrest of alcoholics for drunkenness produced substantial community planning for change. There is thus some irony that Justice Marshall's prevailing opinion in Powell decided against decriminalization not so much on constitutional grounds as on pragmatic grounds of the lack of viable alternatives to arrests for drunkenness (U.S. Supreme Court, 1968, p. 1265).

To a considerable degree, the strategy of the test case was a strategy of focussing public attention. Even if Powell had been decided as expected, it would not have outlawed public drunkenness arrests, but only arrests of chronic alcoholics. Although local in effect, the strategy of refusal by local judges to convict was potentially more far-reaching, in that it effectively totally nullified the public drunkenness law. To be effective, the strategy typically required at least the passive cooperation of presiding and other local judges. The general dissatisfaction of municipal judges with their role in the "drunk court" was an important element in the events leading to the Uniform Act.

The civil-liberties lawyers: During the 1960's, the concept of civil liberties, and in particular the concerns of the American Civil Liberties Union, broadened beyond earlier narrower concerns with first and fifth amendment rights. Lawyers, law students and civil libertarians started to take a strong interest in and seek reform of what were seen as the effectively discriminatory or unjust effects of the existing legal system in a number of areas — juvenile court proceedings, mental illness commitment hearings, capital punishment determinations, etc. In line with these interests, a spate of articles about arrests for intoxication appeared in law-school journals, starting in the mid-1960's.

American Civil Liberties Union lawyers took a primary role in the test cases concerning public intoxication. In alliance with elements of the alcoholism movement, and as we have mentioned often with the cooperation of the municipal court judges, the test cases concentrated on the disease concept of alcoholism, seeking to apply to alcoholism the precedent set for opiates in Robinson vs. California (U.S. Supreme Court, 1962) that a person could not be punished for illness. This was not the only possible ground for attacking the drunk-court system. Public drunkenness laws are often potentially unconstitutionally vague, and for that matter they might be attacked as punishing persons not for an act but for being in the particular mental state of drunkenness. Certainly, the drunk-court system could have been totally immobilized by insisting on applying to it the standards of procedural due process in criminal cases which were developing during the 1960's. The adoption of the disease concept of alcoholism as the preferred strategy of defense, then, was not an inevitable choice, and reflected the alliance of the civil-liberties lawyers with the alcoholism movement.

But the civil liberties lawyers also had a contribution to make to the substance of the alliance, a contribution which fundamentally affected the Uniform Act. The proposition that chronic public drunkenness reflects a disease and should be shifted from penal to therapeutic handling is, as we have suggested, a recurrent historical theme. Usually, however, the proposition has been accompanied by the corollary that the inebriate should be involuntarily committed for treatment for an extended period of time. The nineteenth-century author quoted earlier is typical on this point: he proposes a course of treatment

> involving detention, more or less prolonged, in an inebriate reformatory situated some distance from any large center of population. The establishment should not present a prison appearance. . . . The inmates, or more properly speaking, patients, would be habitual drunkards. . . . After a certain number of appearances before the Courts a person might be deemed an habitual drunkard, liable to detention in the Reformatory. Such detention should not be for less than one year. No possible good could be effected in less time for such cases (Neitenstein, 1896).

In tune with these sentiments, public and quasi-public inebriates' reformatories, with associated powers of involuntary commitment, were set up in many places in the late nineteenth century — including at least the United States, Scandinavia, England, and Australia.

In the early 1960's, the drift in the alcoholism literature was clearly in the direction of long-term involuntary treatment as a major alternative to public drunkenness arrests. In part because of the voluntaristic and middle-class-oriented traditions of Alcoholics Anonymous and the Yale Plan Clinics, the alcoholism movement had a historical predisposition towards voluntary treatment — often expressed in terms of the concept of "motivation." An unmotivated alcoholic, one who was not "ready," could not be helped; the objection was thus pragmatic rather than explicitly ethical. In the early 1960's, evidence was gathered to support the proposition that compulsory treatment could be effective, that it could be seen as "one more technique in the caretaker's armamentarium of tools for enhancing the motivation and needs we assume to exist in alcoholics" (Chafetz, 1964). An influential article argued that the concept of motivation was "a source of institutional and professional blockage in the treatment of alcoholics" (Sterne and Pittman, 1965). At a federally-sponsored conference of judges in 1965 on "the court and the chronic inebriate," Pittman proposed in his "overview" presentation that, for the "revolving door group,"

> we should strongly consider the adoption of compulsory treatment under civil commitment procedures for the alcoholic. . . . If we view the alcoholic individual as being not only one who is suffering from a chronic disease but, in the case of the chronic intoxication offender, one whose behavior is a nuisance to society, then we can construct a case for compulsory intervention by public health measures. Experience has shown that enforced custodial care at a penal institution has not radically altered the behavior of the public intoxicant; therefore, we should perhaps attempt to create compulsory treatment facilities, much in the same sense as they have been established for tubercular cases. (Pittman, 1965)

In line with this drift in the literature, two-thirds of a sample of alcoholism agency personnel agreed that "for some Skid Row alcoholics, enforced treatment would probably be successful," and other surveys of treatment personnel showed that "substantial percentages endorse the principle of involuntary treatment" (Sterne and Pittman, 1965, pp. 45, 41).

In any other era, long-term involuntary commitment to treatment might thus have been expected to emerge as the obvious alternative to criminal punishment. Such a solution offered something for everyone: "the conservatives liked the confinement aspects and the moderates liked the treatment provisions" (Kramer, 1970, p. 262). For the therapists, it offered an assured and captive supply of cases for treatment. Even in the early 1960's, in deciding Robinson vs. California, the U.S. Supreme Court, ruling that opiate addiction per se could not be punished, had observed that

> a state might establish a program of compulsory treatment for those addicted to narcotics. Such a program of treatment might require involuntary confinement (U.S. Supreme Court, 1962).

In line with this decision, California had set up a massive "civil commitment" program under the auspices of the Department of Corrections, to which addicts were committed for treatment for terms usually of seven years (Kramer, 1970). Similar programs were set up by New York State and federal authorities.

But the natural line of development in the societal management of alcoholism was interrupted by the coming onto the scene of the civil-liberties lawyers. Often developments in the mental illness and alcoholism fields have proceeded along parallel but surprisingly independent paths, with alcoholism commonly lagging mental illness by a step or two. Thus, for some examples, the era of founding public inebriate reformatories in the nineteenth century occurred well after the establishment of state mental hospitals; alcoholism is only now going through, in the form of "responsible drinking" campaigns, the equivalent of the "positive mental health" community organizing campaigns of the 1950's; the doctrine of the "co-alcoholic" gained acceptance well after the "discovery" that the seat of mental illness might be in the family as a whole rather than the presenting individual. In the mid-1960's, as alcoholism headed towards a policy of long-term involuntary commitment, mental illness was heading away from it. Since the late 1950's, long-term involuntary commitment for mental illness and its institutional embodiment, the state mental hospital, had been under attack from a number of directions: from the countervailing ideology of the community mental health centers movement; from the focus of sociologists on depersonalization in the "total institution" and stigma outside it; from literature calling in question the extent and effectiveness of treatment in the hospital; from attacks on the disease conceptualization of mental illness; from fiscal conservatives unsympathetic to psychiatrists and to expensive state institutions; and from legal attacks on the process and substance of commitment proceedings. In California in the late 1960's, these trends culminated in the Lanterman-Petris-Short Act, effectively eliminating long-term involuntary commitment, and the Reagan administration decision, only partially carried out, to close down all state mental hospitals.

The lawyers broke into the developing cycle of alcoholism thought by bringing with them firmly-held and concretely-based perspectives forged in the battles over involuntary commitment for mental illness. Again, their position was not unprecedented; the nineteenth-century author noted that his proposal was "no doubt of a stringent character. . . . Probably well-meaning people would cry out that the liberty of the subject is being unduly interfered with" (Neitenstein, 1896). But it had a new forcefulness. As a staff member for the 1967 President's Commission on Law Enforcement and Administration of Justice put it, citing an American Bar Foundation study's "excellent description of abuses surrounding the commitment of the mentally disabled,"

> placing alcoholics in confinement against their will, whether on grounds that they pose a threat to their own or other's safety or no stated grounds at all, is simply a continuation of the warehousing program which exists today. Although it may be laced with the illusion of an altruistic treatment program, it is in fact

> an attempt to get an undesirable population out of our hair, and, more important, out of our sight. Also, it is — whether we care to recognize it or not — a greater threat to the civil liberties of impoverished alcoholics than the method used today (Stern, 1967a, p. 46).

At an annual meeting of the National Council on Alcoholism, Peter Hutt, the ACLU counsel on the Easter and Powell cases, stated the lawyers' position unequivocally:

> 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.)

In its decision on the Powell case, the Supreme Court was clearly affected by the winds of change in perspectives on involuntary commitment. Justice Marshall's prevailing opinion notes that

> One virtue of the criminal process is, at least, that the duration of penal incarceration typically has some outside statutory limits. . . . "Therapeutic civil commitment" lacks this feature; one is typically committed until one is "cured." Thus, to [rule that alcoholism is unpunishable] might subject indigent alcoholics to the risk that they may be locked up for an indefinite period of time under the same conditions as before, with no more hope than before of receiving effective treatment and no prospect of periodic "freedom." (U.S. Supreme Court, 1968, pp. 1265-6)

Although the lawyers were bent on halting the drift toward involuntary treatment, they shared a number of fundamental assumptions with the other parties involved: that public drunkenness should be decriminalized; that there should still be some mechanism for removing drunks from the street; that community authorities should be forced to make treatment and help available to those desiring it. All parties were in agreement that drunks could be held involuntarily at least until the gross effects of drunkenness or withdrawal had passed. With these requirements, it was inevitable that the detoxification center as a "sobering-up station" and referral agency for those desiring further help should become the chosen alternative to the drunk tank.

In its recent history in the U.S., the detoxification center concept apparently originated as a change in police arresting procedures rather than as a separate non-criminal institution. In 1963 the police commissioners in St. Louis, Missouri, "made it mandatory for all individuals 'picked up' from the streets of St. Louis [for drunkenness] to be taken to the emergency rooms of the two city hospitals for physical examination" (Pittman, 1965). Those "in need of medical care" — about 10% (President's Commission . . . Crime, 1967, p. 69) — were "hospitalized instead of being jailed"; the others were "held until sober" by the police and then released. By 1965, the idea of a specific "detoxification center" had caught the eye of the federal Justice Department as a way of reducing what were coming to be seen as extraneous burdens on the law enforcement system. Nicholas Katzenbach, then Attorney General and later chairman of the President's Commission on Law Enforcement and the Administration of Justice, testified to Congress in 1965 that

> We presently burden our entire law enforcement system with activities which quite possibly should be handled in other ways. . . . Better ways to handle drunks than tossing them in jail should be considered. Some foreign countries now use "sobering-up stations" instead of jails to handle drunks. Related social agencies might be used to separate them from the criminal process. (Quoted in "St. Louis Proposal," 1967, p. 50)

In 1966, the Justice Department funded a demonstration detoxification center in St. Louis. A prominent feature of its aims was the reduction of police time spent in processing chronic drunkenness arrests, since it would replace what had become a lengthy arrest process of transportation to the city hospital and then to the lockup. Faced with the Easter decision, the President's Commission on Crime in the District of Columbia in its 1966 report adopted detoxification centers as the mechanism of decriminalization of drunkenness: "Persons who are so drunk that they cannot care for themselves should be taken into protective custody by the police, and taken immediately to an appropriate health facility. . . . All public inebriates, whether arrested because of disorderly conduct or taken into protective custody, should receive emergency medical care [in an] emergency care unit. . . . The incapacitated inebriate would be detained only until he attains sobriety" (President's Commission . . . Crime, 1967, pp. 78, 79).

Although the Commission stressed referral for further treatment, it hedged on the issue of involuntary commitment: "the Commission recognizes that the constitutionality of a civil commitment law for alcoholics, in the absence of a criminal charge, is far from clear. . . . Nevertheless, a narrowly-drawn statute, providing for short-term commitment of severely debilitated chronic alcoholics who pose a direct threat of immediate injury to themselves, might be a useful adjunct to a treatment program. . . . After an appropriate period of experimentation with voluntary treatment of alcoholics under a comprehensive program, the Judicial Conference of the District of Columbia should consider the need for and the constitutionality of a civil commitment statute for chronic alcoholics" (President's Commission . . . Crime, 1967, pp. 79, 81).

It was in the District of Columbia Crime Commission report, then, that the policy settlement later embodied in the Uniform Act first appeared. Not just the "alcoholics" covered by Easter, but all public drunkenness arrests (where no disorderly behavior or other crimes were involved) were to be diverted to an "emergency care" center for short-term involuntary detention. This center would both detoxify its clients and diagnose and refer them for further treatment. Further treatment would for the most part be voluntary, but a limited provision would be made for involuntary commitment of the severely debilitated.

The civil-liberties lawyers clearly influenced this settlement but did not totally control it. The adoption of the concept of a detoxification center did ensure a clear separation between the process of short-term detention and that of long-term commitment for treatment. Beyond the detoxification center, the emphasis was to be on voluntary treatment. But, however de-emphasized and hemmed around with restrictions, provisions for involuntary treatment were still envisaged. The civil liberties position on involuntary commitment was to be represented not so much in the statutory provisions as in the accompanying declarations of intent.

It was recognized that, if the detoxification center was not to become another revolving door and if involuntary commitment was to be a rare event, most clients would have to volunteer for further treatment. On this crucial point in the workability of its solution, the Commission turned to the "alcoholism consultants to the Commission." In line with the general tenor of the literature at the time, which emphasized the depression, dependency, and need for affiliation of the skid-row drinker, the experts gave their assurance. "Experts say that the vast majority of chronic alcoholics, typically passive and dependent personalities, would voluntarily join in an effective, comprehensive treatment program." (President's Commission . . . Crime, 1967, p. 79). It was on this assurance that the policy of the detoxification center as a solution to the problem of the chronic drunkenness offender was built.

Decriminalization and civil detoxification centers were also adopted as policy recommendations by the national President's Commission on Law Enforcement and the Administration of Justice, which reported in 1967. In this report, however, the civil liberties position won a fuller victory; there is no mention of involuntary commitment, and it is indicated that after detoxification, "the decision to continue treatment should be left to the individual." (p. 5) In line with this position, David Pittman, who had earlier called for civil commitment procedures (1965), made no mention of them in his consultant paper for the Commission, although such ambiguous locutions as "supervision" and "placing" of alcoholics are used (Pittman, 1967b). The 1967 Commission report had an important influence in diffusing a collection of significant documents on alternatives to the drunkenness arrest throughout the country.

As Kurtz and Regier note, the Uniform Act came in the wake both of these commission reports and of previous model-law drafting efforts. By the time the Uniform Act was adopted, Congress and several state legislatures had also had before them public inebriate diversion bills. These bills took varying positions on the issue of involuntary commitment. In the California bill of 1969 (which did not pass), an initial provision for compulsory care for a limited time was amended to lower the maximum commitment to be the same as the new state mental illness commitment limits — fourteen days (Miller, 1970, p. 281). Since then, the mental illness precedent has kept any longer-term commitment provision from passing in California.

As noted above, the Uniform Act adopted the solution of the District of Columbia Crime Commission: provision for involuntary detoxification, and limited and separate provisions for civil commitment for treatment for a total maximum period of seven months with three commitment hearings required for the maximum period. In the comments which accompany the Act, all the emphasis is on voluntary treatment, even for the detoxification process:

> A small minority of intoxicated persons are "incapacitated" in that they are unconscious or incoherent or similarly so impaired in judgment that they cannot make a rational decision with regard to their need for treatment. . . . [Protective custody provisions are] intended to assure that those most seriously in need of care will get it. . . . It is anticipated that the need to resort to short-term commitment for emergency medical care under [a section providing for a 5-day hold] will arise most infrequently. (National Conference . . ., 1971, pp. 17, 19)

With respect to longer-term commitments, the emphasis on voluntary process in the comments repeats the earlier Commission's assertion that most alcoholics will volunteer for treatment:

> Voluntary treatment is more desirable from both a medical and a legal point of view. Experience has shown that the vast majority of alcoholics are quite willing to accept adequate and appropriate treatment. . . . Involuntary treatment is permitted only in exceptional and very clearly prescribed circumstances. . . . Involuntary treatment would not be warranted merely because the person needs treatment, or has substantially inconvenienced his family, or has frequently been intoxicated in public, or because his drinking is harmful to his health. Commitment would be warranted, however, if the alcoholic exhibited cognitive deficiencies and was so debilitated that his thinking was confused not only with respect to his drinking problem but in other areas of behavior as well. (National Conference . . ., 1971, pp. 14, 23)

In making separate provisions for detoxification, and in the explanatory comments and procedural limitations on involuntary commitment, then, the Uniform Act did temper its adoption of the therapeutic solution in accordance with the revived concerns for civil liberties at the end of the 1960's. It may be doubted, however, whether the comments and limitations had much effect on the Uniform Act's target audience: a 1973-74 survey of the status of the states' legislation found that "the provision most common in their alcoholism legislation was involuntary commitment to treatment" (Clarke, 1975, p. 224). Eighty-three percent of the thirty-six responding states reported this provision, which may in some cases have antedated the Uniform Act; while 70% reported that decriminalization of public intoxication had become a fact anywhere in the state, and only 26% reported repeal of all public drunkenness statutes (Clarke, 1975, pp. 225-228). The survey suggested that many of the procedural niceties embodied in the Act were not present or effectively used in the state systems; among responding states with involuntary alcoholism commitment procedures, only 62% complied with the Act's provision requiring a physician's examination or certification for commitment, only 10% complied with the Act's preference that a physician testify at the commitment hearing (National Conference. . ., 1971, p. 20), and in only 38% had any commitment application ever been contested.[26]

The new federal agency: Other participants in the events leading to the uniform Act could be identified. For instance, the formation of a separate federal agency specifically concerned with alcohol problems, as a result of an upsurge of Congressional interest in the late 1960's, created a group with an inherent interest in making and being seen to make public policy on alcohol issues, and the adoption of the Uniform Act became a substantial element in the National Institute on Alcohol Abuse and Alcoholism's evidence that it was accomplishing something (see NIAAA, 1971, pp. 85-97, 105-121). NIAAA has regularly charted the progress of states' conformance with the Uniform Act, although, as noted above, the conformance has often been more in form than in substance. The strategy of promoting model uniform legislation has been considered successful, and there have been proposals to apply it to other areas of alcohol legislation such as alcoholic beverage control laws (e.g., Medicine in the Public Interest, 1975).

The 1960's consensus and its unraveling

The social problem of the chronic drunkenness offender has, as noted above, at least three major dimensions: the issue of society's duty to protect the individual from self-inflicted harm; the issue of control of the use and ambience of urban territory; and the issue of tolerance of lifestyles rejecting major social values.

The consensus of the 1960's of which the Uniform Act was the logical outcome identified all these three problems with one another by a simple set of equations: the best way to protect the individual from harm was to get him off the street and into long-term treatment; those who needed help or protection were those affronting social values; a solution to the territory problem (urban renewal of skid-row) would eliminate the affront. The package was neatly tied together with a ribbon of humanitarian and sympathetic sentiment: skid-row men were basically depressed, dependent and isolated individuals who would welcome long-term treatment as a way out of their miserable predicament; and they were in any case going to have to adjust to a change in lifestyles, since skid-row was perceived as an institution in the process of dying a natural death (Bahr, 1967).

The civil-liberties lawyers departed from this set of equations only in a small if crucial respect. Part of their concern with avoiding civil commitment procedures was in fact directed not at the chronic drunkenness offender's civil liberties but at the inevitable consequences for the nature of the treatment system of introducing compulsion into it — a concern founded on bitter experience with mental hospitals.

> A statutory structure devised for punishment is not suitable where treatment is the goal. To my mind the keystone of the punitive framework is its compulsory nature. A truly treatment—oriented system must rely on the voluntary

> desire of the chronic alcoholic to help himself. In the legal framework now evolving in America to handle the derelict alcoholic, there is one major roadblock to a fully treatment-oriented approach. That roadblock is civil commitment. . . . The right to treatment is a fallback position in the struggle to provide humane and effective treatment for the chronic alcoholic [,] if the legislature and the courts refuse to accept the view that civil commitment is unwise, unlawful, or unconstitutional. . . . As long as a city can get away with storing its alcoholics involuntarily in an institution, it will do so. (Goldfarb, 1967, pp. 40, 42) .

In terms of the 1960's consensus about the chronic drunkenness offender, the crucial new element introduced by the involvement of the civil-liberties lawyers was a distinction between short-term and long-term harm. Perhaps by analogy with suicide "observation" procedures, perhaps in deference to the merchant's demand that drunks be removed from his doorstep, the lawyers concurred with compulsory short-term intervention: "few objections would be raised by civil libertarians if immobile drunks were taken to . . . a civil detoxification facility where the length of incarceration would not exceed a few hours" (Stern, 1976b, p. 155). But while they agreed that treatment was the best solution to long-term harm, the liberties of the individual, however misused, outweighed the arguments for making it compulsory:

> The common-law rationale for the compulsory civil hospitalization of citizens is that the citizen is "dangerous to himself or others." . . . What does "dangerous to himself or others" mean? Is the four-pack-a-day smoker dangerous to himself? Or the overweight person who persists in eating fattening foods? Or the religious person who fasts for a month? Certainly, all these people are acting in a physically self-destructive way. They are dangerous to themselves. Yet we do not lock them up in hospitals. . . . Certainly [the alcoholic] is, in some sense, dangerous to himself. He has embarked on a self-destructive course of behavior. I would submit, however, that under developing notions of the content of

> the phrase, he is not legally dangerous to himself. . . . Depriving an individual of his liberty under these circumstances strikes me as an assumption of authority by the government that is without meaningful justification. (Goldfarb, 1967, p. 41)

As we have noted, this position was reintegrated into the consensus by the alcoholism experts' unchallenged assertion that most chronic drunkenness offenders would volunteer for treatment. To the extent that this assertion turned out to be true, all interests would be satisfied — the humanitarian's commitment to saving the downtrodden, however recalcitrant, the civil litertarian's commitment to voluntary processes, the merchants and downtown interests' commitment to displacing the street drinker, the moralist's preference that the Skid Row way of life be proclaimed and admitted to be pathological.

In the meantime, a more thoroughgoing questioning of the consensus position on the chronic drunkenness offender had begun to appear in the sociological Skid Row literature, although it was not reflected in the Uniform Act and is not as yet reflected in any explicit policies on public drunkenness. Sociological observers had long recognized that drinkers on skid rows had their own set of social rules and obligations, but postwar discussions had tended to share the view of official agencies that, to the extent skid row had an indigenous subculture, it was a subculture of desperation no one would willingly belong to. "Any conception of Skid Row as a tightly-knit, well-integrated and organized community where most of the residents interact freely and have a common 'subculture' and tradition is a complete myth. Skid Row seems to be composed largely of discontented individuals who live in semi-isolation, who have few if any close friends, and who survive by being suspicious of everybody" (Bogue, 1963, pp. 169-170).

In 1965 Samuel Wallace directly challenged this view. Wallace noted that "the assumption of the skid rower's abnormality — whether social, psychological, physiological, or even physical — has many exponents. The sanction this assumption gives to prevailing community attitudes might have something to do with its popularity. If the skid rower is socially inadequate, disturbed, or intellectually deficient, community programs such as institutionalization become legitimate. The community may even comfort itself with the thought that these men will be 'happier' in institutions" (Wallace 1968, p. 129). In Wallace's view, "the burden of evidence reviewed herein points toward skid row as a community with rather than without goals and means for its members. . . . Generally they extend to one another those very things which society denies, beginning with toleration, if not acceptance, and ending with mutual sharing" (Wallace, 1968, pp. 135,156). Wallace explained the discrepency between his observations and previous studies as a matter of the "insider's" as against the "outsider's" point of view; Skid Row men tend to mirror back to the outside world what they think the outside world wants to hear (p. 159).

Wallace's distinction between the inside and outside views of skid row was developed in Wiseman's landmark study (1970) of the discrepancies between the skid-rower's and the agency worker's perceptions of their mutual interaction. In Spradley's "ethnography of urban nomads" (1970), the theme of a Skid Row subculture with its own norms and authenticity was further developed.

> A nomadic way of life not only hides what others may consider to be personal failures, but it is a world of strangers who are friends. . . . There is a "brotherhood of the road" in this culture which is often entered while in jail. Of course, liquor, which is defined in American culture as a social lubricant, is widely used by urban nomads. When strangers meet they become friends more quickly when they have had a few drinks. Aside from the physiological effects of alcohol, drinking rituals, bottle gangs, and sharing a drink with another are powerful symbols of acceptance and comradeship. . . . Skid Row bars are not simply places to drink,

> they are institutions where strangers with spoiled identities can meet and find security in their common humanity as tramps (pp. 255-256).

Spradley ends his book with an attack on institutionalization as a policy for dealing with chronic inebriates, calling instead for toleration of the Skid Row lifestyle as one more culture in a multicultural society:

> The lives of urban nomads are surrounded by institutions which act upon them, coercing them to live by their wits, robbing them of a sense of freedom and responsibility for their actions. Most tramps need freedom rather than assistance, respect rather than restrictions. If we grant them this kind of freedom they may drink excessively and appear on our streets in a state of intoxication. . . . There are men who, out of desire, habit, or some other reason, will always be tramps. Is American society large enough to tolerate and even welcome such diversity? . . . Can we allow men to drink from bottles in Skid Row alleys as well as from thermos jugs in football stadiums? . . . Become intoxicated in full public view as well as behind the walls of expensive homes? . . . Recognizing the dignity of urban nomads is a small but important step to creating a world of strangers who are friends (Spradley, 1970, pp. 260-262).

The conclusions of Wallace, Wiseman and Spradley have since been criticized on the basis of findings from skid-row survey studies. Blumberg et al. point out that, in a sample of 236 men in the Philadelphia core skid-row area interviewed by medical students in 1960, only one-twentieth conformed to what would presumably be "the 'pure' type Skid Rower in Wallace's terms," in that they identified themselves as members of Skid Row and liked the neighborhood and wanted to relocate to this or another Skid Row (Blumberg, et al., 1973, p. 131). Comparing a sample of Bowery men with a sample from Park Slope, an ethnically similar poor district of Brooklyn, Bahr and Caplow found that Skid Row men were less distinctive than was often supposed, but did show differences in happiness and well-being:

> We have found that in many ways the Park Slope man is like the Bowery man, and many of the supposed characteristics of skid row life are merely attributes of poverty and aging. The Bowery man's history is less distinctive than formerly supposed with respect, for example, to marginality, or under-socialization. But there is no doubt that, according to the indicators of well-being and happiness available to us, he is distinctly unhappy. . . . Most of the indicators are directly linked to the Bowery man's present location on skid row, his identity as a skid row man, and the stigmatization which accompanies that identity (Bahr and Caplow, 1973, p. 312).

Where Wallace had argued the convenience to the larger society of characterizations of Skid Row which justified intervention, Bahr points out that romantic celebrations of skid row life can "serve as guilt-reduction devices for the average citizen, as well as for the rehabilitation agent. If skid row men prefer the quality of life which characterizes skid row, then the rest of us are absolved of guilt" (Bahr, 1973, p. 8).

Although the dispute over perspectives has tended to be cast in terms of the validity of data (Blumberg et al., 1973, pp. 243-252; Bahr and Caplow, 1973, pp. 352-362), the two perspectives may after all be compatible. Bahr notes that "the skid row man almost always has some good things to say about the row" (1973, p. 167), and Spradley points out that while skid-row men "find they don't like a lot of it," they may still prefer the skid-row lifestyle to "the alternative of steady job, families, and participating in a community with a spoiled identity" ("Public Health Services . . .," 1974-75, pp. 3-4). And there appears to be no disagreement that many of those living in "Skid Row areas" are not part of the skid-row subculture, nor for that matter part of the chronic inebriate population. So the challenge to the consensus of the 1960's posed by Wallace, Wiseman, and Spradley remains valid. However much of a minority they may be, there are apparently men who enjoy a Skid Row way of life, and who will not willingly move nor volunteer to be "cured." Should the larger society respect their decision, rather than continuing the traditional policies of enclaving and degradation, or the newer policies of obliteration or therapeutic intervention?

A third challenge to the consensus of the 1960's is only now beginning to be felt, and derives from the accumulating empirical experience from evaluations of various public inebriate diversion programs (e.g., Lockhart and Desrys, 1975; Lockhart et al., 1975; Lockhart and Heacock, 1975; Lockhart and Cohen, 1975; Young, 1975; Winslow, 1975; Thompson, 1975a). Generally speaking, detoxification procedures and facilities have not accomplished what it was thought they would; as a respondent put it in one evaluation, in terms of the original goals the new detoxification unit had made "no major contribution, except that it's lightened some of the jail's workload. As for the community, the drunks are still there, they are just channeled differently now and with more expense" (Young, 1975, p. 33).

1. A substantial proportion of detoxification center clients do not accept or follow through on referral for further treatment on a voluntary basis. For example, in four California counties, the proportion of cases actually becoming involved in alcohol aftercare programs ranged from about 10% to aboue 30% (Lockhart and Desrys, 1975; Lockhart et al., 1975; Lockhart and Heacock, 1975; Lockhart and Cohen, 1975).

2. Detoxification centers therefore do not eliminate the "revolving door" and in fact tend to replace it with what observers on the scene often describe as a "spinning door" (Lockhart and Desrys, 1975, pp. 910; Lockhart and Cohen, 1975, p. 74), since the client is often back on the street more quickly than under criminal justice procedures. The detoxification center is thus not a solution to the problem of the drunk on the merchant's doorstep. The increased recidivism

"becomes an irritation to the police. . . . They are still receiving complaints from the merchants and the community to clean up the downtown area" (Lockhart and Desrys, 1975, p. 43). "The merchants have placed pressure on the law enforcement system to revert back to the old criminal justice system of long retention in the County jail to remove the inebriants from the street" (Young, 1975, p. 45).

3. For a number of reasons, detoxification procedures do not turn out to be an exact replacement of criminal justice procedures. This history of the failure of expectations that one solution to a problem will entirely replace another is lengthy; for instance, alcoholism treatment facilities were closed all over the country at the onset of prohibition in the confident expectation that they would no longer be needed (Corwin and Cunningham, 1944, p. 19). Similarly, in Sacramento, "initially the detoxification center was expected to replace the existing system including the city jail drunk tank," and in fact "the city jail drunk was phased out of operation" (Lockhart and Desrys, 1975, pp. 84, 86). Often the detoxification center holds clients longer than some of them would be held under informal police "kick-out" procedures; in one case this has produced a recommendation to increase the capacity of the detoxification center by shortening the average stay of clients (Thompson, 1975a, p. 59). Often the detoxification procedure or center attracts a clientele somewhat different from that of the drunk tank. Those arrested for public inebriacy are, after all, only a portion of the potentially drunk and ill population. Detoxification centers attract some voluntary clients who, in terms of the original rationale, take beds away from the target population (Thompson, 1975a, p. 58). In some cases these "volunteers" come in because they see the police paddy wagon coming (Winslow, 1975, p. 30), but it is clear that there is some demand for detoxification services that the police do not "serve." For instance, when a Mobile Assistance Patrol

was initiated in San Francisco to transport public inebriates who do not refuse its services to detoxification facilities, it was stiuplated that the counselors should not go into private places such as homes and hotel rooms, since the intention was to reduce the police role in public drunkenness. But in practice the Patrol responds to the needs it finds:

> Often calls are made by hotel managers or friends of a client who ask MAP to come into the hotel to pick the client up. MAP in that case urges the caller to get the client at least into the lobby, but often MAP must go into the room. When the counselors were asked, "How often do you enter a building to assist a public inebriate?" their replies can be summarized as "more often than we should," but "no more often than necessary," which turns out to be about 40% of the time (Winslow, 1975, pp. 18-19).

The evaluator of the Patrol pointed out that it and the police were in part addressing different problems:

> Those people who make a public disturbance or a public nuisance of themselves when they have been drinking, even only a few drinks, are the main target for this police precinct, whereas those people who are in need of detoxification or medical care, primarily for their own well being instead of directly for the well being of others, are the main target of the Mobile Assistance Patrol. . . . The police are performing their function in arresting people who are causing a disturbance as a result of alcohol and the Mobile Assistance Patrol are performing their function by picking up clients who have essentially a health problem. Whereas these populations do overlap . . . the populations are not totally the same. Thus . . . arrest statistics will not necessarily be substantially reduced as a result of the Mobile Assistance Patrol (Winslow, 1975, p. 32).

The detoxification staff often take actions to increase the disparity between the police and detoxification populations. When detoxification facilities are limited, the acceptance of voluntary clients in itself increases the disparity (Thompson, 1975a, p. 34-35). In addition, staffs will often discourage or refuse particular clients or classes of clients. In two of the four California centers evaluated, the staff for a time maintained formal "Do-Not-Admit" or "Undesirables" lists (Thompson, 1975a, pp. 15, 35-36; Young, 1975, p. 32). Even in detoxification centers, the treatment staff seem to seek to redefine their concerns towards a more hopeful and respectable clientele, and find themselves in conflict with community pressures to focus in on the visible problems (Roizen, 1972).

4. Diversion of the public inebriate to a detoxification center is unlikely to cost less than public drunkenness arrest procedures. In three out of four California counties, the total cost of handling public drunkenness rose when detoxification centers opened (Lockhart et al., 1975; Lockhart and Heacock, 1975; Lockhart and Cohen, 1975); in the fourth, the decline in costs resulted from a change in criminal procedures following the closing of the drunk tank, so that the proportion of those arrested for drunkenness who were released without trial after 4-12 hours rose from 1% to 68% (Lockhart and Desrys, 1975, p. 89). These calculations do not take into account the loss of jail labor force and the fact that police and jail systems are to some extent fixed-cost systems — their resources can be diverted to other tasks but not really "saved" (Thompson, 1975a, pp. 31-34).

The issue of costs and their allocation is crucial in any settlement of chronic inebriacy policies. The handling of public drunkenness in the U.S. has traditionally been a local matter, dealt with at the city or county level by local authorities acting often under local ordinances. Although federal and state law enforcement assistance authorities may have viewed the issue of costs primarily in terms of the reallocation of police resources to more "important" work, at the local level the issues of cost have always revolved around the total net cost to the local budget. Beauchamp's detailed history of events in the District of

Columbia surrounding the Easter decision shows the strength of these budgetary forces even in a federal enclave (1973, Chapter 7). The judges, civil liberties lawyers, and alcoholism movement people could force changes in the legal framework for processing public drunkenness, but not, in the absence of new "outside" funding, in the substance of the process: in the wake of Easter, a wing of the Workhouse was transferred to the Health Department, and its correctional officers simply redesignated as "alcoholism counselors."

The issue of the financing of the handling of public inebriates is particularly crucial in the present era of stagflationary pressures on local budgets. Local authorities have usually been quite willing to change procedures for handling public drunkenness if federal or other "outside" money will finance the new facilities, particularly if the changes open the possibility of closing down the locally-financed drunk tank. However, if the money is not earmarked for public inebriate programs, it tends to be used for other purposes, often more related to the maintenance of county hospitals and other existing institutions than to an overall plan for alcoholism treatment facilities. Outside money spent on public inebriate facilities has usually been in the form of demonstration grants, which are made only to a few places, with the presumption that the program will eventually be transferred to local funding. In this situation, a permanent and pervasive solution must seek local funding. The argument for such funding can take two forms: that the program is a necessary or proper responsibility of local government in a humane civilization; or that it is cheaper than any available alternative. The latter argument builds no public understanding of or constituency for a program, but it is always the line of least political resistance. Unfortunately, it is often falsifiable (Room, 1973) — in general for therapeutic programs, with their generally high-cost and intensive labor requirements, and in particular for therapeutic solutions to public drunkenness. The general experience of the postwar era of therapeutic solutions to social problems appears to have left local authorities with a considerable skepticism about arguments that treatment programs will save them money. Thus, California allowed for therapeutic diversion from a public drunkenness charge since 1969, and provided for and expressed a policy preference for civil protective custody and detoxification as an alternative to arrest since 1971. Yet only a few counties have established identifiable public inebriate detoxification facilities, and these facilities appear to be funded largely from "outside" sources (Thompson, 1975b, pp. 21-22).

Ironically, the problem of costs has led to an abandonment of the medical rubric which was the original aim of the disease concept of alcoholism: in California, state policy now favors non-medically oriented "social model" detoxification centers (Thompson, 1975b, pp. 33-34). Such non-medical detoxification centers appeared as policy alternatives rather suddenly in 1973. In late 1972, Morris Chafetz, then Director of NIAAA, stated that detoxification "is a medical problem and the resources for taking care of any kind of drug overdosage ought to be handled in a medical setting" ("Interview . . .," 1972). By six months later, he was quoted on the subject as stating he was "not convinced that health facilities are the proper place for alcoholic people. Just because it has been the way we've followed in the past, doesn't mean it is the best way" ("The Trend . . .," 1973).

Another recent strategy to solve the issue of permanent and pervasive funding has been the efforts in a number of States (e.g., California SB 204, 1975) to establish funding for alcoholism programs, notably including detoxification centers, in an earmarked tax on alcoholic beverages. This general strategy has a long history, stretching back through the Connecticut Yale Plan clinics (Beauchamp, 1973, p. 217) to the nineteenth century; thus, public patients at the

Kings County Inebriates' Home at Fort Hamilton, New York in the 1880's were financed with a tax on Brooklyn tavern licenses.

The Alcoholism Concept and Public Drunkenness

As Robinson (1972) has noted, "ideas cannot be locked away like drugs in a cupboard"; the successful ideological entrepreneur is likely to lose control over his or her conceptualization, just as the too-successful manufacturer loses property rights in a trademark. In the wake of the alcoholism movement's efforts, the governing image of alcoholism as a disease marked by loss of control over drinking behavior was successfully integrated into the general matrix of American "progressive" thought. As such, it became a handy tool for the ideological entrepreneurship of a number of other moral and material interests, who sometimes had little knowledge of the image's rationale and frequently applied it in directions at cross-purposes to the interests of the alcoholism movement.

Thus in the late 1960's the alcoholism image became a tool in efforts by highway safety interests to stiffen enforcement of drunk driving laws. Believing that a major block to arrest, conviction and sentencing of drunk drivers was the feeling of those involved in the legal processes that "there but for the grace of God go I," the federal Department of Transportation and casualty insurance companies set out to change the public image of the drunk driver from an emphasis on the social drinker to an emphasis on the alcoholic, with the explicit purpose of increasing the perceived deviance of the drunk driver (Swinehart and Grimm, 1972; see Room, 1972b). While this campaign was built on a research base, the research, motivated by policy considerations, considerably overstated its case (see Cameron, 1977). The campaign traded upon the alcoholism movement's imagery of the alcoholism as qualitatively different from normal drinking and involving uncontrollable behavior. But the effect of the campaign would clearly be in the direction of diminishing the social standing and worth of the alcoholic, in direct opposition to the alcoholism movement's interests.

For similar reasons, the 1970's furor over teenage alcoholism has created considerable unease in alcoholism movement organs (see O'Gorman et al., 1977). While the public attention to alcohol issues is welcomed, the tendency to link teenage "alcohol abuse" to "abuse" of other drugs, the extended use of "alcoholism" to refer to any disapproved-of drinking behavior, and the frequently punitive tone of discussions, all tend to erode the social position of the alcoholic.

To a considerable extent, the movement to decriminalize public drunkenness which we have examined in this chapter is another example of the governing image of the alcoholism movement being turned to different and partially cross-purposes. The Washington lawyers' interest in alcohol issues was initially welcomed by the National Council on Alcoholism: in 1958 Marty Mann coopted them into reviving the local NCA affiliate (Beauchamp, 1973, p. 266). An open divergence in perspectives seems to have occurred only in the mid-1960's, and to have resulted from two extraneous developments. The Supreme Court's Robinson vs. California (1962) decision for the first time opened up the possibility of an "eighth amendment" defense for a crime like public drunkenness, and this defense depended on invoking a disease concept in the Skid Row context. And the developing civil-liberties and public-interest legal concerns of the 1960's brought an infusion of young lawyers into the arena with their own set of definitions of the situation. In general these lawyers had only a superficial knowledge of the concept which was the key to their argument: Johnson (1973, pp. 373-4) records that Peter Barton Hutt, the leading attorney in the Driver and Powell cases, discovered that the movement's disease concept had some vulnerabilities only when preparing his Supreme Court appeal brief on Powell.

A successful governing image thus acquires a historical presence and momentum of its own, which is not necessarily in accord with the intentions of its ideological entrepreneurs. This is particularly the case with a governing image like the disease concept of alcoholism, where the specific disease model was not always clearly specified. While the alcoholism movement was dedicated to the proposition that alcoholism was a disease, many in the movement were at best uneasy about the corollary of handing custody of alcoholics over to the medical profession (see Johnson, 1973, pp. 314-324).

As we have suggested above, the problems of and conflicts over Skid Row are real and intractable, although the extent to which they are alcohol problems is open to debate. A definition of the problems as alcohol-related — of the problems as issues of public drunkenness and order — tended to identify them as located in individual defects of the Skid Row residents, rather than in problems of social structure or civic amenities, and thus was congenial to the interests of urban redevelopers and "downtown" interests in American cities. The nascent institutions of the alcoholism movement at the local level thus quickly found themselves under sustained pressure to accept as their primary client the Skid Row alcoholic. This pressure has been resisted, only in part successfully, in line with the alcoholism movement's aim of upgrading the public image of the alcoholic.

The "urban renewal" policies of the redevelopment programs eventually elicited a reaction from poverty workers, neighborhood groups, and civil liberties lawyers that in many places brought the programs to a halt. Partly as an early manifestation of this reaction, civil liberties lawyers, often in an alliance with the municipal court judges, sought to disrupt the "assembly-line justice" of public drunkenness arrests and convictions, and, in line with a general movement to decriminalize "victimless crimes," to transfer the handling of public drunkenness from a criminal to a health rubric. While the alcoholism movement was generally in sympathy with this change, it did not play a major role in the early moves to bring it about. The decriminalization campaigners, however, found themselves in need of a forceful argument for a health rubric for public drunkenness, given the vested interests in the existing system. In the wake of Robinson vs. California, they found this argument in the alcoholism movement's disease concept of alcoholism. The alcoholism movement found its governing image tied to a population it had tried to disown, and to a solution — three-day drying out in a detoxification center — which was at odds with the movement's general action model of recovery as a lengthy and indeed lifelong process. The intractable problems of public drunkenness were partially wrenched out of a criminal and into a health rubric, but the solution adopted was undoubtedly in the long run less stable than what it replaced.

CHAPTER 10: Conclusion: An End to Governing Images or a "Post-Addiction Model?"

We noted in Chapter 2 that a very wide variety of intractable problems have at one time or another been given an alcohol or drug attribution. There is a great deal of variation from one era to another in whether or not problems are given such an attribution. For instance, riots were a recurrent social problem in eighteenth-century America, and the colonial authorities noted a frequent association of rioting and drunkenness. But since there was then no cultural belief in the disinhibiting power of alcohol, they did not attribute the rioting to drunkenness, as nineteenth and twentieth century authorities have often done (Levine, 1977). Conversely, in gin-besotted eighteenth-century London, doctors noted the effect of drinking on fetal development (Warner and Rosett, 1975). In one form or another, allusions to this linkage recur through the temperance era, although often undifferentiated from genetic effects. Yet in the "problem minimization" period that succeeded Repeal, the linkage was denied.

> Prevailing biological scientific assumptions in the 1940's were diametrically opposed to claims of the temperance movement. For example, temperance messages emphasized that alcohol could have a direct deleterious effect on body organs; that it could damage the brain, stomach, liver, heart and fetus. Most scientists tended to reject the concept of direct damage and assumed that alcohol related disease was due to nutritional deficiency, unhygienic living, or other concomitants of heavy drinking. In light of recent modifications of scientific thinking about alcohol and organic disease and fetal damage, it is interesting to conjecture whether the need of scientists to disassociate from the temperance ideology and from being labeled as "drys" may have profoundly influenced the questions that scientists were asking, thus

> precluding the discovery of answers that were socially undesirable (Straus, 1977).

Following the "discovery" of the fetal alcohol syndrome in the last few years, in an era of "problem maximization," governmental and alcoholism movement organs have vied with each other in overreaction and overextension, culminating in the National Council on Alcoholism's recommendation that pregnant women abstain entirely from drinking. Challenged about biologists' responsibility for correcting the overinterpretations of their data, a leading alcohol biomedical researcher replied blandly that biological scientists could usefully use any extra resources resulting from the public attention to the fetal alcohol syndrome (Room, 1977c).

These examples of the waxing and waning of the attribution of intractable problems to alcohol and drugs could be indefinitely multiplied. The general historical drift for alcohol is clear. Throughout the nineteenth century, under the impetus of the temperance movement, an ever larger roster of social and health problems were given an alcohol attribution. In the scholarly literature, a mild reaction set in around the beginning of the twentieth century. Thus the reports of the Committee of Fifty to Investigate the Liquor Problem at the turn of the century represent a serious effort to sift through temperance claims for what was and what was not supportable. By the 1920's , studies that directly supported a minimization of alcohol's role in problems were appearing — for instance, Raymond Pearl's findings that moderate drinkers live longer than abstainers (1926). Such studies caused vigorous controversy. But the defenders of "problem maximization" continued to decline in strength, so that such exercises in "problem minimization" as Haggard and Jellinek (1942) and Hirsh (1949) met minimal scholarly opposition.

In recent years, the list of problems attributed to alcohol has again entered a period of growth, particularly since the advent of substantial governmental funding of an alcoholism treatment establishment and a specific federal alcohol problems agency in the late 1960's and 1970's. Today it is a rare popular work on alcohol problems, and an even rarer governmental report, that does not start with a stock collection of statistics on alcohol's role in a variety of social and health problems.

For the alcoholism movement, the gradual shift from problem minimization to problem maximization marked the movement's transformation from a volunteer movement solely concerned with the public image and social handling of the alcoholic to an interest group with personal and institutional stakes in the level of government effort and funding of alcohol-specific programs. So long as the movement was primarily a public-relations arm of Alcoholics Anonymous, despite a strong interest in raising public consciousness about alcoholism, it wished to present alcoholism as a "clean" disease, as little as possible associated with potentially stigmatizing problems such as skid row, homicide, drunk driving or insanity. As the movement increasingly became a pressure group for greater governmental effort and funding for alcohol-specific programs, a strong interest developed in underlining alcohol's role in the broadest possible range of problems — particularly those in the forefront of public attention, which concomitantly often carry considerable stigma. To emphasize alcohol's role in a broad range of problems is seen as the primary mechanism for raising alcohol's position on the societal agenda, and also creates a larger negative balance in arguments for the cost-effectiveness of alcohol problems. Very similar incentives had fueled the temperance movement's broadening of the list of problems due to alcohol. Thus Chipman (1845) used his survey of poorhouses and jails to argue on behalf of a temperance policy not only in terms of the magnitude of problems due to alcohol but also in terms of the potential savings to the taxpayer from alcohol's elimination. Although still clothed in alcoholism imagery, the rhetoric of alcoholism movement organs and agencies is in fact increasingly taking on a tone reminiscent of temperance arguments.

Like the temperance movement literature, this new literature of the institutionalized alcoholism movement makes little distinction between association and causation, and gives no recognition to the conditional nature of alcohol's role in the causation of most problems. It is assumed that if alcohol is associated with a problem, then the problems should be attacked and will be resolved by an alcohol-specific strategy. Counter-evidence on the effectiveness of such strategies, e.g., from the somewhat separate drunk driving literature, has been neither welcomed nor recognized. With greater or lesser acquiescence, researchers find their work transformed in official reports into an exercise in problem magnification. Aware of this dynamic, the present writer and his coworkers, in reviewing the literature on alcohol's role in casualties and crime (Aarens, et al., 1977), attempted to avoid giving a single modal figure which could be interpreted as the proportion of homicides, for example, "due to" alcohol, giving instead the range of figures on the association reported in the literature. But in the official government report based on this review, the results are reported throughout in terms of "up to," giving the high end of the range reported in the review (National Institute on Alcohol Abuse and Alcoholism, 1978, pp. 85-92).

In the period since the 1950's, then, the alcoholism governing image has been strained at the seams to cover an ever-increasing list of intractable problems. In the previous chapter, we examined this process at work in the case of the problems of skid row, where an "alcoholism solution" was adopted despite some opposition from alcoholism movement organs concerned about the stigma of the association of alcoholism and skid row. This process of "building an arena" for alcoholism as a social problem (Weiner, 1978) has been accompanied by a progressive weakening of commitment to the alcoholism image of alcohol problems, so that Levine (1978) can in fact write of an emergent "'postaddiction' model of drug and alcohol problems."

The decline of the movement's disease concept of alcoholism as a governing image for alcohol problems has been a subtle and gradual process. In the first flowering of the movement, indeed, the image was seen not as a policy statement but as an advance in knowledge, a "new scientific approach" in contrast to the old "moral approach" of the temperance movement. But today's science becomes tomorrow's moralism; the temperance movement, after all, had always prided itself on its "scientific" approach. By 1960, social scientists were beginning to talk of the "alcoholism movement" (Straus, 1960) rather than the "new scientific approach," and of a new generation of alcohol scholars which was, in implicit contrast to the early movement, committed to "the freedom to think," an insistence on "tightness and rigor in methodology," and a freedom "from contamination of an emotional involvement with the alcohol problem" (Straus, 1960). By the early 1960's there was some public recognition that "alcoholism is a disease" is a statement about policy more than a contribution to knowledge (Seeley, 1962).

But the gradual distancing of sociologists from the movement's governing image gained less public notice than the growing claims of behavioral psychologists, who posed a more immediate threat by putting their ideas into practical actions as therapists. Behaviorists tend to regard alcoholism as a "bad habit" rather than a "disease" (Reinert, 1968) and many have undertaken to train clients to drink in a "normal" rather than "alcoholic" fashion.

This enterprise inadvertently trespassed on a crucial ground of the alcoholism governing image and its associated therapeutic action model, the maxim that an alcoholic could never drink normally again and that the only proper goal of treatment was lifelong abstinence. As the oldline alcoholism movement has increasinlgy moved into a defensive posture, this arena has proved the main public battleground. Several behaviorists have lost jobs or contracts over their commitment to "controlled drinking," and attempts have been made to suppress publications, and to impose a commitment to a treatment goal of abstinence as a requirement of government funding. Behaviorists have fought back with vigor and imagination, and have not lacked their own institutional resources. Behavioral therapists seem to be particularly concentrated in institutions under psychiatric dominance, such as state mental hospitals and Veterans Administration Hospital psychiatric services. To the distress of the alcoholism movement, psychiatrists have always tended to view alcoholism as a symptom of underlying mental disorder rather than as a disease in its own right, and thus tend to regard it as appropriate to call in a behaviorist to extinguish the symptom.

Although the most public battles have been with the behavioral psychologists, the most fundamental threat to the classic disease image's hegemony has been, ironically, the very index of the movement's success: the rise of substantial governmental structures with custody over alcohol problems. The goal of institutional survival and growth imposes incentives and constraints on those manning these structures which often conflict with the alcoholism governing image. For instance, government-funded treatment systems need to justify themselves in terms of a rate of successful cures, but a criterion of permanent abstinence consistently shows a "success rate" for treatment of only about 10%. The needs of program managers to justify their programs and budgets have thus been a main force in the shift away from abstinence to "improvement" as the criterion of treatment success (although, in deference to movement sensitivities, abstinence is often retained as the theoretical goal of treatment).

In the interests of broadening the responsibilities of their agencies, program managers at federal, state and local levels have led the way in the broadening of the ambit of alcohol problems which we noted above. Towards the alcoholism movement's governing image, and indeed towards governing images in general, their response has been bifurcated. On the one hand, as central actors in the continuing fight for societal attention and governmental allocations for "their" problem, they have been fully alive to the necessities of symbolic politics -- to the need for messages which dramatize the extent of the problems and yet offer hope for their solution. Their public measages have thus commonly followed the line laid down in the earliest years of the alcoholism movement (Anderson, 1942) as the public expression of its governing image.

To this basic theme have gradually been added a number of other partly discordant public themes, appealing to somewhat different constituencies and interests. For instance, the emphases on "teenage alcoholism" and on the seductive power of alcohol advertising are themes which appeal to the still strong if unorganized temperance sentiments in the country. The older, nongovernmental organs of the alcoholism movement have found such emphases disquieting, in part because the themes tend toward a frontal attack on the alcoholic beverage industry, and thus are seen as bringing an unwanted and potentially disruptive politicization of the field. In general, in the last few years, officials at all levels of government have been tending towards a "dryer" line. But whether with the traditional alcoholism imagery or with the new elements in the mixture, the public rhetoric has retained the simplification and overgeneralization characteristic of governing images.

On the other hand, as overseers of systems and programs and indeed of "alcohol abuse and alcoholism" as a whole, the managers have been committed to a pragmatic and technocratic stance towards managing and reducing alcohol problems. At least at the federal level, this has resulted in a number of contracts with social scientists and others to conduct empirical studies, even though such studies have frequently resulted in politically unpalatable and embarrassing findings.

As pragmatic technocrats, alcohol program managers have shown an increasing enthusiasm for a sociological perspective which has become known as the "disaggregation" line.[28] To some extent this position is a specific representation in the field of alcohol problems of the generally critical and nominalist stance of contemporary sociologists toward the handling of social problems under clinical rubrics and disease labels. An early and simple statement of the position and its policy implications was made by Kettil Bruun, the foremost Finnish alcohol sociologist. Bruun (1973) enumerated the social and health problems related to drinking which seemed to occasion the greatest social concern, and remarked that these problems covered the problems of "alcoholism," so that if the social and health problems were successfully handled then alcoholism did not need special attention.

In American thought, the disaggregationist line can be traced back to the concerns of the second wave of alcohol social scientists mentioned above. About 1960, as the federal government, in the form of the National Institute of Mental Health, first moved to fund alcohol research, there was a commitment to recruiting new blood into the field and to taking a generally "value-free" and empiricist line in alcohol studies. In line with these perspectives, NIMH funded survey researchers with no previous experience in alcohol studies to carry out empirical survey studies of drinking practices, and later of drinking problems, in the general population. Under the leadership of Genevieve Knupfer, who combined clinical and sociological training, these studies attempted to measure at its face value "any problem connected fairly closely with drinking" (Knupfer, 1967) mentioned in the literature, and then to examine their empirical interrelations — as Knupfer remarked, to "turn assumptions into hypotheses to be tested." It quickly emerged that alcohol problems in the general population were far more diffuse and less clustered than in clinical populations (Clark, 1966) — so that eventually the project staff came to talk of the "two worlds of alcohol problems," general population and clinical. In the 1970's, as the government managers began to take seriously their responsibilities to do something about the prevention as well as the treatment of alcohol problems, it was natural to turn for advice to those with knowledge of drinking patterns and problems in the general population. In a series of papers and reports over the last five years (e.g., Room, 1974; Room and Sheffield, 1976) ideas for prevention programming based on a disaggregated approach to alcohol problems have been laid out. At least some elements of this approach have made their way into governmental planning.

But although the disaggregated approach offers the technocrats a way of responding differentially to the smorgasbord of alcohol-related problems they have taken on, it also has some political drawbacks. Given the drier wind which has been blowing over alcohol politics, government officials have been notably quicker to pick up on suggestions concerning a reevaluation of alcohol control policies than on suggestions about ways of making the world safer for drunks. Another political drawback is the emphasis on non-alcohol-specific strategies for dealing with alcohol-related problems, since this threatens the assumption that an alcohol-specific agency should always have primary jurisdiction over all alcohol-related problems.

To some extent, then, the alcohol problems field at present is marked by a weakening of the old governing images, with some movement to a disaggregated and nominalist stance towards dealing with alcohol problems. The reader will probably not be surprised that this approach is congenial to the present writer. Much mischief can and has resulted from the simplification and overextension which are the hallmarks of governing images of intractable problems. But one must recognize, on the other hand, the political difficulty or impossibility of organizing societal attention and gathering resources without an integrated and singleminded perspective covering a significant spread of problems. By their nature, governing images are powerful instruments of intellectual, moral and political organization. However uneasy they are under the old dispensation, the program managers and alcohol sociologists are paid to pay attention to alcohol problems today because of the success of a social movement organized around a compelling governing image.

Footnotes

[1] There is also the counter-tradition of "in vino veritas," which Caplow and McGee (1965, p. 107) record in the form of an academic department wanting to "pour a couple of drinks into" prospective colleagues to "see how they are" before hiring them. Depending on the rhetorical demands of the situation, the "real" person can be either the drunk or the sober one, the Jekyll or the Mr. Hyde (see Roizen, 1977 b).

[2] Scheff is unclear about the relations between his "conceptual packages" and disease entities, and also expresses dissatisfaction with his own choice of terms (p. 146).

[3] It is true that, by the use of such terms as "social pathology," disease concepts are often used in discussing social collectivities. But such uses are essentially analogic, part of the common use by functionalist and evolutionalist social theorists of organic metaphors for society (Bock, 1963, p. 235).

[4] For instance, in some parts of the country it is now common for attendance at AA meetings to be required by judges as part of the sentence for drunk driving and for AA group officials to certify for the court the individual's record of attendance at meetings.

[5] Recent survey data on public acceptance of alcoholism as an illness appear to be mostly limited to urban samples: the two U.S. samples and the New Zealand sample reported by Blizard (1969) and the New York City sample reported by Haberman and Sheinberg (1969) all find that between 62% and 66% of urban populations will identify a vignette of alcoholismic behavior as indicating illness. Mulford and Miller (1964) found that 65% of adult Iowans would apply the term "sick person" to the alcoholic. In a 1971 sample of 615 white San Franciscan men, we found that 58% agreed that "alcoholism is a physical condition or illness of the body," 82% agreed that "alcoholism is a mental condition or mental illness," and only 6% disagreed with both these statements. Mulford and Miller's analysis imposes a strong caution on interpretations of these findings, since they found that acceptance of an illness conception does not preclude acceptance also of putatively competing conceptualizations. In fact, in our San Francisco sample, a mental-illness concept and a moral-weakness concept were positively associated: 49% of those agreeing that alcoholism is a mental illness, but only 34% of those disagreeing, also agreed that "alcoholism is a sign of moral weakness."

[6] A comparison and critique of these uses can be found in Room, 1966, pp. 4-12.

[7] Although social theorists using these models often claimed to be applying to social science the lessons of Darwin's Origin of Species, the models actually considerably predated Darwin, and in fact bore a closer analogy to ontogenetic than to phylogenetic biological models (Bock, 1955). These models were applied most prominently and explicitly by social theorists in discussing the evolution of human societies, but were successfully disposed of, at least in their pristine forms, by the detailed studies of the historicalist school of anthropologists centering around Franz Boas.

[8] The Marihuana Commission's second report (National Commission . . ., 1973) includes a discussion of "contagion"/epidemic models (pp. 271-272), but makes what seems to me the confused argument that drug use cannot be contagion because it happens with the "victim's consent," while in the same paragraph mentioning drug dependence rather than drug use as the thing that is risked. With the assumptions implied in this discussion, a logical counterargument would be that there is an exact analogy to VD, with "dependence" in the role of the venereal disease, and "drug use" in the role of voluntary sexual intercourse. As argued in the text, however, "consent" is not an issue for adherents of an epidemic model.

[9] Of course, in areas where it is the intensification of a behavior which is regarded as a disease, only the occurrence of the intensifications is counted in the epidemic. In principle, a "normal" laugh would not be counted in an epidemic of hysteria.

[10] For an attempt at an analogous calculus of the relative balancing of costs and risks in occupational and transportation safety, see Starr, 1969.

[11] This is a problem in interpreting Dr. Snow's response to his cholera epidemic, too: the epidemic was apparently already on the wane when he took matters into his own hands.

[12] Verden (1968), who carefully distinguished ambivalence from ambiguity, draws on social psychological experiments to argue that ambiguity is often tolerable but those exposed to ambivalence "give evidence of strain and discomfort" (p. 256).

[13] See Edwards' critique of Chafetz as having assumed the role of "preacher," persuading "by rhetoric rahter than by statistical significance" (Edwards, 1970, p. 354). Chafetz replied that Edwards had indeed "spotted my Talmudic scarf showing below the hemline of my academic robes" (Chafetz, 1970b).

[14] In Bleuler's discussions of ambivalence, he recognized the inconsequentiality of mixed feelings in everyday life. "For the healthy person as well [as the schizophrenic] everything has its two sides. The rose has its thorns. But in 99 of 100 cases the normal person draws the sum total from the subtraction of the negative and positive values. He loves the rose in spite of the thorns" (1911, p. 305; original in German).

[15] The problems with this kind of equation have, in fact, been demonstrated empirically in the anthropological literature, in which Simmons has described one culture and referred to others with an integrated set of norms supporting hard drinking, a low rate of alcoholism — but a high rate of ambivalence (Simmons, 1962). It is perhaps in the light of his anthropological work that Lemert, as we mentioned earlier, reinterpreted Myerson's ambivalence into a meaning of a double perspective — while sober and while drunk — on drunken behavior, and does not assign any special explanatory importance to the concept (Lemert, 1962).

[16] See Cohen's (1965) discussion of the concept of strain.

[17] Verden comments stiffly that this "interpretation reifies the concept of society in an undesirable manner" (1968, p. 253).

[18] The card inserted in a copy now in the Social Research Group library reads: "With the Best of Good Wishes from The Methodist Board of Temperance. This volume, 'ALCOHOL, SCIENCE AND SOCIETY,' is being sent to you and to other leaders of the Methodist Church, in the confident belief that you will find it of real value in service and that thereby the cause of temperance may be strengthened and the ultimate goal of a beverage alcohol-free civilization may be hastened. Ernest H. Cherrington, Executive Secretary."

[19] Hirsh, a professor of Preventive and Environmental Medicine at the Albert Einstein College of Medicine, was involved in both the Research Council on Problems of Alcohol in its late, beverage industry-dominated days, and in the industry-dominated Committee on Problems of Alcohol of the National Research Council. He wrote the "Introduction" to the 1957 edition of the Licensed Beverage Industries' publication, Programs on Alcoholism Research, Treatment and Rehabilitation in the United States and Canada.

[20] See Room (1977b) for a discussion of the context of Bacon's paper.

[21] Later known as the Committee on Drinking Behavior and then as the Drinking and Drugs Division of the SSSP.

[22] Two competing alcohol research groups — a moderationist International Committee for the Scientific Study of Alcohol and a proposed temperance-oriented Institute for Alcohol Study — had unsuccessfully sought Rockefeller support in 1911-1915 (Gordon, 1946). The Rockefellers had financed a study of liquor control policies which was influential in state law-making at repeal (Fosdick and Scott, 1933).

[23] Remarks at a Symposium on Research Priorities on Alcohol, Rutgers University, October 9, 1977.

[24] Robert Straus, personal communication.

[25] Neither in their original article nor in their rejoinder to comments on it (Regier and Kurtz, 1976) do Kurtz and Regier give any hint of what such a solution would be.

[26] Interview by Ronald Roizen with Lt. Harold Mijanovich, Commanding Officer, Oakland Jail.

[27] These percentages are all based on the states which answered yes or no to the question.

[28] The reader is warned that the present writer is one of the principal protagonists of the disaggregation line.

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