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**IMPROVING THE QUALITY OF LIFE OF HISPANIC  
ALCOHOLICS IN AN ALCOHOL TREATMENT CENTER: A  
PROCESS OF RESOCIALIZATION**

by

ANGELA CORDERO

**A dissertation submitted to the Graduate Faculty in Sociology in  
partial fulfillment of the requirements for the degree of Doctor of  
Philosophy, The City University of New York  
1997**

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This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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## **Abstract**

### **IMPROVING THE QUALITY OF LIFE OF HISPANIC ALCOHOLICS IN AN ALCOHOL TREATMENT CENTER: A Process of Resocialization**

by

**Angela Cordero**

**Adviser: Professor Charles Winick**

This study describes and explains the recovery process of Hispanic male alcoholics in an alcohol treatment program. It investigates improvements in the quality of life of this group through the theoretical perspectives of resocialization and symbolic interactionism.

Two hypotheses were examined:

(1) that the more socially involved the client is in the alcohol treatment program and Alcoholics Anonymous (AA), the greater will be the improvement in his quality of life, and

(2) that the more anomic the life situation of the client, the less socially involved the client will be in the alcohol treatment program and AA, and the less the improvement will occur in his quality of life.

The subjects of this research were 37 Hispanic male alcoholics who were receiving alcohol treatment in an alcohol treatment program. Data were collected through the use of a semi-structured, pre-coded interview guide with fixed-response and open-ended items, and through an in-depth interview with each of five clients. Supplementary research methods included participant observation and a document review (clinical charts). The research instruments collected data on knowledge and involvement in the treatment program and AA, family integration, social isolation, economic stability, legal history, immigration status, alcohol education, and how the client perceived his recovery from alcohol.

Both hypotheses were supported by the findings. Clients who were highly involved in the formal and informal aspects of treatment ( in both the clinic and AA) showed a greater improvement in their quality of life than did clients who were less involved. The informal aspects also provided the clients the opportunity to develop and communicate norms and trust among themselves in the daily use of the day room at the clinic.

## **ACKNOWLEDGMENTS**

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## **CHAPTER ONE**

### **A SOCIOLOGICAL INTERPRETATION OF ALCOHOLISM TREATMENT AND RECOVERY**

This study deals with a group of Hispanic male alcoholics who received alcohol treatment in an outpatient treatment center. A number of research methods were used to gather the necessary data: participant observation, in-depth interviews, analysis of the records, and a survey. The study measures the effectiveness of the treatment received in terms of how it improved these alcoholics' lives. It examines the evolution of recovery of these men as reported by them and as measured by the researcher.

In addition—since the clinic treatment is intertwined with the Alcoholics Anonymous (AA) fellowship model—the study investigates the effectiveness of AA in relation to these men. The AA model is an integral part of the clinic's developmental model of recovery (DMR), and all of its treatment programs, including the Hispanic Outreach Program, incorporate the teachings of AA. The treatment offered at the clinic for all the different programs, including the Hispanic Outreach Program, involves AA. This incorporation of AA's teachings is what makes the difference in treatment, rendering it

more “ reality based,” individualized, and purposeful. The flexibility of the clinic (allowing clients to stay on the premises without appointments) is linked to the significance it attaches to AA. Therefore, in order to comprehend the treatment milieu of the clinic, AA must be included in the analysis of treatment offered to the clients.

In analyzing the treatment offered by the Hispanic Outreach Program (HOP), two terms are introduced: “formal” and “informal” aspects of treatment. Formal aspects of treatment are the structural activities of the clinic, and they underlie, reflect, and interact with the informal aspects of treatment. Informal aspects of treatment include social interactive indicators of wellness and change. They center on informal social situations in the clinic and AA, such as making friends, using the day room, and having lunch with another client.

The process of resocialization occurs on a daily basis in the structure of the clinic and AA as a whole. In order to observe this process of resocialization, the approach known as symbolic interactionism was chosen because it allows the researcher to see the situation from the perspective of the subjects, as well as from the point of view of the agents of change ( in this case, the clinic and

AA). The process of resocialization is observed through the informal social activities of the clients in the clinic. Even though clients are evaluated on their progress during formal activities, such as group and individual counseling sessions, these interactions are not the same as the less formal ones, in which clients relate to each other in less pressured settings.

Resocialization is related to socialization, in which a person learns the ways of his or her society, but the resocialization process denotes the activity of relearning. The person needs to eliminate something that was previously learned in his life that is now causing pain. Two conditions must be met in order to achieve resocialization: (1) the person must feel that something is wrong, and (2) that it is possible for change to occur.

Analysis of the recovery process, in this study, focused on such questions as: What are the indications that a client is improving or is interested in improving?, and How does a therapist become aware of change in a client? Studying change through symbolic interactionism, one can see when the client is ready to work on his recovery. For example, when a client feels comfortable in the clinic and is making friends, this is an indication to the therapist that the client is open to

discuss recovery. The client might not be aware of these subtle changes, but the therapist can pick up the cues and treatment can take a different road.

The clinic is a powerful social structure in which the Hispanic client finds himself. He realizes that once initiation into this social structure is official, life is controlled by it. The welfare client knows that every three months he needs a letter of attendance to continue receiving benefits from public assistance. The Driving While Intoxicated (DWI) client knows that if he does not comply with the program, he will not receive his license. The mother who is referred by the Bureau of Child Welfare( BCW) knows that she needs to comply with the program in order to get her children back.

Such dilemmas force the clients to make a decision, and more than half of them opt to recover. One advantage of mandated treatment is that persons who might not have sought treatment on their own are given the opportunity to see the possibilities of a different world through treatment in a safe environment.

The concept of "time" is also explored in this study. Is time significant in the evolution of the recovery process? How is time handled by the client? How is time managed by the clinic as an agent

of change? The strategy of “second chances” in treatment is used in the clinic with much success. The alcoholic is given more than one chance to become aware of his needs for treatment and to move towards eventual recovery. It is true that some persons would get better on their own and others might never stop drinking, but some individuals need help from treatment centers such as the one under study. For the individual who needs help, time is important, because only after the person becomes aware of his need for treatment, does treatment actually begin. It ends when the individual understands the meaning of the process of recovery.

The study also explores the minority status of the population on which it is focused. Does being part of a minority group increase the chance of finding yourself in an alcoholic treatment center? Does society view Hispanic male alcoholics differently from other alcoholics? American culture does not have a drinking tradition like Italy, France, or Spain, and is very ambivalent regarding the use of alcohol. In general, Americans are not taught how to drink, and ambivalence toward alcohol is pervasive throughout the history of the United States. Similarly, Hispanic culture has mixed feelings about drinking.

**Studies of alcoholism, treatment, and recovery among Hispanics** should not consider Hispanics as a homogeneous group. Even though this point is referred to but not fully discussed in this study, it is important to note that the Hispanic population consists of discrete ethnic groups that share some traditions, but not others. By acknowledging these important differences, and taking them into account, studies can be more persuasive and useful.

Chapter 2 examines the relationship between alcoholism among Hispanics and alcoholism as viewed by the larger society. As people become acculturated into the American culture, they tend to drink in the way that Americans do. The stereotype of Hispanic males as heavy drinkers and *machista* figured prominently in the studies done during the 1960s and 1970s. How does a stereotyped image of oneself affect the image that one presents to the world?

Chapter 3 discusses symbolic interactionism and how this perspective aids in understanding (a) the development of alcoholism (through socialization), and (b) the process of recovery (through resocialization). Chapter 4 deals with background information, methods, data collection, and analysis. Chapter 5 describes the social structure of the clinic and AA. Chapter 6 presents five case

studies, with an emphasis on socialization, and in Chapter 7, resocialization and recovery are discussed. Chapter 8 presents the study results, and Chapter 9 includes a summary and some concluding remarks and implications.

For the purpose of clarity, “treatment program” refers to the Hispanic Outreach Program (HOP), and “client” refers to the Hispanic client in the clinic, unless otherwise specified. “Participant” is also used to refer to the Hispanic client. Since the English and Spanish program are so similar in form and content, some of the discussions might also apply to the English program. For the purposes of this study, “clinic” and “treatment center” refer to the whole facility.

The term “staff” refers, collectively, to all the therapists working in the clinic, and it is confined to therapists unless otherwise stated. There is a total of six social workers, two certified alcoholism counselors, an HIV counselor, a case worker, and a social work director. Hence, there are eleven people involved in the daily treatment of all the clients. However, only four out of the eleven

workers are involved in the Hispanic Outreach Program (HOP).

These four concentrated on the treatment of the Hispanic clients.<sup>1</sup>

Staff meetings that have to do with treatment are usually attended only by the therapists, though the nurse and the psychiatrists attend some of the meetings. All of the therapists have a say on whether a client is accepted by the clinic, regardless of the particular program. Teamwork is especially strong in this area, and all opinions and suggestions are considered important. Administrative staff meetings are attended by everyone who works in the clinic. These meetings are more structurally focused than treatment focused.

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<sup>1</sup> The other staff, such as the nurse, nurse's aid, psychiatrists, clerical support, and recreational and vocational counselors are shared by all the programs (i.e., the English-speaking track, HOP, Ryan White AIDS Services, and Mentally Ill Chemical Abusers [MICA]).

## **CHAPTER TWO**

### **REVIEW OF THE LITERATURE**

The focus of this chapter is a review of relevant literature on the theme of alcoholism treatment and recovery among Hispanic male alcoholics. The task is difficult since the main objective of this study is recovery, a subject of few theoretical investigations involving this population.

Much has been written about alcoholism and alcohol abuse in the general Hispanic population (Caetano, 1983; Alcocer, 1982; Singer, 1989). Most of the literature has dealt with the problem of underutilization ( Abad, Ramos, and Boyce, 1974; Caste, 1979; Gilbert and Cervantes, 1986) by the Hispanic population of the resources of the community ( i. e., not being cognizant of the therapeutic service agencies in the community, due either to lack of awareness of these resources or to lack of understanding of the American system, resulting from lack of acculturation, or from acculturation stress ( [Caetano, 1987; Aviles-Roig, 1973; Grossman, 1990; King, 1990] ). Recovery has attracted less sociological research than causation. ( In Chapter 3, there is a brief discussion of causation considerations).

The recovery process, or the “culture of recovery,” is a formidable topic that needs full explanation and not simple answers. Many of the books dealing with recovery deal with “how to” help clients achieve a better life (Zimbardo, 1977; Brown, 1985; Denzin, 1987a; Metzger, 1988; Burns, 1992). The main literature used in the clinic is the literature from Alcoholics Anonymous (AA). AA literature offers an excellent study of alcoholism and recovery, but a sociological review of this wealth of literature may ignore other factors (Bales, 1962; Maxwell, 1962; Denzin, 1987a). Sociologists, psychiatrists, anthropologists, and many others have written on AA. Most agree on the importance of this organization and what it has given to American society. Historically, the culture of recovery in America has been patterned on AA’s “12 Steps.”

This study of a small group of Hispanic male alcoholics in a treatment center tries to make sense of what alcoholism treatment is about and how the recovery process becomes attainable and workable. The study also deals with the issues of having a minority status in an alcohol treatment center, though it explains how the means and ends to recovery are similar in all groups. For example, no particular group has the exclusive right to a good job, a happy family life, well-raised

children , and the “good life” in general in American society. This is a hope shared by all.

In seeking to be an agent of change, the clinic understands that people do not change chronic behaviors quickly or easily (Prochaska,1991). Alcoholism is a chronic behavior that clients need to change, and every study client stated that attaining recovery is not easy. Prochaska’s model of change is applicable to alcoholism (Prochaska, Velicer, DiClemente, Fava,1988; McConnaughy, DiClemente, Prochaska, Velicer, 1989; Prochaska, 1991). It is a general model of change that was first introduced to study the phenomenon of change and to understand its meaning. It has been used to study how people can stop smoking and how they can make adjustments from an unhealthy status to a healthy status (Prochaska, 1991). This model of change is a stage model of change, similar to the clinic phase model. In both, change is seen not as a dramatic shift from one state to another, but rather as a slow and progressive process.

Furthermore, the process of change is seldom linear. Individuals who try to change a particular behavior usually make more than one attempt and also meet with relapses in the process of change.

Prochaska's model of change has five stages: (1) pre-contemplation (the individual such as the mandated client or the DWI client, is entering therapy but is not sure if he actually wants to change; (2) contemplation ( the individual becomes aware that there is something wrong and that maybe he should try to change it, but he has made no commitment to change); (3) pre- action (the decision has been made to commit to change, and the individual has the necessary insight, but he has not acted on his decision); (4) action ( the individual begins to act on himself or the environment in order to attain change in his life; (5) maintenance (the individual is more in control of his life and realizes the steps he needs to take in order to maintain his recovery).<sup>2</sup>

Many studies on alcoholism have focused on whether alcoholism is an illness. Is it a sickness that the medical profession should be involved in, or is it simply deviant behavior? In this study, alcoholism is viewed as an illness. This study agrees with Jellinek 7:41 PM(1960), Vaillant (1983, 1995), and other scholars who have stated that alcoholism is a progressive illness that needs medical and psychological attention.

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<sup>2</sup> Many clients in the clinic get stuck in the pre-action stage and experience a relapse, or they get stuck in the "dry drunk syndrome" phase, in which there is no actual drinking, but they continue to behave as if they were drinking, e.g., depress and lonely.

Two other areas of importance that need to be discussed are (a) the issue of *machismo*, and (b) the underutilization, by Hispanics, of alcoholism treatment services. These two topics might not be as significant to the Hispanic community in America as they are to the mainstream society. Although these subjects are not unimportant in and of themselves, it appears that *machismo* and underutilization are shared concerns in the literature on alcoholism (Gilbert and Cervantes, 1986; Arredondo, Weddige, Justice, Fitz, 1987). In addition, Hispanic males were deceptively characterized as heavy drinkers (Madsen, 1964; Graves, 1967). In some cases this might be true, but the studies did not explain these themes appropriately and gave a negative image of Hispanics as being childlike and naïve.

According to these studies Hispanic males embody the “archetypal” concept of *machismo*. Yet in studying Hispanics, as any other group, one should examine how the social environment influences the behavior of individuals in the group. Hispanics in American society are not the same as Hispanics living in their former countries. Structurally and culturally, the life of Hispanics in American society is different. For example, a minority status, with all

its implications, is not imposed on a Dominican in the Dominican Republic, or on a Colombian in Colombia.

In order, to understand the recovery process and its development, one must examine the host society's values and normative standards concerning alcohol and alcoholism. Since the core data of this study examine a minority group that has established itself in American society, the society can be expected to have had some influence on this minority group's perceptions of alcohol and alcoholism. Therefore, this chapter will present a brief discussion on the interrelationships between alcohol and culture, and a historical overview of alcohol in America. There will also be a discussion of the disease concept of alcoholism, a notion that has aided the therapeutic aspect of alcoholism by identifying the alcoholic as sick and in need of help. It has given legitimacy to alcoholism as an illness. The conceptualization of alcoholism as an illness originated from the inebriate asylum movement of the late 1800s (White, 1996). However, AA has been given most of the credit for working very diligently, since the 1930s, to develop this awareness of alcoholism as an illness (Chrisman, 1985).

The question of whether a person who has been drinking heavily for many years can return to social drinking is a popular theme in the research on alcoholism (Vaillant, 1983; Chrisman, 1985). Returning to social drinking is not analyzed in this study, because it is clear that not one individual in the sample could achieve such controlled use of alcohol. All persons in the sample have difficulties in controlling the amount of alcohol they consume, and one drink is one too many.

This chapter will discuss the problem of acculturation stress, which might be one of the causes of alcoholism among Hispanics (Graves, 1967; Madsen, 1964; Caetano, 1987; King, 1990; Garza, 1990). Acculturation stress is a phenomenon that occurs when change does not happen properly. For instance, "As a minority group, Hispanics are exposed to the mainstream cultural patterns of the United States and modifications in their values, norms, attitudes, and behaviors may be expected to occur because of this contact" (Marin & Sabogal et al, 1987:184). If changes occur smoothly, the individual learns and adapts details of a new group, nation, culture, or society. But when the process does not occur smoothly and there is conflict, acculturation stress arises. In the case of Hispanics in the United

States, acculturation stress could be caused by difficulty in learning English, lack of success in finding employment and housing, and minority group status (including prejudice, discrimination, and low social standing).

In addition, there will be a discussion of attitudes toward AA, since many researchers see the concept of AA as a driving force in recovery. For some, AA is the only way to a better life.

#### ALCOHOL AND CULTURE

##### Alcohol, Culture, and Society by Clarence Patrick (1952)

sets forth the theme that culture is the basis for the use of alcoholic beverages by particular groups. He uses culture as a theoretical basis for the analysis of the degree to which alcoholic beverages are used, defining culture as,

the total system of invented or learned activities, attitudes, and materials which obtains in a society for the satisfaction of man's needs and desires. It is an instrumental order that has come into existence to satisfy the needs and desires of man through secondary methods rather than through a direct adaptation to his environment. Culture is also a group phenomenon. It is socially acquired and socially transmitted by interaction between the members of a group (Patrick, 1952: 5).

The thesis of Patrick's work is that everything in a society performs a function. Therefore, if alcoholic beverages exist in a

3

society, then they too must have a function. In his search for a function, Patrick asked, "Why do men drink beverage alcohol?," and he divided his answers into two categories: (1) popular explanations for drinking, and (2) scientific reasons for drinking.

The following are some of the popular explanations for drinking that Patrick found: "I drink because it makes me feel good," "I drink alcoholic beverages because I like their taste," "We drink because practically everyone in our group drinks," ... "I drink because it helps me to forget my worries and unpleasant experiences" (Patrick, 1952: 44).

Fourteen scientific reasons for drinking were cited by the author (Patrick, 1952: 45-47), but five are especially relevant for this study: (1) Alcohol is used as an escape from the responsibility and burden of mature emotional life and its decisions. (2) Normal drinkers drink to get pleasure; morbid drinkers drink to evade pain. (3) Alcohol is taken to promote the social instincts and alleviate and narcotize the many mental conflicts to which we all succumb from time to time. (4) Alcohol is used as an escape from life situations that the person cannot face; for example, incurable physical pain. (5) Alcohol is used to find a way of rebelling and allowing relief of destructive impulses; a

man might drink to be a “he man.” These five themes are relevant because they appear in the story telling (the biographical speeches in AA and the sharing in the group counseling) of alcoholics in general in the clinic and AA.

The answer to why people drink is found in the culture to which they belong. A twofold influence occurs for bicultural groups: They are influenced by the mainstream culture and by their culture of origin. For example, studies have shown that Jews have a low rate of alcohol-related problems (Glassner & Berg, 1985) and Mexican Americans have a high incidence of alcohol-related problems (Gilbert, 1985).

Riley and Marden (1959), in their study on the patterns of alcohol drinking in the United States wanted to find out: (a) How many people drink?, (b) What are their social characteristics?, (c) Where do they live?, and (d) What do they drink? They found, in a survey based on a representative sample of adults 21 years of age and over, that 65% of the adult population drink alcohol. In addition, they found that frequency of drinking depends upon many factors, such as economic level, religious affiliation, sex, and geographical location (urban or rural).

Their findings can be summarized as follows: Catholics drink more than any other religious group, while 41% of Protestants, 21% of Catholics, and 13% of Jews are abstainers. In addition, people in cities tend to drink more than people on farms. One factor in regard to which the differences are not very great is economic level. There were fewer regular drinkers (16%) in the lower economic areas and a slightly higher concentration (21%) in the higher economic areas. The proportion of occasional drinkers and abstainers was comparable at all economic levels.

The social characteristics and trends in drinking behavior in the United States continue to be basically the same as those reported by Riley and Marden. More recent information indicates that rates of drinking are higher in urban and suburban areas than in small towns and rural areas (*National Institute on Alcohol Abuse and Alcoholism*, 1987). Both white males and white females exhibit more drinking than African American males and females. Drinking among non-Hispanic whites is also higher than among Hispanic whites (Akers, 1992). Jews continue to have low rates of problem drinking, while Catholics continue to have high rates of both drinking and problems with drinking. Irish Americans have high rates of both drinking and

alcoholism (Akers, 1992). On the other hand, Italian Americans drink frequently and heavily but apparently do not have high rates of alcoholism (Cahalan, Cisin, and Crossley, 1969; Simboli, 1985).

Trice (1966) compares and contrasts American with other societies. The United States does not have a uniform drinking custom. Drinking behavior remains many things for many people. Variances in age, sex, social class, ethnic and religious groups, and rural versus urban living make for differences in drinking according to quantity, frequency, and social meaning. Perhaps customs and sanctions are slowly evolving, but currently they are not highly visible. And, unlike Italy, where clear traditions control drinking behavior, the United States has a high incidence of alcohol problems.

American society is trying to manage its drinking problems, but it has not yet developed a drinking tradition. Drinking of alcoholic beverages is taught early in a person's life in places—like Italy and France—where alcoholic beverages are part of the daily routine. The United States is creating laws to protect society from problems caused by alcoholism and alcohol abuse, such as driving while intoxicated and domestic violence. Though it is true that having a drinking tradition reduces alcoholism problems, it is not always the

case. France, which has a higher alcoholism rate than America, also has a drinking tradition (Clinard, 1974: 451).

Contrasting American society with preliterate cultures, such as the Camba of eastern Bolivia, Trice (1966: 26) paraphrases Heath from "Drinking Patterns of the Bolivian Camba," and says that

No aggression or sexual deviation occurs (when the Camba drink excessively). No drinker is rejected for his behavior. ... [T]he Camba never drink except during [the] fiesta periods, and solidarity drinking is unthinkable. ... [A]lcoholism, as it is known in America, does not exist for the Camba. The Camba have no fear of the results of drinking alcohol, no hangovers, no guilt, and experience no harmful effects on their work.

In conclusion, the existence of alcohol pathologies in a particular society depends upon how that society views drinking.

Where drinking is viewed with no ambivalence, there is less alcoholism. In fact, in many societies which view drinking in such a manner, including the Mohave, Camba, and Polynesian cultures, no types of alcoholism exist (Trice, 1966:26-7). "The ambiguous or inadequate normative guidelines which characterize groups with ambivalent drinking norms are most likely to produce problem drinkers" (Bales, 1946). Both Hispanic culture and American culture are 'ambivalent cultures,' where these important guidelines are not provided. Furthermore, unlike traditional, preliterate societies, our complex society causes more people to deviate from social norms.

Yet it is hard to determine what causes the deviation, since a convergence of factors is linked to any problem (Horton, 1959:265).

#### ALCOHOL IN AMERICA: A HISTORICAL OVERVIEW

The first moves toward the condemning of alcohol occurred during the early colonial period when Increase and Cotton Mather both preached against "demon rum." This was a surprising development because, until that time, rum was accepted in Colonial America (Blum, 1970:36-37). Drinking was not defined as a social problem until the Westward movement, in which heavy drinking was rampant.

The first political-social liquor problem in the United States was the Whiskey Insurrection in Western Pennsylvania in 1794. The farmers in this part of the state generally turned their surplus grain into whiskey. It could be transported over the mountains more easily than wheat or corn, and it brought a better price in the Eastern markets. But the profit was small, and there was much evasion of the federal excise tax of 1791. In July 1794 a United States Marshall, summoning offenders to court, met with mass resistance (Blum, 1970). "Revenue officers were tarred and feathered, and a militia was sent to subdue the

folk in this first test of the power of the congress and the central government to enforce within the states” (Blum, 1970:37).

The following are some “early anti-drinking laws” as cited by Goshen(1973):

1620. Governor Winthrop of Massachusetts banned the drinking of toasts.

1642. Maryland levied a fine of 100 pounds of tobacco for public drunkenness.

1658. Maryland provided for punishment of public drunks in stocks.

1668. New Jersey banned drinking after 9:00 P.M.

1697. New York ordered saloons closed on Sundays.

1719. New Hampshire made it illegal to sell liquor to someone already under the influence.

The temperance movement was born in the nineteenth century. The first temperance organization, the Union Temperance Society, was founded in Saratoga, New York, in 1808 by physician Dr. Billy Clark. Its theme was that drinking was evil, particularly for the working class. This temperance organization did not spread or last (Goshen, 1973).

The prelude to national prohibition was the Women's Christian Temperance Union (WCTU), founded in 1874. Another organization that became very active in the temperance movement, and was the main force in supporting the Eighteenth Amendment, was the Anti-Saloon League, a combination of many temperance movements. The people who supported the League were called "drys." They endorsed no political parties, but supported anyone who was "dry" (Broom & Selznick, 1973).

A typical anti-saloon message was:

#### WHAT THE GIN-SHOP DOES

*This is the woman, with woe-begone face,  
The wife of the drunkard, in rags and disgrace,  
Who is served by the lady, all jewels and lace,  
The wife of the landlord who coins his bright gold  
Out of the ruin of youthful and old,  
Who drink the strong liquors he sells night and day  
At the bar of the gin-shop, so glittering and gay.*

Prohibition, "the Noble Experiment" as Herbert Hoover called it, was legislated in 1919 when Congress ratified the Eighteenth

**Amendment. This was the prohibition of the manufacture, transport, and sale of alcoholic beverages. As Becker (1973) would probably say, prohibition created a new set of deviants—the drinker and the bootlegger.**

**Prohibition was really a conflict between the urban and rural areas. Although there were some big-city advocates of prohibition, on no issue did urban and rural views divide more clearly. The Eighteenth Amendment, in the words of the historian Andrew Sinclair, marked a triumph of “the Corn Belt over the conveyor belt” (Garraty, 1971:308).**

**Finally, by the end of the 1920s, many prominent leaders and competent observers recognized that Prohibition had failed. One of the first presidential acts of Franklin D. Roosevelt was to repeal the Volstead Act and to work for the repeal of the Eighteenth Amendment. In the late 1930s, the Eighteenth Amendment was repealed, the United States entered World War II, and the nation put all its efforts into the war.**

**Prohibition of alcoholic beverages was not strictly enforced (Garraty, 1971; Kessler, 1996). This can be seen in many of the films made during and after the Prohibition Era, such as “The Roaring**

Twenties” (1946) and “The Ziegfeld Follies” (1939). Every neighborhood had its own friendly neighborhood bootlegger. As an epitaph to Prohibition, it can be said that it did not prohibit anyone from drinking.

#### SUTHERLAND’S DIFFERENTIAL ASSOCIATION THEORY

The theory of differential association ( Sutherland and Cressey, 1966; Sutherland and Cressey, 1970) is in essence a learning theory; which was originally constructed to understand how criminals become criminal. The heart of the theory is the assumption that deviant behavior, like all other behaviors, is learned. This theory can also be applied to how the alcoholic becomes an alcoholic in the midst of his environment.

This theory must be applied to the culture and not to any particular individual or household. For example, why do the Irish have a higher rate of alcoholism than Italians or Orthodox Jews? Why do Puerto Ricans have a higher rate of alcoholism than Dominicans or Cubans? Pittman (1967) says that cultures such as the United States, Ireland, France, and Sweden have marked ambivalence about alcohol usage with conflicting yet co-existing values. However, “in other

societies such as Italy, Spain, Japan, and among Jewish groups, attitudes about alcohol are permissive, that is, they have a positive attitude about the use of alcohol. The differences between permissiveness and ambivalence about alcohol seem to be related to excessive drinking and alcoholism” (Clinard, 1974:451).

Similarly, Bales (1959:265), in “Cultural Differences in Rates of Alcoholism,” asserts that there are

three general ways in which culture and social organization can influence rates of alcoholism. The first is the degree to which the culture operates to bring about needs for adjustment, or inner tensions, in its members.... The second way is the sort of attitudes toward drinking which the culture produces in its members.... The third general way is the degree to which the culture provides suitable substitute means of satisfaction.

To illustrate his point, Bales compares the attitudes towards drinking of Orthodox Jews and the Irish. The Irish have been noted for the excessive drinking habits, whereas Orthodox Jews consider drinking as part of their religious ceremonies.

Aviles-Roig (1973:2) describes the problem of alcoholism and alcohol abuse in Puerto Rico by saying that it is common for Puerto Ricans to drink large amounts of alcohol, such as rum and whiskey, during a social occasion. “In every family gathering reunion or party, among close friends of middle and high socioeconomic levels, it is

customary to postpone dinner time, even after past midnight, to serve drinks preferred by the guest. It is assumed that if they eat early, it is not possible to get drunk and thus the party cannot be enjoyed.”

Applying Sutherland’s (1966) theory to the alcoholic, the word “criminal” can be changed to “drinker”. Thus, nine steps can be cited in learning how to be an alcoholic:

(1) Drinking behavior is learned. Alcohol is an accepted part of many social events, such as wedding receptions and dinner parties.

(2) Drinking behavior is learned in interaction with other persons, in process of communication (such as at cocktail parties).<sup>3</sup>

(3) Most of the learning of drinking behavior occurs within intimate personal groups, such as family, intimate friends, and peer groups.

(4) “Why” people drink is very complex. The techniques involved in learning how to drink depend upon the person’s specific motives, drives, rationalizations, and attitudes, and of course on the particular culture.

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<sup>3</sup> “If the cocktail party is not the ‘typical’ setting of middle-class alcohol use in a strictly sense, it is typical in the sense that the external-orientation of the effects of the drug are most clearly expressed in this situation. It is the archetypal context for middle-class social drinking” (Orcutt, 1972:249). Puerto Ricans have *viernes social*—social Fridays—and drinking is more excessive during those days. Social Fridays are now being extended to Saturdays and Sundays (Aviles-Roig, 1973: 3).

(5) The specific direction of motives and drives is learned from the culture, and conforms to what is acceptable to that culture.

(6) It is more likely that a person will become a drinker in an ambivalent culture than in a permissive culture because in the former there are more conflicting definitions about drinking.<sup>4</sup>

(7) Unlike the situation in permissive and abstinent cultures, there is no restriction put upon the individual in the ambivalent cultures. Therefore, “frequency, duration, priority, and intensity depends upon the individual.”

(8) The process of learning a particular drinking behavior through association with heavy and problem drinkers, or with social drinkers' patterns, involves all the mechanisms that are involved in any other learning.

(9) The fact that a drinker drinks excessively does not explain why he drinks. Drinking behavior is an expression of general needs and values, but since non-drinking behavior is an expression of the

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<sup>4</sup> For example, Aviles-Roig (1973:3) makes the claim that children's birthday parties have become adult affairs where alcohol is served. However, “parents disapprove and reproach their youngster when they drink alcoholic beverages. This situation creates ambivalence and guilt feelings towards drinking, a feeling present in cultures where alcohol abuse and alcoholism constitute a grave psychosocial problem.”

same needs and values, drinking behavior cannot be explained by them.

Becker (1973) examines the learning techniques of becoming a deviant; in the case of his study, a “marihuana user.” According to Becker, there is a three-part process, consisting of (1) learning the technique, (2) Learning to perceive the effects, and (3) Learning to enjoy the effects.

#### ALCOHOLICS ANONYMOUS AND THE SICK ROLE

According to labeling theory, once a deviant label is affixed to an individual, other people will deal with the person in terms of the label, and that label itself may have more significance than any other status the person holds (Becker, 1973). Nevertheless, being labeled an alcoholic is not detrimental within the therapeutic and AA structure, where alcoholism is seen as an illness. The first proponent of alcoholism as a disease was E.M. Jellinek (1960). His book, The Disease Concept of Alcoholism, defines alcoholism as a disease entity that is diagnosed by the “loss of control” over one’s drinking and that progresses through a series of phases.

In the sick role, according to Parsons (1951: 285),

first there is an element of dependency, which in terms of our analysis means an element of conformance motivational orientation. Illness is predominantly a withdrawal into a dependent relation, it is asking to be "taken care of." It uses disability as the basis of legitimization of this claim.

The disease concept is a major part of the treatment in the alcoholism program being investigated. When clients are in the initial phase of treatment, they are mandated to attend educational programs in which the main message is that the client has an illness called alcoholism. In this way the stigma of being an alcoholic is slowly reduced, until it is finally eradicated.

Similarly, AA accepts the disease concept. The confessional or qualification speeches, where AA members are asked to talk about their drinking experience and what led them to decide to choose AA, contain this idea, which is set forth in a passage of Alcoholic

Anonymous (1955:18):

An illness of this sort – and we have come to believe that it is an illness- involves those about us in a way no other human sickness can. If a person has cancer all are sorry for him and no one is angry or hurt. But not so with alcoholic illness, for with it there goes annihilation of all the things worth while in life.

The cohesiveness of AA is based on the disease concept or sick role<sup>5</sup> that it inculcates into its members. The first value that AA tries to teach the newcomer is that his problem is a disease, an allergy to alcohol, as set forth in an AA publication:

Today we are willing to accept the idea that, as far as we are concerned, alcoholism is an illness, which like some other illnesses, can be arrested. We agree that there is nothing shameful about having an illness, provided we face the problem honestly and try to do something about it. We are perfectly willing to admit that we are allergic to alcohol and that it is simply common sense to stay away from the source of our allergy (This is AA, 1953:7).

What treatment and AA actually try to do is the reverse of Garfinkel's "status degradation" rituals (Trice and Roman, 1970). Such rituals involve "communicative work directed to transforming an individual's total identity lower in the group's scheme of social types." (Garfinkel, 1957:420). AA, through the process of "delabeling and relabeling" reverses the not accepted behavior of the alcoholic to one that is accepted and supported by society (Trice and Roman, 1970).

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<sup>5</sup> Alcoholics Anonymous also uses the term "allergy concept."

## ALCOHOL, HISPANICS, AND ACCULTURATION STRESS

In "Alcohol and Hispanics in the Northeast: A Study of Cultural Variability and Adaptation," Gordon (1985) describes three groups: Dominicans, Guatemalans, and Puerto Ricans. He states that Dominicans have had greater adaptation to the American culture because Dominican immigration has been characterized by the settlement of entire families, not just (as in the case of Guatemalans) single males. Dominican migration has facilitated the formation of a stable household economy to which the male contributes. In addition, the Dominicans have a strong sense of community and are connected to the church. All of this combines to create a less stressful situation, resulting in less deviant behavior.

On the other hand, Gordon is hard-pressed to explain why there is a high incidence of drinking in the Puerto Rican community. Puerto Ricans, too, have a sense of family and community. Gordon feels that immigration patterns do not strongly affect the Puerto Ricans, but economic policy does. The Americanization of Puerto Rico has had a lasting effect on the Puerto Ricans.

Among Guatemalans, the reason for heavy drinking appears to be obvious. The Guatemalan male immigrates alone, leaving wife

and children back home. The goal is to make enough money to apply for residency and then to bring his family. But this process, for many, is nearly impossible. As time passes, the Guatemalan begins to forget why he came to America and hopelessness sets in. For example, a subject from the present sample was having a difficult time because his wife of more than 15 years had written to him asking for a divorce. She had found someone in Guatemala. She felt that her husband was not going to return to Guatemala or get a “green card” to facilitate her migration to the United States. This created havoc in the man’s life. He was disoriented and unable to make a decision on whether to stay in this country or return to Guatemala. He had been living in the United States illegally for at least ten years, more than half his married life. The situation was chaotic, due to his wife’s letter, and he found himself without employment. This client maintained his sobriety and gave credit to his involvement in AA.

In the 1960s two researchers, Madsen (1964) and Graves (1967), developed what is known as the “acculturation stress theory.” Madsen found that the highest rate of alcoholism occurred among Hispanics who had abandoned their native culture but had not yet been able to gain acceptance by the dominant culture. Graves’ study

revealed that higher rates of problem drinking occurred where Hispanics had adopted the American culture, but had not attained economic success (as among Puerto Ricans).

Two hypotheses regarding Hispanic alcoholics are tested in Grossman's (1990) study, A Study of Immigrant Hispanic Alcoholics in a Treatment Program. The first hypothesis is that stresses of immigration and acculturation to the mainland of the United States contribute to an exacerbation of drinking problems in Hispanics. The second hypothesis is that culturally based beliefs about drinking and alcoholism influence Hispanics' attitudes about seeking treatment for alcoholism. Grossman was able to prove the first hypothesis. She found that the individuals with the highest levels of adaptation to American drinking patterns also had the greatest exacerbation of alcohol-related problems. She was not, however, able to prove the second hypothesis.

Similarly, Neff, Hoppe, and Perea (1987) found in their survey of Mexican Americans that the less acculturated subjects who drank the most and had the highest level of related problems were a group of males who were born in the United States. As this is a group in which one would expect to find the highest levels of acculturation,

they conclude that an individual who has not acculturated to the same extent as his peers may occupy a particularly marginal social position which may be quite stressful, leading to increased drinking. They designate this pattern as a possible variant of a “Cultural Marginality/Stress Model.”

Similarly, four subjects from the present sample were born in the United States. These individuals had not only a chronic alcohol problem, but also a drug problem. Their addiction also extended over a longer period of time.

Caetano’s (1984) study, comparing drinking patterns in the United States and Mexico, indicates the types of differences in drinking patterns that are believed to exist between the two countries. Caetano found that Mexican men tend to drink less frequently, but in larger quantities, than men in the United States and that Mexican women abstain in greater numbers than do women in the United States. This is related to the “Acculturation Model,” which addresses the relationship between acculturation and the exacerbation of alcohol problems.

On the other hand, Gilbert and Cervantes (1986) point out that recent studies indicate a trend among Mexican American men

towards “increased frequency of consumption but retention of the high consumption-per-occasion patterns found among Mexican men.”

They observe that “an acculturation model” would predict a mere “substitution of the United States for Mexican drinking patterns” and, therefore, it does not adequately explain what seems to be occurring among Mexican American men. Indeed, these men have increased their frequency of drinking, making their pattern more like that of the United States men, but they continue to drink heavily when they drink, as is the custom in Mexico. This clearly results in a higher total consumption of alcohol, suggesting the likelihood of an increase in alcohol-related problems.

Using a causal model, King (1990) analyzed his data to understand the role of acculturation in alcohol use and depression among Mexican American, Cuban, and Puerto Rican adult populations. King hypothesized that those in the middle of the acculturation process—that is, those who are still negotiating the transition involved in adapting to the new culture—would be the most likely candidates for acculturation stress. People who have already adapted to the new culture, and those who still remain within Hispanic culture (i.e., those who speak only Spanish and live in Hispanic

communities with little contact with Anglos), would be less likely to experience disruption in their lives. Therefore, it is expected that those in the midst of the acculturative transition would have a greater number of persons experiencing some kind of psychological distress.

To measure psychological distress, King used an index of depression. His hypothesis was that those experiencing greater distress would use alcohol to cope, to reduce depressive mood, or to serve as a buffer to stress. King's model for the relationship among acculturation, depression, and alcohol use is inadequate. Even though he found that Puerto Ricans were having the most difficulty in adapting to American culture, Puerto Ricans do not use alcohol more often (or in greater quantity) than Mexican Americans.

## CONCLUSION

Understanding cultural meanings attached to the use of alcoholic beverages is important in preventing and treating alcoholism (Room, 1985). This study agrees that therapists are more effective when they are knowledgeable about the sociocultural aspects of the people they serve (Westermeyer, 1976). Also, the therapist must be knowledgeable regarding alcoholism. Without an understanding of

both areas—sociocultural issues and alcoholism—it would be difficult to distinguish between alcoholic behaviors and behaviors that can be accounted for by other factors, such as poverty and ethnic differences (Bullough, 1972; Westermeyer, 1976).

This study develops a model to study the process of recovery. It investigates a small group of Hispanic male alcoholics receiving treatment in an alcohol center. A significant premise of recovery for the Hispanic clients in the clinic is the need for awareness of the American culture while at the same time maintaining a link to their own cultural identity. Therefore, to understand the position of the client, the therapist must have knowledge of the cultural situation of the client. At the same time, the therapist must be aware that the client's perception of his circumstances, is just as important as the "outer" conditions of his life. In the model being developed in this study, the client takes central stage. The recovery process is a convergence of a complex combination of factors that come together through formal and informal aspects of treatment.

In addition, for effective studies of alcohol, alcoholism, and recovery among Hispanics, there has to be a greater awareness of American society's perceptions regarding alcohol, alcoholism, and

recovery. The influence that the larger society has on the various groups is great, in so far as these groups develop their own perceptions based on those of the larger society.

## **CHAPTER THREE**

### **THEORETICAL PERSPECTIVES**

**This chapter reviews and discusses the theoretical perspectives used in this study to describe the recovery process of Hispanic male alcoholics in an alcohol treatment program. Recovery can be explored, from a sociological perspectives, by using the concepts of symbolic interaction, anomie, labeling, socialization, and resocialization.**

**This study uses the concept of symbolic interaction, since it provides the most useful sociological perspective to understand a clinical setting. A clinical setting is a structure suited to a “micro” (rather than a “macro”) level investigation, such as symbolic interaction provides. The study focuses on several questions: How does change occur for the alcoholic? How does the alcoholic perceive his world? Is time a significant aspect of recovery? How does the structure of the clinic influence the alcoholic in treatment? Is it necessary to be aware of others’ views in order to recover? The client’s perception of his world and how others perceive him will be**

extensively discussed in this chapter. The other themes are fully discussed in Chapters 5, 6, and 7.

“Anomie” and “labeling” will be discussed first.

“Socialization” and “resocialization” will be examined through a look at symbolic interaction. These two perspectives are also discussed in Chapters 6 and 7.

#### MERTON’S ANOMIE AND BECKER’S LABELING THEORY

Anomie theory defines alcoholism as a form of deviant behavior that results partly from an imbalance in the social structure of society—a disjunction between approved means and goals. From this perspective, alcoholism can be defined as consumption of alcohol that exceeds the established norms of a particular society.

Thus, alcoholism, viewed within the framework of Merton’s (1938; 1968) theory, may provide a means of escape from blocked opportunities and general life conditions that are perceived as unsatisfactory. Cohen (1970), extending Merton’s theory, states that this imbalance creates an “illegitimate opportunity structure.” It is easier for the alcoholic to drink in this environment. For Merton, socialization is at the root of individual deviance (Frazier, (1976: 15).

At the same time, Durkheim's (1933;1966) use of anomie to mean "normlessness," does not explain how an individual restores his life once he becomes a deviant. It fails to explain the process of recovery, or resocialization. It appears that anomie best describes the strain and stress caused by the discrepancy between needs and wants. It views society as an integral whole, rather than on the basis of individual choices.

Anomie can be compared to the concept of alienation (in some literature "anomie" and "alienation" are interchangeable [ Dean, 1961; Reeder, Ramacher, and Gorelnik, 1976; Thomas, 1989] ). Alienation has generally been associated with alcoholism ( Calicchia and Barresi, 1975; Seeman and Anderson, 1983). It can be defined as a sense of isolation, powerlessness, and frustration; a feeling of loss of control over one's life; a sense of estrangement from society or even from oneself (Norton, 1996:14). Anomie, as alienation, explains more the feeling of the suffering alcoholic than the feeling of the alcoholic who has decided to stop drinking and improve his life.

Similarly, Becker's (1973) labeling theory explains how society labels the alcoholic but does not help him put his life back together. Once the label "alcoholic" or "alcohol abuser" is attached to

someone, labeling theorists become interested in the consequences of that label. Becker defines a deviant as “one to whom that label has successfully been applied; deviant behavior is behavior that people so label.”

Most sociological perspectives do not accurately explain the recovery process of the alcoholic. For instance, anomie theory gives an explanation of how a person becomes deviant, but it seldom discusses the possibility that the person might change that behavior. In the same manner, labeling theory establishes the stereotype of “once a deviant, always a deviant.” The person is seen as having no control over his life. Change is not possible after a person has been labeled.

Nevertheless, we know that an alcoholic recovers by developing a stronger self, learning to cope with society, and learning to interact with other people, since a major problem of alcoholics is a painful sense of isolation and loneliness. The alcoholism program, together with Alcoholics Anonymous (AA), assists the alcoholic to create attainable goals with objectives that are realistic and reasonable for him.

Hence, anomie and labeling are not useful in explaining the recovery process; resocialization is a perspective that better explains

individual change. Fein (1990) views resocialization as role change. He shows that a person must become aware of what is going wrong in his outer life before change can occur. It is not a simple matter, because life patterns must be rejected in order to clear the way for the new role. He states that time is an important factor in order for change to happen. Maintenance is also a high priority in keeping the new role. If the new role is not maintained, relapse can occur.

#### SYMBOLIC INTERACTIONISM

Symbolic interactionism is defined as “ a sociological perspective that focuses on how social structures are created and maintained in the course of human interaction” (Kornblum,1988:599). Symbolic interactionism tries to keep the individual at the center of attention; the core of social reality is the active human being attempting to make sense of social situations and the world around him. To make sense of a situation, or to cognitively understand it, is to interpret it and give it meaning. The individual does not respond to the social world directly (Mead, 1934). His experiences take form from the meaning he places on his own acts and on the acts of others (“significant others and generalized others”). The meaning that the

individual places on his behavior is what is significant in the process of resocialization. For instance, a client might decide after many years, that his family is important. This does not mean that the family was not important before, but with newfound meaning attached to the idea of family, the client is now able to see clearly what he has been missing in his life, and he is ready to correct the situation through treatment and a desire to change.

In order for an individual to change, the meaning that he places on his acts must also change. The alcoholic, for example, might be told by his family and friends that he has a drinking problem. He does not listen, however, until he is ready to listen. “I don’t know what made me listen that night to my sister—and not 20 other nights just as similar.... But I did listen and it prompted me to want to stop” (Caroline Knapp response to the question of when did she realize her decision to stop drinking in an interview on “Primetime Live,” on August 21, 1996; she is the author of Drinking: A Love Story, 1996.). She states, in addition, that her sister’s persistent message to her to stop drinking planted a seed that eventually made her aware of her need to give up alcohol.

The act of interpretation gives interaction its symbolic character. For instance, alcohol provided for Knapp a primary relationship—alcohol as the lover. She reports that she felt warmth and a sense of intimacy when she drank alcohol. Similarly, interpretation plays a central role in recovery. The alcoholic needs to learn how to cope with and tolerate the world around him without alcohol. In the 1962 film, “The Days of Wine and Roses,” a character explains that the reason she drinks is that the world appears dirty when she is sober. This suggests that the alcoholic must make a conscious effort to see the world differently. The alcoholic must also understand that this is a difficult and lengthy process. Time is decisive in helping the alcoholic to view his social situation in a more positive way. In the 1990 film, “Clean and Sober,” the main character does not seriously begin his treatment, by cooperating with the agency and staff, until he becomes aware that time is running out.

Bateson (1972) discusses a similar problem that the alcoholic cannot simply return to a pre-alcoholic state. That is because the problem is not merely excessive drinking, but why the alcoholic started to drink excessively. He believes that the drinking is actually the alcoholic’s search for a solution.

In the process of successful resocialization, the alcoholic becomes a better version of who he was before. Many active alcoholics, for example, see the world as a hostile and unfriendly place; they are full of conflicts and a sense of powerlessness and hopelessness. The alcoholic may feel shame and guilt about the way he is behaving, even though in many ways he is in full denial. The alcoholic often does not possess the tools to stop this out-of-control feeling because he grew up in a household that supported the act of becoming an alcoholic. It may have taken many years to arrive at this point in his life. Similarly, it will take him many years to recover from this illness. Denial is the first defense mechanism to be dismantled.<sup>6</sup>

An alcoholic lets his defenses down only after he is ready. Knapp (above) decided to listen to her sister only because she was ready to listen and seek help. Otherwise, she would have continued to rationalize her situation. Her definition of the situation was intact with all the ready-made excuses to continue her way of life.

How does one help an individual who needs to listen, to listen?

First the individual must be in an environment that is conducive to

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<sup>6</sup> Denial is refusing to accept one's alcoholism.

change (e.g., the clinical setting, a caring family, or among a group of friends). Since denial is ever-present at first, the repetitive task of trying to help someone to become aware of his alcoholism is onerous.

Likewise, when the alcoholic comes to the clinic, he tries to maintain an image that he is not in need of help. He tries to manage his situation. This is similar to Goffman's "impression management" (1959). He would like the staff to see him as he thinks he presents himself to the world. He tries to hide the "spoiled identity" (Goffman, 1963) he so desperately wants to abolish.

The alcoholic does not perceive that no matter how desperately he is trying to hide, the therapist is aware of his situation. But even if the alcoholic knew this, it would not make an impression on him because he has not assimilated it into his understanding that only he can change his situation. Denial does not yet allow him to see it. Only with time does the alcoholic allow the therapist to collaborate with him, to help him through the necessary change to reach his goal of recovery.

On the whole, socialization in this sense points to the process of development or change that a person goes through as a result of social influences. Its focus tends to be the development of self-

concept, identity, and various attitudes, dispositions, and behaviors of the person. In viewing the process of socialization through symbolic interactionism, emphasis is placed on symbolic interaction as the natural milieu for human experience. Symbolic interactionism stresses the emergence of the mind, self, and social structure out of this interaction process; the central role played by the actor in the construction of the self, social situation, and personal sense of reality; the significance of role-taking as a mechanism of self-knowledge and knowledge of others, enabling social interaction to take place; and the flowing, somewhat unpredictable, nature of the whole undertaking (Gecas, 1979).

Indeed, some of the data collected for this study are qualitative. Qualitative researchers try to understand people from their own frame of reference—experiencing reality as others experience it. Blumer (1959:86) explains it this way: “To try to catch the interpretive process by remaining aloof as a so-called ‘objective’ observer and refusing to take the role of the acting unit is to risk the worst kind of subjectivism—the objective observer is likely to fill in the process of interpretation with his own surmise in place of catching the process as it occurs in the experience of the acting unit which uses it.”

To summarize, symbolic interactionism stems from the works of Charles Horton Cooley, John Dewey, George H. Mead, Robert Park, W. I. Thomas, and others. Mead's (1934) formulation in Mind, Self, and Society is the clearest and most influential presentation of this perspective. Mead's followers, including Howard Becker, Herbert Blumer, and Everett Hughes, have applied his insightful analyses of the processes of interaction to everyday life (Taylor and Bogdan, 1984).

The symbolic interactionist places primary importance on the social meanings people attach to the world around them. Blumer (1969) states that symbolic interaction rests on three basic premises: (1) that people act according to the meanings they attach to things and other people, (2) that meanings are learned through the process of interaction (i. e., socialization), (3) and that social situations and things are meaningful due to the process of interpretation.

The individual attaches meaning to his world through the process of interpretation. This is how socialization is carried out in our lives. Mead describes how, through significant others and generalized others, individuals internalize the norms and values of their particular society or group and become socialized beings. Both Mead and

Cooley believed that the self develops as a product of social interaction, and the individual becomes truly human only through the process of socialization. In Mead's (1934:34) own words:

The self... is essentially a social structure, and it arises in social experience. After a self has risen, it in a certain sense provides for itself, its social experiences, and so we can conceive of an absolutely solitary self. But it is impossible to conceive of a self arising outside of social experience.

The process of resocialization is successful only after the alcoholic understands his past and is ready to let go. For example, a client in the sample revealed that he disliked his mother as long as he could remember because she had him when she was 38. For this individual, having an "old" mother was a source of embarrassment; also, his mother did not speak English. He reports that he felt guilty all the time for wishing to have other parents. At the time of this revelation the client was 40 years old. He still carried much hostility towards his mother, and even at the time of treatment he did not show affection for her. His father had died a few years earlier. This client's feelings towards his parents were a major setback to his recovery. He saw himself as unattractive and had difficulties relating to women. Thus he had a "spoiled identity" as someone as ugly and unwanted.

When this client was admitted for treatment, he initially rejected what the clinic had to offer. He had his agenda to continue getting high. Yet after being in treatment for over six months, he decided to engage in the process. He reported later that the reason he decided to align with his treatment and therapy was that he felt that his primary therapist cared for him as a person. This was a turning point, when he started to attach different meanings to the same social situation. At first, he did not perceive his therapist as caring enough for him, but when that circumstance changed, he became aware of the meaning of the therapeutic relationship. Once he became aware, the factor of time was no longer as important. The client saw his world in a more positive and meaningful way.

In "Definitions of Time and Recovery in Paralytic Polio Convalescence," Davis (1972) describes how perceptions of time and recovery of the patient are modified by the hospital and staff. The change in time perspective is brought about by the medical information and knowledge provided by the professionals to the patient and the patient's family. The hospital redefines recovery as a slow process that is full of uncertainty. Similarly, recovery is defined by the clinic

as a hard and difficult road. Treatment is mapped out for the client to follow if he wants to recover.

At first, the factor of time matters to the client, who eagerly awaits the day when he can leave the clinic. When the client begins to feel better—urges and desire to drink lessen—he looks on the long-term aspect of recovery and discovers that progress in recovery is a lifetime commitment. As AA puts it: “It is a way of life.”

## **CHAPTER FOUR**

### **BACKGROUND AND METHODS**

This chapter focuses on the methods used in this study, the nature of the clinic setting, and how the data were collected. Both formal and informal aspects of treatment are crucial to the recovery of clients in the clinic under study. Since the basic theoretical perspective adapted here is symbolic interaction, the clients' perceptions of treatment, and the role of the social structure—the clinic—as seen by client and staff, are fully discussed. Two distinct positions exist side by side and usually converge for the benefit of the client: the clients' position and the clinic's position.

The study explains and describes the recovery of Hispanic male alcoholics by studying how a client internalizes and generalizes what he has formally learned in an alcohol treatment program. In this sociological study four research methods have been implemented to gather the necessary data: participant observation, in-depth interviews, semi-structured pre-coded interviews (questionnaire), and the analysis of written documents (clients' charts).

The data collected are a mixture of quantitative and qualitative data, gathered for the purpose of describing the recovery process—a process of change. The findings test the hypotheses: (1) that the more socially involved the client is in the alcohol treatment program and Alcoholics Anonymous (AA), the greater will be the improvement in his quality of life, and (2) that the more anomic the life situation of the client, the less socially involved the client will be in the alcohol treatment program and AA, and the less will be the improvement in his quality of life.

The hypotheses appear to be tautological, but they are not. It seems obvious that if one is involved in the treatment program and AA, the end result will be success in attaining recovery and improvement in the quality of one's life. However, the kind of involvement is crucial, since one is not merely complying with the rules of the clinic and AA. Attendance is a basic requirement, but a client can attend an individual or group counseling session, or an AA meeting, and not really be involved in his treatment. A client can sit in the day room and not partake of any conversation. A client can go through the treatment program and maintain his isolation from others in the therapeutic setting. Hence, the involvement that is being

investigated and examined, in this study, is the integration of the client into the clinic or agent of change, and the obstacles that keep the client from this integration. The data can be beneficial to treatment programs in helping them to enhance treatment for maximum effectiveness. The key issues are how to integrate and keep clients in treatment, enabling them to graduate from the program.

In collecting the data, two aspects of treatment have been examined: formal and informal. The formal aspect of treatment is defined as the comprehensive service offered by the treatment program. The services offered are group and individual counseling, vocational rehabilitation, recreational counseling, referral, and medical/psychiatric services. The informal aspect of treatment is what happens in the clinic and AA on a daily basis, the social interaction among clients and staff. It is the process of relearning social skills and interrelationship. As the client becomes involved in the informal aspects of treatment, it is assumed that the client will become more socially viable in all areas of his life. Hence, the client's attendance and participation in the activities of the clinic is significant.

**Qualitative research is significant in the study of resocialization because it is a systematic attempt to discover the knowledge a group of people have learned and are using to organize their behavior (Spradley, 1980). The researcher tries to understand the “definition of the situation” that people under study have of their world (Spradley, 1980). The process of resocialization in this study, is twofold: (1) the client makes a conscious effort to change his life, and (2) he is gradually influence, through time, to conform to the environment of the clinic and AA.**

**In this chapter, a description of the setting and background, the subjects, and the methods and procedures of data collection will be set forth. There is also an explanation of the instrument used to gather the quantitative data.**

#### **SETTING AND BACKGROUND**

**The study was conducted in a hospital-based alcoholism outpatient clinic, which was operated under the auspices of the Department of Psychiatry. The clinic is located five blocks from the main hospital. It has both an English-speaking and a Spanish-speaking**

Program, and it is the only city-run Spanish-speaking alcoholism treatment program in Queens, one of the five counties of New York City.

The clinic has easy access since it is located on the second floor above a main subway terminal in western Queens. There is no defined catchment area, and the clinic receives referrals from the five counties of New York City. The main sources of referrals are the court system ( family, Driving While Intoxicated [DWI], probation, and parole departments), public assistance agencies, and other hospitals and clinics.

The initial intake visit to the clinic is for screening. If the client is accepted, he is given an appointment for the psychosocial and medical examinations. The client is expected to follow the schedule given and to attend AA. The clinic comprises four phases: orientation, phase I, phase II, and phase III. There is an explanation of these phases in Chapters 5 and 7.

The alcoholism treatment program is comprehensive, offering counseling, medical, nutritional, psychiatric, and vocational services. Treatment is based on the developmental model of recovery (see Chapter 7) and the 12- step AA model. Each stage must be resolved

before going on to the next stage or step. Alcohol addiction is viewed as a physical, mental, and spiritual disease. The staff consists of a director, a coordinating supervisor, four social workers, two certified counselors, an HIV coordinator, a registered nurse, a nurse's aide, a medical director, an administrator, two vocational rehabilitation counselors, and clerical personnel.

The clinic is spacious and clean, and clients appear comfortable in its physical surroundings. To the left of the entrance is the reception desk where the client can be informed about any activities in the clinic. Before the client enters the clinic proper, he must sign his name on the roster. Clients do not need an appointment to visit the clinic. Those who come to the clinic usually go to the day room where they wait to be called if they have an appointment. If the client is there for the purpose of socializing, the day room is the area to visit with friends. Clients are expected not to loiter in the hallways. The clinic is well organized, and clients generally know where they are supposed to be. Everyone knows what to do and what is expected of them.

AA meetings and Al-Anon<sup>7</sup> meetings are held in the clinic in both English and Spanish. Clients are mandated to attend the AA meetings, and family members are urged to attend Al-Anon meetings.

Clients enjoy playing pool and talking to each other in the day room. The coffee pot, located in the day room, is usually the most popular spot. Clients congregate around the coffee pot in the morning, greeting each other; this is the beginning of their day. After the morning coffee, each client goes to his group therapy or individual appointment. All clients tend to get along with each other, but Spanish-speaking clients tend to stay together and socialize with each other.

#### SUBJECTS

The three major ethnic groups in the total population of the clinic are White, African American, and Hispanic, but there are some Indians, Chinese, and Koreans, also. At the time of the study, there were a total of 215 clients in the clinic. The present sample consists

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<sup>7</sup> Al-Anon is an organization for the spouse of the alcoholic, who is a member of AA. Here families that have gone or are going through similar problems come together to discuss them and help one another.

of the total population of Hispanic males in the clinic. At the time of the study, there were 50 Hispanic male clients.

All Hispanic males in the clinic were asked to participate in the study. Appointments were given for the pre-coded interview, but only 37 were actually interviewed. Of the 13 clients who left treatment, some had resumed drinking and others simply stopped coming to the clinic. When a client misses a week of therapy, a letter is sent to his home. Thirteen letters were sent but none of the clients returned to the clinic. It was not unusual for clients to stop coming to the clinic or avoid responding to a letter. The 37 clients who remained in treatment were generally demographically similar to the 13 who left.

Of the 37 interviewed, five were asked to return for the in-depth interview. These five were chosen because they typified the Hispanic male population of the clinic. The five were interviewed for approximately 2 to 6 hours each. Some clients were more open about their life situation and found it easier to talk about themselves.

## **CHARACTERISTICS OF HISPANIC MALE CLIENTS IN THE HISPANIC OUTREACH PROGRAM**

**Table 4.1 below provides some characteristics of the Hispanic clients admitted to the treatment program. The mean age of the sample population is 42.24, with the youngest male client being 28 years old. One reason that the sample population represents older Hispanic alcoholics (the age range is 28-65; most fall within the 35-50 range) is because the development of the illness of alcoholism is lengthy, and also because the Hispanic male alcoholic typically tries to control his drinking before seeking professional help. Self-referrals are rare; only one client in this study was self-referred. A total of ten (27%) reported self-referral on the questionnaire; however, when cross-checked with the information on the chart, only one (3%) was actually self-referred. In addition, over 90% of the clients interviewed had participated in at least one other treatment program before attending the clinic.**

**In spite of the fact that many of the clients are chronic alcoholics, 27% are either married or living as married, and 46% live with their family of origin or a friend. This suggests that Hispanic families are inclined to keep the male alcoholic within the household.**

**TABLE 4.1**  
**CHARACTERISTICS OF HISPANIC MALE CLIENTS IN THE**  
**TREATMENT PROGRAM (N=37)**

Characteristics	n	%
<b>AGE</b>		
30 and younger	1	3%
31 thru 40	15	40.5%
41 thru 50	16	43.5%
51 thru 65	5	13.5%
		100%
<b>MARITAL STATUS</b>		
Single	10	27%
Married/Living as Married	10	27%
Divorced/ separated	17	46%
		100%
<b>LIVING ARRANGEMENT</b>		
With Family	16	43%
With friend	3	3%
Alone	18	49%
		100%
<b>EDUCATION</b>		
7 <sup>th</sup> grade or less	11	29%
8 <sup>th</sup> grade graduate	5	13.5%
Some high school	5	13.5%
High school graduate	9	24.3%
Some college	4	10.8%
College graduate or more	3	8.2%
		100%
<b>NUMBER OF YEARS IN USA</b>		
0-5 years	1	2.7%
6-10 years	5	13.5%
More than 10 years	27	73%
Born in USA	4	10.8%
		100%
<b>RELIGION</b>		
Roman Catholic	33	89.2%
Protestant	3	8.1%
None	1	2.7%
		100%
<b>LEVEL OF FLUENCY IN ENGLISH</b>		
High	9	24.3%
Middle	3	8.1%
Low	17	46%
None	8	21.6%
		100%
<b>INCOME</b>		
Public assistance	23	62.2%
Employed	13	35.1%
Retired	1	2.7%
		100%

When a woman is an alcoholic, her husband or boyfriend is likely to leave the household.

Educational level varies, from 29.7% having achieved a formal education of seventh grade or below, to 24.2% having graduated from high school (mostly in the country of origin). However, the level of English fluency is low, with 67.6% of the sample having little or no fluency in the language. Indeed, some 73% of clients living in the United States for 10 years or more did not know the language of the host country. Roman Catholic clients comprise 89.2% of the sample, and 8.1% are Protestant.

Most clients who attend the day program are unemployed, but most of the evening clients are employed. Public assistance helps to support 62.2% of the sample. Most of these clients are in the day program; only one client in the evening program receives public assistance. In all probability, the women who live with these clients are also on public assistance, and they may have acquired welfare benefits by claiming abandonment by the husband or boyfriend. It is common knowledge in the clinic that many of the clients are not being truthful on their public assistance application.

Almost half (49%) of clients reported living alone. At least two of these clients were not telling the truth and were actually living with their girlfriends. Hence, one must question the veracity of some of the clients' statements in relation to the welfare issue.

The social environment that these Hispanic clients find themselves in is stigmatizing and anomic. For instance, through socialization in the Hispanic culture, the man is generally taught that a man can drink, but that he also must be the provider for his family. Thus, a result of their drinking behavior, these clients find themselves in a formidable predicament. Since these men are not providing for their families, they also are not being honorable—another important Hispanic value. Furthermore, the women who live with them, are also being dishonorable, and this causes tremendous conflict within the household, as reported by some of the clients. Both the alcoholic and the woman with whom he lives, may be struggling with dishonesty towards others, including public assistance.

In the Hispanic culture, drinking is an important aspect of being a man. Drinking, and sometimes drinking to excess, are not considered to be a problem, especially if the drinking occurs during a celebration ( baptism, birthdays, weddings, etc.). In addition, if a man

is a good provider and takes care of his family, drinking is considered to be a reward (Aviles-Roig, 1973; Panitz, McConchie, Sauber, Fonseca, 1983).

Hence, the counselors in the Hispanic Outreach Program find themselves in a dilemma. They must explain to a client that part of recovering will be to risk the loss of welfare benefits. Dealing with the loss of welfare benefits might be one of the biggest decisions a client in this treatment program might have to make, and at the same time it is one of the biggest obstacles to recovery.

#### PARTICIPANT OBSERVATION

Participant observation is perhaps the best method to collect qualitative data. Participant observation is defined as “a method of social research in which the researcher becomes a participant in a naturally occurring social activity” (Jary and Jary, 1991: 355). Data is collected informally by the researcher among the subjects. In the case of this study, the day room was a significant place in term of participant observation because clients were more opted to socialize in the day room than in any other areas of the clinic. Participant observation helps the researcher to understand the subjects being

studied in a more intimate way. This method is particularly significant for this study because one of the major focus of the study is to understand how clients internalize the ways of the clinic and AA.

Observations around the clinic were made on a daily basis. Observations in the day room, at different times of the day, and at least one evening per week, were made for a period of six months. A daily routine was noted. Most of the clients had group counseling in the morning and they generally went directly to the day room to get coffee and sometimes a danish pastry. Throughout the day, there was usually a group of clients, including Hispanics, that hang out at the facility. They would interact socially or compare notes in regards to their treatment. This group also entered into conversation with some of the staff, especially the clerical staff who were more accessible, since they were usually in the reception areas. Clients also tended to gather around the waiting area where the security guard had his desk. This area was reserved for new clients or visitors. (See Figure 4.1 to get a better visual picture of the clinic.)

As the researcher participated with the clients in the day room, conversations became more profound and insightful. These social conversations created an atmosphere in which clients felt more at

ease, since they knew they would not be recorded on their charts.

During this time observations were made that certain clients sat next to particular individuals. Cliques were formed, and language was a great divider. The importance of language was revealed in the fact that Hispanic clients tended to socialize with each other; however, Hispanic clients who spoke fluent English had no problem making friends in both tracks. Language kept many clients apart, even though they had many things in common.

The evening clients, who were mostly DWI clients, attended the treatment program twice a week. They were there on Mondays and Wednesdays from 5 to 8 p.m. These clients congregated in the day room and waited to be called to see the medical doctor, psychiatrist, or therapist. They also participated in group therapy from 6:30 to 7:30 p.m.—on Mondays it was an alcohol educational group and on Wednesdays it was a therapy group.

The DWI clients mainly played pool in the day room while they waited to be called for treatment. Pool was a popular day room activity enjoyed by most of the clients at the clinic. Clients who did not know how to play were taught by another client, and

conversations happened around the pool table. There was no television in the day room, which further encouraged clients to socialize.

The mornings were the most hectic time, due to the scheduling. Almost every client had a group counseling session starting at 9:30 or 10 a.m. Clients consistently sat in the same seat, or the same area, for the hour-long session. Most clients preferred a seat by the window. Orientation groups were larger than the more advanced groups. There were 8-15 clients in an orientation group, and 3-5 clients in an advanced group. (See Table 4.2 for the group schedule.)

Orientation groups gave the clients an understanding of therapy, making the process more accessible and less confusing. Clients questions are answered in the orientation group and followed up later in individual counseling. The technique of having clients face other in a circle is the preferred method of the therapists in group therapy. In this way, all clients are equal.

FIGURE 4.1

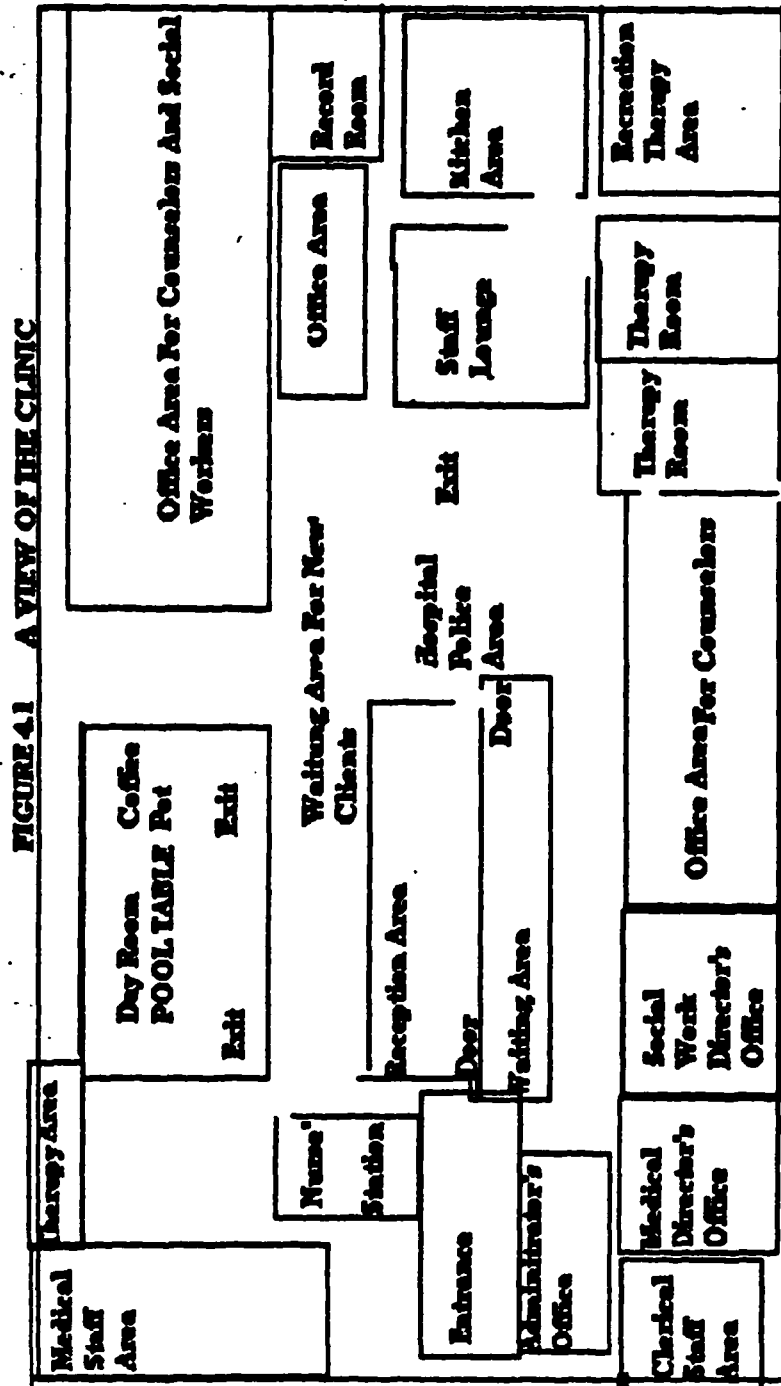


TABLE 4.2

## THE PHASES: GROUP SCHEDULE

<b><u>ORIENTATION</u></b>	<b>(8 weeks)</b>
Orientation Group	2 times per week
Education Group	1 time per week
STEP Group Workshop	1 time per week
Weekend Planning Group	1 time per week
A A Meetings	2 times per week
<b><u>PHASE I</u></b>	<b>(3 - 5 months)</b>
Phase I Group	1 time per week
Vocational Group	1 time per week
Special need/interest group	1 time per week
A A Meetings	2 times per week
STEP Group	
<b><u>PHASE II</u></b>	<b>(3 - 5 months)</b>
Phase II Group	1 time per week
Vocational Group	1 time per week
Special need/interest group	1 time per week
A A Meetings	1 time per week
<b><u>PHASE III</u></b>	<b>(4 - 6 months)</b>
Phase III Group	1 time per week
Vocational Group	1 time per week
Special need/interest group	1 time per week
A A Meetings	1 time per week

In the AA meetings where observations were made, there was no need for disguised observation. It is considered to be a form of participant observation (Becker, 1961). An announcement was made in the counseling groups that the researcher would be visiting some of the AA meetings in the area. The AA groups visited were the three most frequently mentioned by Hispanic clients: Honestidad, Alfa y Omega, and 24 Horas. There was one visit to each group.

Not too many clients attended these meetings that were actually observed. These meetings were very similar in content. At Hispanic AA meetings, people tend to talk less in the style of AA than they do at English-speaking meetings. In many of the studies done on AA, to talk in the frame of reference of AA is very desirable (Denzin, 1987[a, b]). Yet, in the Hispanic meetings, not much importance was attached to this AA style of speaking. This was also noticeable in comparing the English-speaking AA and the Spanish-speaking AA at the clinic. The English AA was more formal in the way the chairs

were arranged, the rules were upheld, and the participants expressed themselves. In the Spanish AA, chairs were arranged in a circle and everyone present was asked to take part in the discussion. The Hispanic AA in both the clinic and the community tends to be more like group counseling than a traditional AA meeting.

The atmosphere of the Spanish-speaking AA meetings appears to be very soothing for the members. The pressure on them is minimal. People are at ease and friendly, and one can understand why some become “addicted” to AA. For example, there was a client whose wife was upset because now that her husband was not drinking, he was spending an enormous amount of time at AA meetings. In many of the Spanish AA groups, the meetings last two hours, and some have marathons on Friday nights from 8 p.m. to 3 a.m. These marathons are peculiar to Spanish-speaking meetings. Discussions in these meetings are not entirely focused on alcohol-related issues.

During group therapy, the counselor encourages the clients to go together to AA. This is an effective strategy because once a client promises to attend AA with someone in the clinic, he tends to keep his promise. It is one way of introducing AA to the client, and it also

entices clients who have refused to attend meetings. Eventually all clients attend community-based AA meetings.

The only regular assignment given to the client is to attend AA and to have the attendance sheet signed by the leader of the group. Counselors do not assign reading material to be taken home, but they do suggest readings concerning the process of treatment and recovery. Hispanic clients as a whole do not like to read. If any reading is to be done, it is read and discussed during group session.

It is expected that clients will stay sober. Breathalizing<sup>8</sup> the clients is a technique used to keep them sober, at least, when they attend the clinic. This rule was officially enforced in 1994, and tests are performed in the morning before the clients start group counseling. It is rare to find a client with an alcohol reading. Generally, a client who is drinking does not attend the clinic that day, and he eventually drops out of treatment if he continues to drink.

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<sup>8</sup> To breathalize a client a small machine is used called the breathalyzer. The client is asked to blow into the machine and a reading will light up. If the client has been drinking, the machine will indicate a percentage. If not, then the machine will indicate zero amount.

Through participant observation, a researcher is able to have a feeling for the whole spectrum of the client's life. Participant observation permits the researcher to see from the subject's point of view in order to understand how the subject feels and interprets the world around him. If the researcher becomes too sympathetic to the plight of the subject, a problem of maintaining objectivity might arise. Thus, the researcher must be aware of this pitfall and the rules of participant observation must be adhered to. Two problems arose in doing this study: (1) the difficulty of minimizing and controlling the researcher's influence on the social processes observed, and (2) ethical issues and methodological dilemmas in how to enter and leave the field, including the problem of whether to reveal the purpose of why the researcher was there. These problems were overcome and this method was invaluable to this study.

Spradley (1980) states that cultural inferences must be based on three types of information: what people do (cultural behavior), the things people make and use (cultural artifacts), and what people say (speech messages). Cultural behavior and speech messages were the two sources of cultural inference most important for this study. Since alcoholism is such an insidious disease, which covers a person's every

action, it is important to completely understand it and gain insight into its mechanisms and dynamics in order to be able to describe the lives of these alcoholics, and understand how it is that they are able to reconstruct themselves and their lives from the ground floor up.

#### IN-DEPTH INTERVIEW

The in-depth interview is an exploratory research tool that helps in understanding social behavior. Through such interviews, we learn about “the inner life of the person, his moral struggles, his successes and failures in securing his destiny in a world too often at variance with his hopes and ideals” (Burgess, quoted in Taylor and Bogdan, 1984:7). Taylor and Bogdan (1984:77) define in-depth interviewing as “repeated face-to-face encounters between the researcher and informants directed toward understanding informants’ perspectives on their lives, experiences, or situations as expressed in their own words.”

The purpose of the in-depth interviews in this study was to explore the nuances of how the clients felt about attending the treatment program and AA, what meanings they attached to these

activities, and whether their lives had changed in any way for the better or for the worst.

Five clients, who were representative of the total population, were selected to be interviewed. Within the five cases, important variables are present, such as: born in the United States, came to the United States at a young age, came to the United States as an adult, attended school in the United States, attended school in the country of origin, started drinking early in life, started drinking later in life, came from a single-parent home, came from a two-parent home, is an only child, has many siblings. These five cases represent the sample in all aspects.

Each client was given an appointment that would not interfere with his therapy. The interviews took place in an office located in the clinic, where clients felt comfortable since it was familiar.

Rapport was easy to establish. Each client was asked to tell his life story, which all were eager to do. Clients were asked to describe their lives from the time they started drinking and using drugs, and to give examples. They were asked to give their opinions of the clinic and AA, and to elaborate on their involvement in treatment.

**In-depth interviewing is an intimate face-to-face interaction.**

**During the interviews, the clients wanted to make themselves understood, as they explored their actions or their feelings in respect to their drinking. They examined such questions as, why they disliked their parents or siblings, why they had not decided earlier in life to get help, and so on. Several blamed such things on the manner of their upbringing, poor parenting, or not having the opportunities necessary to choose another course in life. The theme of fate or destiny was present throughout most of the interviews. Most clients had a fatalistic attitude when they were drinking. As each client made progress in his sobriety, he felt increasingly empowered towards having some control in his life.**

**It was important that the clients feel safe in telling their stories and confident that the researcher would listen without being shocked. All of the interviews were successful. Although the family theme was usually a touchy subject, the clients became very candid during the interview. Once they realized that the researcher was there to listen, not judge, and that the interview was confidential, many revelations were made. For instance, a client who had never revealed during five previous months of therapy, that he had been sexually**

abused, opened up during the in-depth interview about his four-year abuse from male siblings. The interviewer was caught off guard and the client noticed the surprise on the interviewer's face. He said, "You do want me to tell you the truth? I'm trying to be as truthful as I can remember about my life."

Once the client entered the office and the tape recorder was turned on, he started to talk without hesitation. Each client wanted to make sure that his story was understood, and he went to great lengths to explain to the researcher how he was raised and how he became addicted to alcohol and drugs. Some made declarations of forgiveness towards people who had hurt them. The in-depth interview helped the clients to engage in introspection.

#### CHART REVIEW

The chart is a written document that contains the history of the client from the moment of his admission to the treatment program. It describes the client's progress as perceived by the primary worker. The primary worker oversees the total treatment of the client. The client will see many health workers throughout his treatment in the treatment program, but the primary worker will be evaluating him and

deciding if he is ready to graduate. The charts are used by all the health workers in the clinic, but the primary worker—social worker or counselor—makes sure that all the documents needed are enclosed in the chart.

The review of the charts was important because they provided concrete data, such as the length of time the client had taken to complete each phase, how many relapses the client had in the past and when they occurred, the length of stay in the program, and information on detoxification and alcohol rehabilitation. All of this concrete evidence was used to verify and confirm the data gathered through the other methods. The charts also provided information on marital problems that the client might not have been willing to discuss in the interview or questionnaire. The charts furnished information on how much active support the clients received from their spouses during the course of their recovery.

It was crucial to check the reliability of information reported in the interview and questionnaire. For instance, in one question in the pre-coded interview, all clients answered positively; however, the chart review showed that this was not true. In this way, bias answers were detected and the responses were placed in the proper light. In addition,

there were extensive discussions with each primary worker to determine the level of growth of each client. The perspective of each primary worker was important because they evaluate clients every three months by preparing a treatment plan and reviewing it with the client.

#### SEMI-STRUCTURED PRE-CODED INTERVIEW

The instrument used to survey clients' participation as a measurement of the recovery process was a semi-structured pre-coded interview in the form of a questionnaire (See Appendix A ). This questionnaire consisted of ten parts. The headings indicate the focus of the questions asked: demographic information; program knowledge and involvement: degree of participation and social involvement; AA knowledge and involvement: degree of participation and social involvement; social isolation; economic stability: work history; immigration status; alcohol education; and the recovery process.

This semi-structured pre-coded interview consisted of 72 pre-coded questions. In addition, there were three open-ended questions which requested the opinion of the respondent on his

experience with the clinic and AA. The respondent was also probed on the meaning of the term “surrendering to a higher power.” The respondents were informed that there were no right or wrong responses to any of the questions being asked.

The tape-recorded interviews took place in an office at the alcohol treatment center. It took one hour to complete the average interview, and most of them were done in Spanish. The decision to interview the respondents, rather than have them fill out the questionnaire on their own, was based on the fact that some of them have difficulty reading, Spanish and/or English.

An objective of this study is to explain whether there is improvement in quality of life for the Hispanic male alcoholics who attend the alcoholism program. Improvement in quality of life, for the purposes of this study, is defined as enhancement of coping skills in a non-addictive way, development of a sobriety support system, understanding of the changes occurring in one’s life, integration of family life, and a feeling of overall satisfaction with life.

The in-depth interviews, the review of the charts, and the interview guide in the form of a questionnaire were the main methods

employed to gather the data and measure the variables. The independent variables being measured are program knowledge and involvement, AA knowledge and involvement, and length of sobriety as self-reported by the client.

Finally, it is proposed in this study that the independent variables will directly cause a positive effect on the dependent variable, which is improvement in quality of life. The indicators or predictors used to describe, to explain, and to measure the effect on the dependent variable are family integration, social isolation, economic stability, legal history, immigration status, alcohol education, and recovery issues.

#### **ETHICAL PRINCIPLES: INFORMATION TO PARTICIPANTS AND ISSUES OF CONFIDENTIALITY**

Before the methods discussed above were implemented to gather the information from the clients at the clinic, the study had to be approved by the human subjects research committee of the hospital. After the appropriate forms were filed with the committee, it took over two months to get them approved. After approval, the study had to be explained to prospective participants (clients). The participants signed

an informed consent before being interviewed. All subjects' anonymity was guaranteed. There were 37 subjects who participated, out of a total of 50. The other thirteen clients left the clinic due to drinking, before they were interviewed. This is not an unusual situation in the clinic. The procedure is to send a letter to the client explaining the need for him or her to attend an inpatient detoxification and an inpatient rehabilitation. If the client does not respond, the clinic does not continue to try to get the client in treatment. In reality, many clients eventually return on their own, and another chance is given to them to start treatment again.

## **CHAPTER FIVE**

### **THE ALCOHOLISM TREATMENT CENTER AND ALCOHOLICS ANONYMOUS: A DESCRIPTION AND EVALUATION**

This chapter focuses on the setting, on how the clients develop a network of recovery within the structure of the Alcoholism Treatment Program (or, as staff and clients call it, “the clinic”) and the social world of Alcoholics Anonymous (AA).

According to Denzin (1987a), treatment aligned with AA transforms the self of the alcoholic to a higher level, and recovery takes place. It is a hypothesis of this study that successful resocialization depends upon the alcoholics social involvement in the treatment program and AA activities. How the clinic is able to help the client achieve this level of recovery is the crux of this chapter.

A brief history of the clinic will be discussed, together with the influence of AA, which has shaped the structure of the clinic as much as anything else, including the bureaucracy of the main hospital, and the community itself. The Hispanic Outreach Program (HOP), the youngest of the programs in the clinic, is crucial since the study focuses on the Hispanic client. However, the Spanish and the English

tracks are highly similar in form and content; the main difference is the language in which treatment services occurs.

This chapter presents a description of the admission procedures to HOP, which is composed of the day program and the evening program (Driving While Intoxicated[DWI]). The treatment available to the client is described in terms of symbolic interaction, the theoretical perspective underlying this study.

When a client is accepted for treatment at the clinic, he might already be familiar with the daily activities of other treatment settings. Over 90% of the clients are mandated by other agencies( e.g., public assistance, criminal court, Bureau of Child Welfare [BCW]), or Department of Motor Vehicles [DMV]), to receive alcoholism treatment. Over 95% of clients have already been in at least one other treatment facility, such as a detoxification unit<sup>9</sup> (which is usually 3-5 days), a rehabilitation unit<sup>10</sup> (which is usually 30-42 days), or another treatment center (which can last up to a year). These percentages are based on information gathered from reviewing the charts.

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<sup>9</sup> A detoxification unit is a medical unit located in a hospital for the purpose of alcohol detoxification.

<sup>10</sup> A rehabilitation unit is a facility located in a hospital but the emphasis of treatment is on the social aspects rather than medical. It allows the client time to reflect on his predicament. Detoxification from alcohol is a pre-requisite.

Thus, the person who is referred to the clinic, realizes that he is in some sort of difficulty. He knows that he must deal with the physical and internal structure of the clinic and AA, in order to be successful in recovery.

For the alcoholic, the consequences of surrendering to alcoholism are monumental. To admit that one is an alcoholic is not easy. To admit that one can no longer drink is not something that comes easily to adult males and females in our society. To enter a treatment center for alcoholism is also not easy to do. Nor is it easy to talk to a group about one's ugly alcoholic past. To admit these facts about oneself and to engage in these actions implies that massive changes are occurring on one's life (Denzin, 1987a:77).

Finally, commitment to recovery is concretely revealed by the client in the way he is involved in the daily activities of the clinic and AA. The alcoholic decides to change only when he understands his own internal need to change. Through treatment, he becomes aware that he must deal with a hostile external world that perceives him as "deviant." By being in a secure environment, where the client feels safe to make mistakes, he learns to deal with staff and other clients in the clinic through social interaction.

For example, a client approached his counselor to inform the counselor that he was not feeling "right." It took a week of counseling for him to finally comprehend his feeling of resentment toward his

family, specifically his mother, for emotional abandonment. This feeling of abandonment was triggered off by a woman whom he had invited to a dance and who had rejected his invitation. For a whole week, the client felt uncomfortable and couldn't understand why he felt this way. Later, after clarifying his feelings, he reported that, in the past, such a situation would have led him to use heroin and drink alcohol. But in a safe environment, he could bring out these feelings in group and individual counseling and get a better understanding of himself. This represents an example of the process of resocialization: a gradual process of replacing the dysfunctional role for a more functional. After the client had a better grasp of the situation, he was in awe of what had taken place, because he felt he had control over his actions, and that alcohol and drugs were no longer in charge of his life. He realized that he could direct his life in a positive way, and that although all his problems had not been solved, he was not just a person waiting for things to happen to him.

At the same time, AA creates a world for the client that is accepting and friendly, a world with values—justice, compassion, honesty, truth, and salvation—and the willingness to teach techniques to the client to maintain sobriety, if he is ready to listen. “Treatment is

3% of the solution. AA is the other 97%. Treatment is discovery, AA is recovery” (Denzin, 1987b:88).

This chapter also discusses the concepts “formal” and “informal” aspects of treatment in the clinic and AA. These terms are defined and elaborated. The formal aspects are easily grasped and understood since they are part of the structure of both entities. On the other hand, informal aspects are the superstructures and thus more difficult to perceive, since they are always changing. There are no sets of rules to follow in the informal aspects of treatment; these aspects are always emerging and developing.

#### A BRIEF HISTORY OF THE CLINIC

The Alcoholism Treatment Program became a separate department in the hospital in 1971. Originally the program consisted of only the outpatient clinic (the clinic), but it has since grown to a 20-bed in-patient detoxification unit, a 35-bed co-ed halfway house, and the clinic composed of various programs (English-speaking track, Spanish-speaking track, Ryan White AIDS Services, and Mentally Ill Chemical Abusers [MICA]). The clinic continues to be considered the

core of the alcoholism program. This study focuses on the clinic in general and the Hispanic Outreach Program in particular.

The clinic's philosophy is that alcohol addiction must be supported with lifelong abstinence. It is important to note that the AA philosophy is ingrained in the clinic's philosophy. The clinic has made it its own. The clinic provides supportive rehabilitation services to alcoholics. A primary program goal for each client is abstinence from alcohol, which allows the client the support to regain physical health and to fulfill family, community, and work responsibilities. At the same time, a major goal of the clinic is to serve the community. It does not have a local catchment area for the Hispanic Outreach Program, especially for the evening Driving While Intoxicated (DWI) program, since it is one of the few Spanish-speaking programs in New York City. Clients are accepted from the five counties of New York City. The clinic is located in a busy commercial area of Queens and the neighborhood is ethnically mixed.

The Hispanic Outreach Program was implemented in 1988 to meet the needs of the community, and it attempts to meet its original goal of helping Hispanic alcoholic families. The DWI evening

program has been very successful, with 100% graduation for the last three years.

The clinic, however, has had a difficult time recruiting Hispanic clients, and not much outreach has been done in the community. Although many plans have been developed, few have been carried out. Hence, the Hispanic Outreach Program is constantly in need of clients. At the time of this study, there were fifty men and ten women in the Hispanic Outreach Program. Although eight persons are needed to run the Hispanic Outreach Program, only four were actually on staff during this study. The personnel office was not hiring additional staff due to lack of generated income from the treatment program.

The influence of AA in shaping the structure of the clinic makes recovery available for anyone who chooses to get well. AA has been permitted to facilitate its meetings in English and Spanish from the inception of the clinic. But the difference now is that AA teachings, such as the 12-step program and the reading of AA literature, are also incorporated in the treatment program.

The incorporation of AA into treatment was made possible when the clinic changed to a psychiatric model in 1990. The clinic was mandated by New York State to change from the medical model to the psychiatric model. It was the last alcohol program in New York City to carry out this transition. The clinic, however, has not fully adjusted to its new reality.

Under the medical model, the clinic functioned as a regular medical facility. Clients were seen by appointment only, and rarely they were involved in group counseling. The medical doctor was the primary caregiver, as opposed to the alcoholism counselor or social worker. This created limited socializing, since clients were expected to come to the clinic approximately four times a year for their medication (Antabuse).

Antabuse, the major treatment approach from 1971 to 1989, is prescribed to the alcoholic by the doctor to prevent relapsing by blocking the craving for alcohol. However, if given without supportive counseling, it was usually ineffective. Since Antabuse is deadly to some people when mixed with alcohol, the chances of abusing are great in the absence of counseling. Even though a counselor or social worker evaluated the client before entering the

program, the core of treatment was the visit to the physician; therapy was not involved.

When the clinic adopted the psychiatric model, many things had to change: a new medical director and a new social work director were hired, social workers and addiction counselors became more involved in treatment planning, the program demanded of the clients more time and involvement in their treatment, and the clinic adopted a developmental model of recovery (DMR) (Brown, 1985; Gorski, 1989).

In the developmental model of recovery, each phase must be completed before going on to the next phase. This model is congenial with AA 12-step programs. In the 12-step program, each step must be achieved before going to the next step. The term “developmental” means to grow in stages or in steps; to learn through a gradual effort, new and progressively more complex skills. A developmental model of recovery assumes that a person can grow from simple abstinence to a meaningful and comfortable sobriety. People confront and attempt to solve new problems while abstinent; sometimes they fail, and sometimes they succeed. Whatever the outcome, they are expected to learn from the experience and try again (Gorski, 1989).

Under the developmental model of recovery, the client is expected to invest more time in treatment. The client attends the clinic at least three times per week, and group and individual counseling takes center stage. Antabuse therapy is relegated to extreme relapse cases, and it is sometimes used for intervention purposes. For most clients, it is no longer considered a lifelong treatment.

Historically, the clinic had adhered to a precept that alcoholism was a lifelong disease that needed lifelong treatment. Prior to 1990, no one graduated from the program. One of the reasons that the clinic did not graduate anyone was directly linked to financial matters. It was financially dependent on the income provided by Medicaid, since most clients were welfare recipients, if a client were to graduate, the clinic would lose his income, and the client, himself, would lose his welfare benefits. Many clients “messed up” simply to remain patients of the clinic and, at the same time, assure themselves of an income. The system was self-perpetuating, with disastrous consequences. Recidivism was high and clients did not improve. Recidivism was high because the treatment offered did not involve the client. The client was not held responsible for his

treatment. There was no investment of himself and of his time in treatment. The conditions surrounding the treatment offered to clients made it easy for the client to continue drinking and not feel responsible since they were required to come to the clinic a few times a year.

However, with the arrival of the new developmental model of recovery, the clinic could begin to play a pivotal role in socializing the client, and at the same time, assures itself of an income from Medicaid, since clients are mandated by the new treatment model to spend a great deal of time in the clinic. In addition, the impending threat of losing welfare benefits was eliminated since clients are required to continue in a vocational program after alcohol treatment to prepare for employment.<sup>11</sup> As a result, the potential to develop relationships is present. Clients are able to socialize in an informal environment, in contrast to the individualistic approach of the past. A social cocoon begins to develop as clients step into the world of alcohol therapy. Life—from admission to graduation—is structured for the client.

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<sup>11</sup> However, there is a problem where to send clients who are not ready for employment, but are in the process of recovery.

## A BRIEF HISTORY OF ALCOHOLICS ANONYMOUS (AA)

A history of Alcoholics Anonymous is a history of “Bill W.,” on whose life AA is based. William Griffith Wilson (referred to as “Bill” in the literature of AA), was born in East Dorset, Vermont, on November 26, 1895, the only son of Emily and Gilman Wilson. His elementary education began in a two-room schoolhouse in East Dorset, and continued in Rutland, where his father took over the operation of a marble quarry. He then attended Burr and Burton Seminary in Manchester and completed his secondary education at the Arlington (Massachusetts) High School (The Co-founders of AA, n.d).

In 1914, during World War I, Bill joined the army. He became a Second Lieutenant and was sent to France with the 66<sup>th</sup> Artillery Corps. It was during this period of military service that he started to drink. Bill was invited to a high society party and felt inferior and out of place. He had a couple of drinks to loosen up, and suddenly he became self-confident; the evening was an unexpected success.

Returning home after the end of the war, he worked for the insurance department of the New York Central railroad. Finally, in 1925, he finished a night law course at the Brooklyn Law School and became a field investigator for various groups (Kessel, 1962).

By 1931, however, Bill's drinking had become a serious problem. He continuously promised his wife, Lois, whom he had married in 1918, that he was going to stop drinking. He also made promises to his business associates, but nothing came out of them. His career, a promising one, deteriorated as he drank, and with time, his drinking got worse. Dr. Silkworth, the family doctor, stated, "In late 1934 I attended a patient who, though he had been a competent businessman of good earning capacity, was an alcoholic of a type I had come to regard as hopeless"(Alcoholics Anonymous, 1955:xxiii).

In November 1934, a long-time friend and drinking companion ("Ebby") told Bill about the Oxford Group,<sup>12</sup> and how it was sometimes able to help alcoholics. At first Bill thought that what Ebby had told him was nonsense. He not only continued drinking, but (due to Prohibition) made his own whiskey. Then, a month after Ebby's

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<sup>12</sup> The Oxford Group was started by Frank Buchman as a nondenominational, evangelical religious group. Its meetings attracted many alcoholics in the late 1920s and early 1930s (White, 1996).

visit, Bill got sick and was taken to a hospital, where he reflected upon Ebby's message. "Bill has described what then occurred as an overwhelming and awesome spiritual experience, carrying the conviction of a release from drinking and an insight that in helping other alcoholics he could maintain his own sobriety" (The Co-founders of AA).

Ebby's message to Bill has been incorporated into the philosophy of AA: To admit utter defeat. To be entirely honest with yourself. To confess your weaknesses to someone else. To make amends for harm you may have done. To try and give of your best without hope of reward. To pray to God, however, you may conceive of Him, if necessary simply as an experiment (Kessel, 1962:102).

This message is incorporated in the 12 steps developed by AA.

Bill joined the Oxford Group's mission in the Calvary Church, and its impact shaped the religious connotations of AA. While attending the Oxford Group meetings over the next six months, he tried, unsuccessfully, to sober up many alcoholics. In May, 1935, a business trip to Akron, Ohio, led to his meeting with Dr. Bob, who became the second successful recovery—and Alcoholics Anonymous was born (Kessel, 1962:106-116).

The inception of AA can be characterized as two alcoholics coming together for the purpose of helping one another. Nevertheless,

as Sagarin (1969:34) states, AA would have remained a small and unknown fellowship, had it not been for a man named Jack Alexander. In March 1941, Alexander wrote an article in the Saturday Evening Post, describing the organization in “glowing terms.” Since then, membership in AA has grown enormously.

Bill devoted his life to making AA a workable organization. He formulated AA’s recovery program (The 12 Steps), codified into a set of traditions the first ten years of its group experience (The 12 Traditions), wrote four books for the movement, published many articles about AA to educate the public, and made speeches to medical, psychiatric, and religious organizations. In 1951 he introduced the idea of “world services” for AA (The Co-founders of AA).

The AA program breaks down the alcoholic’s social isolation, which has resulted from the stigma of his excessive drinking. It draws him into an intimate, primary group in which he is accepted as a past drunkard. An alcoholic feels at home with other alcoholics in the group who, like himself, have known degradation and the stigma of being an alcoholic (Lofland & Lejeune, 1970:102-111). The life stories “qualifications” told at meetings are helpful to the members, as

is the reading of the “big book,” Alcoholics Anonymous, which is the basic text containing many stories of recovering alcoholics.

In addition, the conceptualization of alcoholism as a disease is one of the most significant ideas in the AA literature. This is one of the ways in which the stigma of alcoholism is removed. AA is probably the most widely known and successful of all informal group approaches to the social reintegration of the alcoholic. Its program is based on the principle that the alcoholic must be “delabeled” and accepted back into normal society.

The “allergy concept” is a term used by AA to refer to what is otherwise known as the “disease concept.” This concept, which is very important to AA, creates a common base for all alcoholics. Alcoholics come from every socio-economic status, but the idea that bonds them together in AA is that they have an illness called alcoholism. Bill’s life has meaning to the alcoholic because he can learn to create a better life for himself, using Bill as an example. Bill used his life experience and his perception of the world to develop AA.

The story of Bill’s life is thoroughly discussed in the Hispanic AA meetings. Aspects of his life are selected to give

examples of how a life can be turned around. It inspires old members to continue their sobriety, and newcomers to achieve sobriety, and at the same time it gives substance and a historical perspective to the AA group.

#### FORMAL ASPECTS OF TREATMENT IN THE CLINIC AND FORMAL ASPECTS IN THE SOCIAL WORLD OF ALCOHOLICS ANONYMOUS (AA)

##### THE FORMAL WORLD OF THE CLINIC

Goffman (1961) describes the world of the inmates and the world of the staff as separate entities in the same institution. “It is characteristic of inmates that they come to the institution with a ‘presenting culture’...derived from a ‘home world’ –a way of life and round of activities taken for granted until the point of admission to the institution (Goffman, 1961:12). On the other hand, “the first thing to say about the staff is that their work, and hence their world, have uniquely to do with people. This people-work is not quite like personnel work or the work of those involved in service relationships; the staff, after all, have objects and products to work upon, not services, but these objects and products are people” (Goffman, 1961:74).

In the clinic, the world of the counselors and the world of the clients are distinct and separate. Boundaries are clearly defined for both worlds. The counselor is not allowed to be emotional in dealings with the client. Objectivity is sought in all endeavors; sets of rules define the demeanor of the counselor and client, whether in group session or individual counseling.

Therefore, one essential rule is that all interactions with the client must be recorded. There is a saying in the clinic ( which is usually repeated in the staff meetings), “If it is not on the chart, it does not exist.” Hence, the paper trail is considerable. “And just as an article being processed through an industrial plant must be followed by a paper shadow showing what has been done by whom, what is to be done, and who last had responsibility for it, so a human object, moving, say through a mental—hospital system (or treatment center), must be followed by a chain of informative receipts detailing what has been done to and by the patient and who had most recent responsibility for him” (Goffman, 1961: 75).

This paper trail starts from the initial intake interview. Many times, the client is requested to bring “references” from the agency which is referring him to treatment. Thus, referrals for the day

program usually bring a letter of referral from the Department of Social Welfare (public assistance). The evening clients bring referral letters from court or Probation Department. The client has a ‘vested interest’ in being accepted, because acceptance means that he will receive a monthly check and Medicaid card from public assistance. Occasionally a referral does not want to be in treatment, but he soon realizes that it is more advantageous than the alternative, i. e., prison.

After the intake is completed, the prospective client is requested to call within a week, in order to find out whether he has been accepted. The call is important not only as a matter of procedure, but also as a measure of motivation on the part of the client. If the prospective client does not call within a reasonable time, he is not accepted for treatment; if he returns after the deadline, he must go through the intake protocol once again.

The criterion for acceptance to the clinic is a primary diagnosis of alcohol dependence based on the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition). It describes nine symptoms of dependence. Briefly, these symptoms are (1) the person drinks more than intended, (2) the person tries to control or reduce the drinking, (3) the person spends a great deal of time around

the activities of drinking, (4) the person becomes intoxicated when expected to fulfill role obligations (work, school), (5) the person withdraws from family and social activities, because of the drinking, (6) the person continues to drink despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by drinking, (7) the person's tolerance increases, (8) the person experiences characteristic withdrawal symptoms (e.g., shaking, trembling, nausea, etc.), (9) the person drinks to relieve or avoid withdrawal symptoms. At least three of these symptoms must be present for a person to receive a diagnosis of alcohol dependence. In addition, a diagnosis of alcohol dependence is based on at least one maladaptive pattern of alcohol use (for example, recurrent use of alcohol in situations in which use is physically hazardous, such as driving while intoxicated).

The definition of alcoholism that is most prominent in the treatment program is from NCADD (National Council on Alcoholism and Drug Dependence, Inc.). They define alcoholism as a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized as continuous (daily drinking)

or periodic (binge drinking), and it involves impaired control over drinking, preoccupation with the drug (alcohol), use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

When the client comes to his initial appointment to see his assigned counselor, a battery of forms is completed: psychosocial, AA attendance sheet, medical appointment, and mental health status form. During the initial visit, the client is informed of the treatment program's expectations regarding his time in the clinic. In addition, he is made aware of the importance of AA, by reviewing the AA attendance sheet; he is also given a "Directorio de Grupos Hispanos" (A Directory of Spanish- Speaking Groups). The client is reminded that there is an AA meeting on Friday afternoon, which he is expected to attend as a requirement towards his graduation, but that also just as important is his attendance at AA in the community. The assumption is that if the client connects with AA, he will have support during the times when the clinic is closed. The client is reminded that the clinic closes its doors, but that AA does not. The clinic, as an agency makes a statement that AA is important; the willingness to attend is regarded as equivalent to wanting to stay sober.

#### **THE FOUR PHASES OF TREATMENT**

Once the client is accepted into the treatment program, he is given a schedule to follow, including all the group he is required to attend. The program unfolds in phases and lasts between 18 months and 2 years. The first phase deals with orientation.

The orientation phase introduces the client to the institution as a whole, including the workings of the bureaucracy. It also helps the client become acquainted with other institutions, such as public assistance, Medicaid, food stamps, family agencies, etc. In addition, it focuses on alcohol education; the client is reminded to read the literature of AA. The client is expected to attend the treatment program four or five times per week, and also to attend AA meetings outside the clinic. The orientation phase lasts 8 weeks, unless the client relapses. If he relapses, he must repeat the phase once again. This is true for all the phases.

On a typical day in the treatment program, the client comes between 9:15 to 10 a.m. for his morning group. He has a cup of coffee in the day room, then goes to his assigned room for his group session.

He might be asked to show his attendance sheet and to discuss briefly the AA meeting he attended the night before.

Participation is encouraged at all times, since participation is a measurable objective to assess the client's behavior. The information the client chooses to share in group gives the counselor a sense of whether the client is improving. Equally important, clients who participate in group sessions tend to socialize more outside of group. Discussions which commence in group sessions usually continue in the day room. This gives the clients the opportunity to get to know each other and to create a cohesive group as a cohort of clients.

After the morning session is over, the clients eat lunch. The clinic provides lunch in the day room. There are usually five to ten clients, not all Hispanics, present in the day room at this time. Not too many clients stay for lunch because, according to some of them, the lunch is not appetizing, and they prefer to eat outside or at home.

In the afternoon, clients attend recreational activities: arts and crafts, drama, games, and movies. Individual counseling sessions are also scheduled during this time. On Friday afternoon, from 2-3:30 p.m., all of the Hispanic clients are required to attend the AA meeting sponsored by Alfa y Omega held at the clinic.

Of all the clients questioned, 68% attended outside AA meetings, as well as the AA meeting provided at the clinic. Of all the clients in the orientation phase, 50% attended AA. Each time the client attends AA, he must ask the AA leader to sign the attendance sheet as proof that he has indeed attended the meeting. This provides an objective measure for the treatment program of at least some sign of motivation to become sober. Even though AA attendance is a requirement, some of the clients do not abide by it.

The second phase ( known as phase I) is focused on relapse prevention and alcohol education. Before a client is promoted to this phase, the assigned worker must present his case at a case conference. This is true for all promotions to a new phase. To promote a client to another phase, the input of other workers is essential. The staff sees itself as a team, working together to bring about the best outcome for each client in the clinic. This image of team work is important and effective for the staff as a whole. It makes them feel empowered in regard to the going-on of the clinic. The time the client spends in phase I is between 3 and 5 months.

In the third phase (phase II), the client begins to deal with personal and vocational issues. Individual counseling sessions might

increase to two or three per month to accommodate the need of this period. The client is also assigned a vocational rehabilitation counselor who begins to prepare the client to apply to school, if the client wishes, or obtaining instructions in job training or English. The client begins to evaluate his work history and learns how to work a resume and conduct a job interview.

The fourth and last phase (phase III) deals with stress management and developing a support system. The client is focused on the outside world and learns how to cope with it, understanding that he will soon be on his own. Ideally, by now, the client should be involved in outside AA meetings and attending school or ready to start a job training program. Clients who are physically disabled due to chronic illness, and who are not able to attend school or work, are referred to an appropriate agency for aftercare. Hence, after the completion of this phase, which can last from three to six months, the client graduates. (See Table 5.1, below, for the distributions of clients in phases, and Table 5.2 for AA attendance.)

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TABLE 5.1  
DISTRIBUTION OF CLIENTS IN PHASES (N=37)

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Orientation	32%	(12)
Phase I	8%	(3)
Phase II	11%	(4)
Phase III	22%	(8)
DWI	27%	(10)
	100%	

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TABLE 5.2

## AA ATTENDANCE (N=37)

	Yes	No
Day Program	49% (18)	24%(9)
Evening Program	19% (7)	8%(3)
	68%	32%
		100%

## THE EVENING PROGRAM

The Hispanic evening program consists of referrals from the criminal court, Department of Probation, Department of Motor Vehicles ( DMV), and attorneys. The program is only for DWI (Driving While Intoxicated) clients, and it lasts eight months to a year. DWI clients are alcoholics who have found themselves in trouble with the law; as mentioned, they tend to reject the label of “alcoholic.”

Evening clients are required to attend two groups per week, Monday and Wednesday evenings between 5 and 8 p.m. Like the day client, the evening client is assigned to a counselor, sees the medical doctor at least twice during his time in the program, sees the counselor once per month for individual counseling, and must attend

AA. He is also breathalized by the nurse or counselor and must give urine and blood samples every so often. The admission procedure is the same as for the day program.

After the completion of the program, a long form is completed for the Department of Motor Vehicles (DMV) and a letter is sent to the Department of Probation and the court. DWI clients are mostly employed in service positions and usually work outside the City of New York, so they need their driver's license, which has either been suspended or revoked. As a result, they tend to be highly motivated, and they usually graduate after the completion of the program.

During the admission process, most clients try to save face by attempting to convince the intake worker that they do not have a problem with alcohol. Others try to appear highly motivated. Either way, the client tries to control the situation, and this is especially true of the DWI client. At this point, the alcoholic is engaged in "impression management," He wants to convey an image of who he thinks he is so that he can influence the "definition of the situation" (Goffman, 1959: 3-4). For instance, a DWI client, referred by his attorney to complete one year in the evening program as a way of demonstrating to the court his remorse over the death of an elderly

woman as a consequence of his drunken driving, stated the following in the Wednesday group session, a week after he had been admitted to the program:

It wasn't my fault. She should have watched where she was going. The light turned and I was simply concentrating on the light. When it turned, I moved. I wasn't going very fast. She was too old, that's the real reason she died.

After making the statement, the client smiled to the group. At the same time, he was highly motivated during intake and later complied with all requirements during his stay in the evening program. Intuitively, his counselor commented that he would probably return to drinking since he exhibited no insight into his illness of alcoholism. But since he had complied, he received his letter of completion, and forms were sent to the Department of Motor Vehicles at Albany.

#### ADMISSION AND THE STRATEGY OF SECOND CHANCES

After the intake interview is concluded, the counselors meet to discuss whether or not the referrals are suitable for admission to the clinic. How the staff perceives a referral will determine whether he is accepted. Goffman's discussion, in Asylum (1961) of the tension between staff and inmates in a mental institution can be applied to the

relationship between counselor and client at the clinic. There are rules and regulations set by the institution to keep the client in his place. These rules and regulations do not appear intrusive unless a client decides to test the limits.

The testing of limits is demonstrated in the case of a particular client who was not initially accepted to the treatment program because the team of counselors felt that he was a heroin addict, not an alcoholic. He had a secondary diagnosis of alcoholism, but the counselor who had interviewed him felt that he was not appropriate for the treatment program. On the other hand, the agency making the referral insisted that the clinic act responsibly and give the client a chance to be treated for alcoholism. They argued that the client needed a structured environment where his drinking problem could be addressed, so as not to jeopardize his heroin abstinence. The referral agency was the Methadone Program, located in the same hospital as the clinic, where the client was receiving methadone three times a week.

Due to the tenacity of the Methadone Program, the client was eventually accepted. Nevertheless, the staff in the clinic, as a whole, had low expectations of the client; most believed that he would

relapse and drift away from the clinic. To test the client's motivation, he was immediately admitted to detoxification. The justification on the chart was that he had admitted to drinking one beer at the time of his initial interview. Later it became known that the client was in reality in a relapse mode. There were many warning signs, such as minor depression, daydreaming and wishful thinking, irregular sleeping habits, development of an "I don't care attitude," self-pity, and loneliness, but the intake worker had not been aware of them.

The Methadone Program had previously suggested that the client attend Narcotics Anonymous (NA), but he had refused to go, stating, "I don't identify with those addicts." He later reported that he could not admit to himself that he was an addict, because an addict is a horrible, dirty person. But he was able to identify with AA, and he became involved in all its aspects and also developed an attachment to the clinic and to his counselor. He never relapsed while he was in the treatment program, and he graduated, returning to work and school. This was a truly successful conclusion to a case that had all the earmarks of potential failure. The client not only chose to "work the system" and AA, but in the end, he even attended Narcotics Anonymous (NA).

This story reveals the significance of second chances for alcoholics and addicts. Without second chances, few alcoholics or addicts would be recovering. In Passage Through Recovery, Gorski (1989:3) explains that

chemical dependency is a disease that causes a person to lose control over use of alcohol or other drugs. It is an addiction. This loss of control causes physical, psychological, social, and spiritual problems. The total person is affected.

Thus, it is not an easy matter for a person to decide that he needs help.

#### GROUP AND INDIVIDUAL COUNSELING

In the formalization of alcoholism treatment, the client is expected to attend group sessions. He is given a schedule of groups to attend from the orientation phase to the last phase in treatment. The orientation phase is the most intensive, and during this period, clients are expected to attend group five times per week. It is believed that the group process initiates, develops, and forms a particular bond among members. The group is an essential part of recovery.

First, alcoholism is a lonely dis-ease of self. The alcoholic feels alone even when with others. In order to recover the alcoholic must learn how to get outside himself or herself. This occurs best in groups of fellow alcoholics. In groups the alcoholic is in a sense forced to interact with others. In so doing he or she learns how other alcoholics are learning how to recover from alcoholism" (Denzin, 1987a:73).

Second, groups provide contexts for many different kinds of interaction. Friendships are formed, and the stigma is overcome together (Denzin, 1987a:73-74). In the group there is instillation of hope, imparting of information on alcohol and alcoholism, corrective recapitulation of the primary family group, development of socialization techniques, imitation of behavior, interpersonal learning, group cohesiveness, personal catharsis, and existential factors include such issues as, the here and now and dealing with the present time.

In a group setting, there is constant evaluation and assessment by the therapist of the members of the group. With the help of the facilitator, members plan the purpose of the group and the goals and objectives they hope to accomplish. The focus is on treatment and counseling, which is geared to the type of group it is. For example, there are relapse prevention groups, alcohol education groups, and therapy groups. Confidentiality is an issue which is frequently discussed, in order to create an atmosphere of trust. Respect for the counselor-client relationship is paramount. Furthermore, rapport is essential if the group is to succeed; the clients must feel comfortable in order to open up. This takes time to develop, and communication skills are usually a focus of the group.

Another expectation of the formal aspects of treatment is individual counseling. The client meets with his assigned counselor at least once a month, and the session lasts from 30 minutes to an hour. These sessions are scheduled in advance, and the client must be on time. Constant lateness for appointments might cause a client not to be promoted to the next phase. Punctuality is considered a life skill that clients should learn.

#### THE FORMAL WORLD OF ALCOHOLICS ANONYMOUS (AA)

The criterion for acceptance in AA is the alcoholic's desire to stop drinking. AA is a voluntary association, and no one is forced or mandated to join it. In fact, AA insists that it be the individual's own decision to join.

Clinard (1974: 172-173), quoting Gellman, gives a number of characteristics which distinguish AA from many other voluntary associations:

- (1) Membership is comprised exclusively of social deviants.
- (2) Despite the deviant nature of its membership, the organization has achieved the recognition and approval of the general society.

**(3) Membership is anonymous.**

**(4) Membership is self-determined (by an expressed desire to stop drinking).**

**(5) The deviant within the group, as defined by AA norms and values, is often supported, not rejected.**

**(6) No authority exists to expel members.**

**(7) Identification with the fellowship is neither secondary nor segmental. AA is a “way of life,” implying primary involvement.**

**(8) The total organization, nationally and locally, is financially self-supporting. There are no fund-raising campaigns or solicitations from outside sources. In fact, such contributions are firmly and politely rejected when offered.**

**(9) There are no dues or fees. All contributions from the members are made on a voluntary basis. No single donation may exceed \$100.**

**(10) There is no terminal point in view for the association. The goal of the program is to help alcoholics achieve and maintain sobriety, “not to cure alcoholism.” The AA member is a sober alcoholic, but he must never think he is cured.**

These characteristics of AA represent the heart of the AA approach, which eventually empowers the alcoholic by engaging him in his recovery. Each of the 12 steps is taken up separately in the meetings and interpreted. The 12 steps (See Appendix B for a list of the steps and Appendix C for a list of the traditions) are guideposts for the individual alcoholic, while the 12 traditions are a “series of rules governing the behavior of AA groups and individuals as AA members in relation to outsiders” (Ripley and Jackson, 1959:44).

The 12 steps can be summarized in four principles: (1) relying on a power greater than oneself and recognizing that one is powerless to deal with alcoholism ( the “greater power” is given a personal interpretation), (2) making an inventory of one’s problems to get in touch with oneself, (3) making amends to those one has harmed, and (4) carrying the message to others (and, in this way, being reminded of who one was) (This is AA, 1984).

Slogans have also played an important role in AA. For instance, “First Things First” reminds the alcoholic of the priority of sobriety in any attempt to rebuild his life. “Easy Does It” reminds the alcoholic to pace himself. And “Live and Let Live” reminds the

alcoholic that no matter how many years of sobriety he has, he cannot afford to let himself become intolerant of others (This is AA, 1984).

In principle, an AA meeting is possible anywhere because an AA group has no actual walls, and hence no physical restrictions. A historical tradition is that when two alcoholics meet, you have an AA meeting. In a sense, this is a reaffirmation of the 1935 meeting between Bill W. and Dr. Bob. Furthermore, the AA group is larger than its individual components. The coming together of members is what AA is about, as well as creating a safe environment from recriminations. AA members are allowed to express themselves as they feel appropriate, within their own frame of reference—the life story.

At an observed AA meeting, the member telling his story was permitted to use profanity. Some people in the audience appeared uncomfortable, especially some of the women, but that was not a deterrent. Later, it was explained to the researcher that the person “qualifying” (telling the story) expressed himself in that way because for him it was a cultural norm, and if he were not allowed to use profanity, he would not be able to tell his story.

**MANAGING EMOTIONS IN THE CLINIC AND ALCOHOLICS ANONYMOUS**

Emotions are not necessarily kept within the boundaries of the AA meeting. Since everyone is on an equal footing, discussion of the qualifications (stories) continues after the meeting is over, and it is time for coffee and cigarettes. On the other hand, the containment of emotions within a proper setting is a constant concern of the clinic. It gives the client a schedule, with objectives and goals to attain, and it expects the client to achieve these objectives and goals within a time frame. The client is expected to work within the structure of the phase system, and to accomplish the day-to-day task of making his group session on time, and keeping all his appointments with staff.

As the client makes progress through the phases, he learns the system of statuses and roles in the clinic and learns to behave accordingly. He learns to manage his impressions as he becomes a recovering alcoholic. In group, for example, the client is permitted to vent his feelings of anger, resentment, guilt, etc., but he must do it in a way that does not offend anyone in the group. He is reminded, that group sessions must be constructive at all times, never destructive. If a client becomes offensive, he is asked to leave the session and wait in the day room. When the group session is over, the counselor speaks

with the client in her office and asks him to explain his behavior. If the counselor is satisfied with his explanation the client is allowed to return to the next group session, but he must apologize to its members.

By contrast, in AA, if a member gets out of hand, the group as a whole is involved in controlling the situation. However, AA is tolerant of difficult situations and allows the members space to move (the use of obscenities during qualification, as described above, is a good example).

#### THE COUNSELOR-CLIENT RELATIONSHIP AND SPONSORSHIP IN ALCOHOLICS ANONYMOUS

The individual counseling session, like the group session, follows a set of rules, of which both counselor and client are aware. The purpose of the session is for the client to tell his story and for the counselor to listen, and the rules of the clinic constrain how they behave and act with each other in this interaction. Usually the counselor sits behind a desk, and the client faces the counselor. This is a private and confidential meeting; however, the counselor interprets the session as she writes on the chart, and the client has no control over what is written. In this face-to-face interaction, the client shows,

through his revelations to the counselor, that he is improving. In one meeting between counselor and client, the client becomes “real in the fullest sense of the word” (Berger and Luckmann, 1967:29).

On the other hand, the relationship between the sponsor and the recovering alcoholic is expected to develop into a lifelong friendship. This is in sharp contrast to the counselor-client relationship, which is expected to remain distant and professional. In AA, informal aspects are obvious, while in the clinic they are more subtle.

The ethical principles of counseling prohibit the counselor from divulging her personal experiences to the client. In a way, the counselor must maintain a sort of aloofness in order to be able to do her job objectively. The sponsor, on the other hand, is expected to share his life experience with his new charge.

The counselor’s aloofness is important but also maintaining her authority because the moment the counselor loses her authority, she loses her ability to work with the client. For instance, a client who had a master’s degree in philosophy felt that his counselor was not knowledgeable enough to be his counselor because she was only a high school graduate and a Certified Alcoholism Counselor. This created a tense situation, but the clinic supported the counselor and

did not act on the client's request for a transfer. Unable to accept the circumstances of having to work with this counselor, the client eventually left the clinic.

#### THE FORMAL CONNECTION BETWEEN THE TREATMENT PROGRAM AND ALCOHOLICS ANONYMOUS

The Hispanic Outreach Program does a good job in preparing the client to accept and enjoy AA. For instance, a client reports that it took him approximately six months before attending AA by listening to the staff describe AA meetings as resembling the group sessions at the treatment program. (The counselors wanted to lessen his fear about attending AA, thus, they used the comparison, but in reality AA meetings are more informal than group counseling.) The client said, "If they are the same, I have nothing to lose." He later decided to "check out" a meeting and see how he felt. At that first meeting, he had a revelation: "This is the place I have been searching for all my life." He said that he felt as though he had come home to people who cared for him and who sincerely wanted him to get better, though they asked for nothing in return. This client has been sober for

approximately five years, and he carries the message of AA by organizing meetings at the detoxification unit of the main hospital.

The purpose of all the activities performed in HOP and AA is the development of social and communication skills. The client is expected to participate in group sessions, to be punctual, to dress appropriately, and to volunteer for simple tasks, such as helping to set up lunch in the day room. The improvement of social and communication skills holds the key to recovery. The clinic's goal is personal growth of the client – to help him feel comfortable with himself and able to cope with life without alcohol or drugs. AA speaks of this process as “surrendering”—giving up the old self and becoming a new self. Ultimately, the client must internalize the teachings of the clinic and AA if he is to continue on the road to recovery. He must feel connected and supported by these organizations in order to make the shift from mere compliance to true recovery.

Consequently, the treatment program is a temporary condition in the life of the client. The significant ties which the client develops with the treatment program through the process of treatment,

must be eventually severed. At the same time, AA, which is a lifelong involvement, must flourish in the individual's life.

Thus, AA requires the member to give attention, energy, and interest to its affairs; it affects a member's whole lifestyle, not just a segment, or portion of his life. It is stated in the 12 steps and 12 traditions that a member, for his own sake, should participate fully in attending the meetings. The first tradition talks about unity, without which AA would fall, taking with it all the alcoholics it has saved from the bottle. So, for everyone's sake, as well as for the sake of the individual, members are expected to participate.

Participation cannot be gauged by time, as in the treatment program. The client must, for the rest of his life, maintain his membership within AA if he is to maintain his sobriety. As a member of AA said during a meeting, "I need to be with other alcoholics to maintain sobriety."

As the client participates in the treatment program and AA, he is made aware, on a daily basis, that his goal is to change. As Denzin describes this experience:

AA offers the alcoholic an interpretive theory of alcoholism. That theory, which he will have confronted in treatment, must now be mastered, if only partially, if he is to remain sober and recover. Now that he is out of

treatment the place he will go to learn about AA is AA meetings. It is there that he will find the answers to directives he has received when he left treatment. That is, only in AA will he find a "home group," a sponsor, and five or more meetings a week to go to (Denzin, 1987b:91).

#### SPANISH-SPEAKING ALCOHOLICS ANONYMOUS

Lofland and LeJune (1970:104) were not able to support their hypothesis that "if the newcomer and the AA group display similar social class presentations, then the initial socialization will be higher, and conversely, if the newcomer and the AA group display different social class presentations, then the initial socialization will be lower." In this study, however, this hypothesis proved to be helpful as observations were made in the three AA groups: Alpha y Omega, Honestidad, and 24 Horas. Hispanic AA groups, like their English counterparts, are generally given names. The names are usually taken from AA literature or the name of the church where the group has its meetings, or a significant historical date or event is selected from the members' native country. For example, Honestidad (Honesty), established in 1970, is composed of Dominican members. It is located in Corona, Queens, where there are many Dominican immigrants. This group has the flavor and accent of this ethnic group. Alpha y Omega, established in 1982, has a mostly Colombian

membership, but includes members from other Central American countries.

On the other hand, 24 Horas (Hours), established in 1969, has a large membership of Guatemalan immigrants. This group is known for its commitment and seriousness in bringing the message of AA to all Hispanics suffering from alcoholism. Gordon (1985:230-232) explains that Guatemalans generally use AA rather than professional treatment, and they have a large AA membership. He notes that, several years ago, AA was also successfully established in Guatemala, so the immigrants are often familiar with its principles even before their arrival in the United States. There are 112 Hispanic AA groups located in New York City, Long Island, Westchester county, and New Jersey; of the 112, 54 are located in New York City.

#### INFORMAL ASPECTS OF TREATMENT IN THE CLINIC AND INFORMAL ASPECTS IN THE SOCIAL WORLD OF ALCOHOLICS ANONYMOUS ( AA)

##### THE INFORMAL WORLD OF THE CLINIC

Informal aspects of treatment are an ongoing process that occurs daily in the clinic, and they create integration and cohesiveness among clients. While the process of recovery is taking effect, many

things happen to the client that he might be unaware of and might even think unimportant as he follows his assigned schedule. For example, after the completion of each group session, clients usually congregate in the day room. Of all clients questioned, 78% had used the day room at least once. Clients gather around the coffee pot in the day room and usually have a cup of coffee before and after group sessions. The pool table is another focus of socializing. Clients negotiate who is going to play, and in what order. The pool table transcends the language barrier, and usually whoever is present in the day room will play if someone else wants to play. Overall, clients who are consistently involved in social activities such as these tend to improve more than the clients who are not.

The focus of informal socializing happens in the day room. The day room is the location where the clients have the freedom to talk and do what they want, such as jokes, stories, discussion of problems, read a book, or just spend time with other clients. The pool table is in the center of the day room and is a source of conversation that helps clients to break the ice by using the pool table. Clients invite each other to play. This is the most popular activity in the day room. Some clients reported that they would make time to meet in the day room for

the purpose of playing pool. Although clients might be unaware, this is the development of friendship.

Clients are encouraged to spend time in the clinic by the staff. The clinic as an agent of change realizes that the more the clients spend time together in a safe environment, the more likely are they to improve, started offering lunch to clients. One of the recreational counselor was in charge of supervising the lunch; however, it was the clients who did all the planning and arrangements on a daily basis to have the lunch ready in the day room for whomever wanted to eat. Not too many people stayed for lunch, but for the clients who did stay, they enjoyed this time of day by eating and talking in a relaxing manner. The same clients that stayed to eat lunch together, appeared to have developed a friendship. They tended to go together to get carfare, stayed together around the clinic, and sat near each other in group counseling sessions.

Further, clients who are socially involved in the clinic are also involved in other areas of clinic life, such as the training programs. These clients are more confident in asking for help, and their self-esteem appear to be intact. They also tend to be less shy with other staff. Many of the staff, therapists and clerical, would also visit

with clients in the day room. These clients were the ones that spend a highly amount of time in the clinic, whether helping around the clinic or as an official volunteer to help around the clinic.

In order to know whether the alcoholic is improving, the treatment program must become aware of how the client perceives his world within the program. Indications of this are found in the way the client expresses himself and the way he acts with other clients and staff. Informal situations in the treatment and AA settings, such as making friends, using the day room, having lunch with someone from the clinic and AA, and accompanying someone to an AA meeting, are measurable indicators of improvement. When a client enters this social environment that understands his predicament, he is more apt to become a part of the environment. He no longer has to play a role to hide himself from others, and he finds himself enjoying his participation. When the client remains longer in the clinic than is required, and attends AA meetings without being forced, he is on his road to recovery.

As indicated below, in Tables 5.3 and 5.4, 67.6% of clients made more than six friends in the clinic, and 32.4% made more than six in AA. In addition, 21.6% of friends made in the clinic also

socialized outside the clinic, while 29.7% of AA friends socialized outside of AA. There is a higher percentage of friends made in the clinic (89.2%) than in AA (56.7%); however, there is a larger percentage of clients socializing outside of AA with friends made in AA. At the same time, 32.4% of clients in AA have sponsors (see Table 5.5). Although clients who are friends do not usually socialize outside of the clinic, they reported that they sometimes walked together to the hospital to pick up their carfare. The main hospital, where the transportation department is located, is five blocks away from the clinic. Clients reported that they stopped to window shop and buy coffee, and they sometimes wound up taking the same train or bus together.

The friendships that developed during the course of socializing in the day room and going to the main hospital to pick up carfare (and often deciding to take the same transportation), frequently extended to other areas in the clients' lives, such as exchanging telephone numbers and attending the same AA meetings. By spending more time together, the clients became more sympathetic towards their shared plight, often this was the beginning of a support network to help maintain their sobriety.

#### THE INFORMAL WORLD OF ALCOHOLICS ANONYMOUS (AA)

During participant observations in Honestidad, Alpha y Omega, and 24 Horas, only open as opposed to closed meetings were observed. Since these AA groups are frequently visited by the clients of the Hispanic Outreach Program, the researcher was not a stranger at their meetings. As soon as the researcher arrived, the treatment program clients in attendance introduced her to other members; generally everyone was friendly, and the researcher was shown around the facility. A basic observation was the ease of interaction among the members (from old and new). They were like old friends meeting in someone's house. The social atmosphere was very warm and inviting.

Though it is easy to understand how isolation can be chipped away, and how the desire to stay sober can become a commitment, the AA groups also work against themselves by insisting that the alcoholic accept the very social activities he has been running away from all his life. Shyness is a difficult learned behavior, which the alcoholic has had to live with all his life. In a way, it is "bad luck" in learning. Many clients have reported to say in the past, "I don't like AA." But this is not what they meant. It appears that the very essence of AA

frightens the “pigeon,” the newcomer, because AA signifies sociability. This keeps the client away, since he does not understand that he is not expected to be outgoing at first; only his presence and attention is required. Only when the client comprehends this, is he ready for AA.

As previously discussed, the clinic helps in preparing the client to understand AA. When attending AA is no longer a burden, the client begins to see the potential that AA holds for his recovery. AA becomes fun and enjoyable to attend. For example, clients who attended the marathon meetings on Fridays reported that they looked forward to these meetings because they felt comfortable in this friendly environment. They had made a few good friends and would relax together.

AA members are also ready to help one another. When a client needed to move to another location, he did not have enough money for the move. Members from his home group got their resources together and helped him to move. The client was very grateful and reported to the researcher that he now understood the meaning of support. This man’s sober support network became real and concrete at his time of need.

The cementing of this sober support network starts when AA meetings are regularly attended. When the alcoholic finds a meeting place where he feels comfortable, he calls it his “home group.” He attends most of his meetings here. This is where he develops friendships and selects a sponsor.

All AA meetings are formal even though Spanish-speaking meetings are less AA traditional. After the meetings, the members stay and socialize with one another. Refreshments are served. An informal atmosphere develops. Old members introduce themselves to newcomers and conversations develop, usually questions are focused on the newcomers and what AA can offer. The interchange is not confrontational, it is caring and usually the newcomer leaves with a feeling that he is welcomed. However, the old member do expect that in time the newcomer will commit to sobriety, but they do understand that it is not easy and it will take time, but their willingness to help the newcomer is there and it is made clear to the newcomer.

Dances are another informal aspect of AA. AA home groups have dances throughout the year. There are dances for holidays, such as Christmas and New Year’s Eve, for special occasion ,such as anniversaries, and to raise funds. The dances are events that although

they put some pressure on the members, they give the opportunity for the member to deal with these very social events. It takes time for many of the members to feel comfortable enough to attend, but eventually, the ones who are truly involved in their treatment and AA, do attend. And, sometimes become part of the home group committee in charge of dances.

Sponsorship, although part of the formal aspects of AA, also leads to the informal aspects by creating social situations that lead to a sober support network. Since each new member is requested to select as his sponsor an older member who has had at least two years of sobriety, the selection process itself involves new social situations (see Table 5.5 below, which indicates how many clients have a sponsor). This is an anxious time for clients who have difficulties approaching people. Some clients have reported the feeling of vulnerability and fear of being rejected. In AA meetings it is urged that everyone choose more than one sponsor, just in case the first choice is not available. Ideally, the sponsor is someone who has been successfully coping with an alcohol problem and is ready at all times to help his charge. A client reported that his sponsor has helped him to maintain

his sobriety by lessening his loneliness through empathy and understanding. Denzin (1987b:92) explores the meaning of “alcoholic understanding” as something that is essential to maintaining sobriety. It can only be learned in AA through a process of transforming the alcoholic into a “talking subject” who learns to speak about his or her lived experiences within the language AA provides.”

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TABLE 5.3  
MAKING FRIENDS (N=37)

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	AA	CLINIC
More than 6	67.6% (25)	32.4% (12)
2-5	21.6 % (8)	24.3% (9)
None	10.8% (4)	43% (16)
	100%	100%

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**TABLE 5.4**
**SOCIALIZING OUTSIDE WITH FRIENDS (N=37)**


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	CLINIC	AA
Yes	21.6% (8)	29.7% (11)
No	78.4% (29)	70.3% (26)
	100%	

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**TABLE 5.5**
**SPONSOR (N=37) (Do you have a sponsor?)**


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Yes	32.4% (12)
No	67.6% (25)
	100%

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**THE IMPORTANCE OF FORMAL AND INFORMAL ASPECTS OF  
TREATMENT IN THE CLINIC AND THE SOCIAL WORLD OF  
ALCOHOLICS ANONYMOUS ( AA)**

**The clinic and AA are two separate entities, but both are needed for the client to achieve recovery. The significance of the interplay of these two entities in the recovery of alcoholics is demonstrated through both formal and informal aspects of treatment. Formal aspects of treatment, as previously defined, represent the essence of the clinic and AA. The informal aspects emerge out of the formal aspects in both organizations.**

**In order for the informal aspects to exist, physical space must be available to enable people to congregate and interact with each other. Many treatment centers, due to cramped quarters or a lack of flexibility in the schedule, do not have the necessary space to provide a place for the clients to use on their own.**

**In the clinic, the day room is designated for informal social activities. In addition, clients are encouraged by the staff to speak with one another. Clients are allowed to come to the clinic without an appointment, and anyone is permitted to enter the clinic proper**

between 9 a.m. and 4 p.m. on a daily basis. This encourages clients to spend time at the clinic.

Even though counselors encourage clients to stay around the clinic, actually doing so is not a required part of the treatment program. It is a voluntary decision, on the part of the client, to stay and enjoy the social dynamics in the day room. A client can graduate from the clinic without getting involved in the informal aspects of treatment, and he can also attend AA meetings without getting socially involved in AA activities. Compliance with treatment is the goal of the clinic, since it can be measured. It is the only condition needed in order for the client to graduate and leave the clinic in good standing. Yet if the decision to recover is personal, and can only be made by the client, then his involvement in informal activities is a prelude to his commitment to recovery. The decision to get involved is also a commitment to improve his life because the client is investing time in involvement.

Formal activities are the rules of the organization. Clinic rules include an attendance requirement (showing up for individual and group counseling appointments, going to AA , and keeping medical appointments), successful completion of each phase before

graduation, dealing with relapse, and any other activities deemed necessary by the primary counselor. Formal aspects of AA include attendance at the different types of meetings, reading the literature, adhering to the system of sponsorship, and the 12 steps and the 12 traditions.

The counselor-client relationship is also part of the formal aspects of treatment. The counselor and client must work through all disturbances and disruptions (including transference issues) before the relationship can be beneficial to the client. This relationship is not an “equal” one, but it aids the client in understanding and putting into perspective the world in which he must participate.

Out of formal situations, informal situations emerge. This is true for all formal situations (group therapy, sponsorship, meetings). For example, after group therapy many of the clients return to the day room and continue the discussion among themselves. They don't have to do this, but in the process of group, clients often feel people are listening to them for the first time. This can be a turning point in a client's life.

Initially, the client does not come to the clinic or AA with the idea that he is there to make friends. He is there to stop drinking,

however, in time, if he is serious about his recovery, he realizes that only through social interaction in a sober support system is he able to learn to stop drinking, and at the same time, learn about himself. He learns that he is not such a terrible person because his counselor supports him, his sponsor is willing to talk to him, and the friends he has made are there for him when he needs to talk to someone. The client begins to see a change in priorities, with involvement in the treatment program and AA placed at the top of his list. He needs to be physically present in order to obtain maximum benefit from the treatment. Attendance is important for both formal and informal aspects, because if the client does not come to the clinic, the counselor is not able to evaluate him, and he is not able to be part of the resocialization that is taking place. His involvement in the treatment program and AA activities insures his resocialization to becoming a recovered alcoholic.

The client is given tools, through the formal aspects of treatment, to manage and survive in a world in which he has not had much success. The informal aspects help the client test the tools he has acquired. When a client chooses to speak at an AA meeting, or chooses to invite another client to play pool in the day room, he shows

that he is willing to take a risk. He might not succeed all the time, but whatever the result of his risk-taking, he will learn how to survive.

He begins to trust the network he has built to get him through the tough parts of the recovery process: the counselor, the sponsor, friends from the clinic and AA, and people from other areas of his life, such as church and family.

As the client becomes socially involved in the activities of living within the parameters of the clinic and AA, he is indicating to his counselor that he is improving. At first the client is not aware of what is happening to him, because awareness takes time. When he does become aware of his situation, he is on the road to recovery.

As the client becomes more involved in the clinic and AA, one can observe his increased participation in the informal aspects of treatment. The client is seen more often in the day room, attends more AA meetings, and stays in the clinic longer. By placing himself in these social settings, the client is obliged to engage in the social activities that present themselves. For example, if a client is in the day room, he will be asked to play pool, and clients in the day room are always engaged in conversations. This is the beginning of making friends. In this way, the client learns good social skills that will help

him to manage his life in a more sensible way without alcohol and drugs.

Managing life is the goal of the recovered alcoholic, shyness is one of the biggest problems the recovered alcoholic wants to learn how to manage. Through the informal aspects of treatment, the alcoholic learns how to take control of his life. For example, the need to obtain a sponsor is a formal aspect of AA, but the actual process of obtaining the sponsor is informal. When a newcomer comes to AA and decides he wants to get a sponsor, he must socially interact at the end of the meeting in order to meet the members. This means that he must talk to the older members, but it does not mean that the newcomer is comfortable talking to strangers, since shyness keeps many alcoholics isolated and leads them to avoid intimacy, which leads many times to loneliness.

Through the process of selecting a sponsor, the client commits himself to change. He evaluates the old members of AA and then makes a selection. The person chosen will learn many intimate details about his new charge. A sponsor is a person who is no longer drinking, who is aware of his or her recovery, and who is willing to set aside time for his or her new charge. Both sides have

responsibilities they must keep in order for the formal function of sponsorship to be effective.<sup>13</sup>

The process of resocialization evolve on a daily basis when clients come together to talk in the day room. This social experience helps the client to develop important social skills, such as learning the art of conversation, learning about another person, learning to adapt to changes, learning to have patience, and learning about networking. If one observes the day room from a distance, one can see the people intermingling with each other, laughing, talking, and listening. If one enters the day room, one can hear the actual conversations, and these conversations are usually related to recovery.

The clinic itself is a favorite topic of conversation. The clients who have been longer in the program usually inform the most recent clients about the workings of the clinic. This is one of the ways that a client learns about the world of the clinic, and the fact that it can only educate and guide him; he must choose to recover.

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<sup>13</sup> The clinic makes obtaining a sponsor one of the requirements of the program. Yet the number of clients with a sponsor is about half of the total population. Nevertheless, with the exception of the DWIs, almost all clients graduating from the clinic usually have a sponsor-type relationship (e.g., a member of an evangelical church).

Loneliness might urge a client to become involved with others who are in a similar situation. By allowing himself to become part of a social unit, the client begins to develop the skill of managing life without alcohol and drugs. Many clients assume that happiness eludes them but not other people. This misconception is dispelled as the client's perception of himself begins to change and as his involvement with sober people increases. The risk of relapsing lessens as clients become more in tune with themselves through the informal aspects of treatment. For example, a client rejected by a woman he had asked to attend an AA dance did not feel as dejected as he would have in the past. He asked another woman to go with him, and she accepted. This taught him that only by trying can he actually succeed. Success is relative to each individual.

Face-to-face interactions of communication are the heart of informal aspects of treatment. The client learns to be at ease in these social milieus by taking part in such interactions on a frequent basis. Both the clinic and AA encourage the client's involvement; they work together to achieve the goal of recovery. For instance, many therapy sessions are preparation for taking one of the steps in AA. In step five, for example, the person must tell someone of at least one

behavior or action from the past that he is ashamed of. He comes face-to-face with another person for this ordeal. A client from the sample spent two months preparing to actualize step five. Telling someone a shameful secret is not an easy thing to do; it is a powerful act when accomplished. Clients who have put themselves in this situation are in the process of recovery.

Formal and informal aspects of treatment are the means by which a person becomes recovered, from the point of view of the client himself and the treatment center. Both points of view are significant if the alcoholic is to succeed in treatment. This chapter has illustrated that both aspects have important roles to play in making recovery a reality for people seeking recovery.

## **CHAPTER SIX**

### **THE CASE STUDIES OF FIVE ALCOHOLICS**

**This chapter presents the case studies of five alcoholics who attended the clinic from six months to four years. Selection of these five cases was based on how well they represent the Hispanic male population in the clinic during the time of the research. Each client was interviewed for several hours. "Depth interviewing is applicable to topics where the actor's point of view and inner feelings are important to the research goals" (Wiseman & Aron, 1970:31). The client was allowed to describe his childhood in detail, and he was asked to focus on his perceptions of family roles and relationships as he was growing up.**

**The case study approach is "perhaps the most popular research method for gaining insight into why an individual acts a certain way and how he is likely to act in the future" (Wiseman & Aron, 1970:73). This study is interested in the client's version of why he became an alcoholic; the reasons that his life took a particular road. The client was also given the opportunity to describe his present condition. Many believed that they were in recovery, some had had recent relapses or had used a substance other than alcohol (such as cocaine or**

marijuana). Hence, this chapter is also concerned with explaining what recovery meant to each person. A persistent theme is a perceived dichotomy between the use of illegal or prescribed drugs, on the one hand, and the use of alcohol, on the other. It appears that using illicit or prescribed drugs (bought on the street) is not considered a relapse.

The discussion will focus on "turning points" in an individual's life. Wiseman and Aron (1970:73) explain that

the basic assumption underlying the case study method is that many of an individual's social attitudes and behavior patterns have developed from his attempt to deal with important events and experiences that were significant as "turning points" in the course of his life. Because of these events his life has been changed, and he has gone in a new direction. These modifications in his behavior may affect his entire future.

In the process of telling his story, the client generally pinpointed what he felt was the turning point in his substance abuse pattern. The turning point is usually one event, or a combination of events, that adversely affected the client. Each case under study is a description of this turning point, although not all clients were aware of this. For example, in the first case, MM reports that he was sexually molested for four years by his male siblings. Even though all his life he has had a feeling of unworthiness, he was unable to see this early experience as affecting his present life situation. He mistrusts people

and has not been successful in maintaining a fulfilling relationship, circumstances that connect with his early experience of abuse.

On the other hand, the client known as CO was able to describe his turning point in detail, and he is aware of the impact it has had on his life. When he migrated to the United States from Honduras at the age of 20, his expectations were so great that he became depressed and disappointed. As he puts it, "It was the worst possible experience in my life." He had problems with his father, faced discrimination due to his skin color, and was unable to obtain a higher education because his family could not afford it. He became very anxious and fearful about living in New York City because he felt worse off than in his country of origin. "I had no status," he explained; "I couldn't even live with my family because there wasn't room for me." He added that he started drinking heavily within a year of his arrival in New York City.

Similarly, AL is very sure when his major turning point occurred: "I was 15 years old when I had my first two beers, and I felt good." AL reports that after this episode, he had two beers for lunch, until one day the effect was no longer there. So he increased the amount, and continued to do the same, until he discovered hard liquor.

**JMP states that his life turned around completely for the worse at age 11, when his father died. Yet many small events led him to become a chronic alcoholic and drug abuser. Loneliness, low self-esteem, and shyness have been a constant concern of JMP and have caused him to use alcohol and drugs as an answer to isolation and lack of social skill.**

**WR understands that his turning point was not having a responsible family to protect him as a child. At the age of 5 he was drinking, at the age of 9 his father taught him how to sniff cocaine, and at the age of 10 and a half, he left home.**

**In this study, the underlying theoretical perspectives are symbolic interaction, the process of socialization, and the process of resocialization. Symbolic interaction places the individual at the core of social reality, where he or she tries to make sense of social situations. To make sense of a situation is to interpret it, to lend it meaning; the individual does not respond to the social world directly. His experience takes form from the meaning he places on his own acts and on the acts of others (Broom and Selznick, 1973:9).**

**Therefore, to comprehend the process of alcoholism and recovery from the point of view of the client, one must allow the client**

to describe and explain his own experiences. Why does he think he became an alcoholic? Why has he decided to stop drinking? The case study method allows the story to be told in the words of the client.

Socialization is defined as “the process by which we learn the ways of a given society or social group so that we can function within it” (Elkin & Handel, 1984:4). As the cases unfold, themes will emerge which are significant in shaping the lives of the five individuals. For example, the family, as a social group, is so critical, and the influence of it so powerful, that if an individual is not properly socialized by the family, he will encounter various impediments to a satisfying life. This theme is illustrated in the lives of all five clients.

The clinic and AA are utilized as agents of resocialization, and – as such – they teach the clients to unlearn old behaviors and replace them with more acceptable behaviors. In treatment situations, resocialization is the relinquishing of a dysfunctional role behavior, replacing it with a new role behavior that is accepted by society (Fein, 1990). The dysfunctional role, and the mechanism blocking its replacement, must be recognized before it is possible to let them go. Successful resocialization depends upon the cessation of behaviors that produce undesirable results (Fein, 1990).

Resocialization is not complete until viable new patterns of living emerge. The person will be no better off than when he started, until the construction of new, satisfying, and appropriate social roles takes place. Successful resocialization, as explained earlier, depends upon the alcoholics active involvement in the treatment program and AA. If the alcoholic becomes socially involved, he is more likely to complete treatment and to successfully recover from alcoholism.

Among the five interviewees, JMP and MM did not complete the program. JMP continued using cocaine, although he denied it.

Similarly, MM left the clinic because he was suspected to have been drinking and using cocaine. MM also refused to attend AA in the community.

It has been said that "the goal of recovery is to put the sober self back in charge" (Gorski, 1989:53). Nevertheless, much occurs before recovery is achieved. Fein (1990:107) has observed that:

Because role change is not automatic, because it can be impeded in so many different ways, often the person who is most in need of it has the greatest difficulty in achieving it. He finds himself trapped in dysfunctional roles by the very processes that established them in the first place. Though he may desperately want life to be better, the various elements of his role scripts conspire to keep him from changing. As much as he may desire more satisfying ways of living, a mysterious barrier seems to frustrate his ambition.

If resocialization is to happen, the person in distress will need help. A counselor – that is, someone who is skilled in helping others achieve change in their lives – is essential. Usually people confronting the prospect of change are too frightened and confused to take the necessary steps. Thus, an alliance with another person or organization may inspire in the client the necessary courage to act on changing his life (Fein, 1990).

Furthermore, "addiction is a combination of two problems: (1) the drinking problem—the problem with alcohol and other drug use; (2) the thinking problem—the problem with irrational thoughts, unmanageable feelings, and self-defeating behaviors" (Gorski, 1989:52).

These five individuals were raised in dysfunctional families, where boundaries were nowhere to be found. Violence and abuse (verbal, physical, and sexual) from other family members are a repetitive theme. Hess and Handel (1985: 40) observe:

A family theme is a pattern of feelings, motives, fantasies, and conventionalized understandings grouped about some locus of concern that has a particular form in the personalities of the individual members. The pattern comprises some fundamental view of reality and some way or ways for dealing with it. In the family themes are to be found the family's

implicit direction, its notion of "who we are" and "what we do about it.

If violence and abuse are the dominant themes in these individuals' families, then this theme also becomes a way of life for them. For instance, WR battered the women he lived with to show them who was boss. Growing up in his family, he frequently saw his father beating his mother, especially when he was drunk. WR was always fearful of his father and felt repulsed by him. He recalls that he was also ignored by his mother. Yet, throughout his life, WR imitated his father; he had felt like a scapegoat, and now he looked for others to fill that role.

The emergence of a deviant pattern in the lives of these five individuals was left unchecked until it was too late to divert. Many times "no one cared" what happened to them. In struggling to survive in a world that appears hostile, and in which it offers little support, the troubled individual searches for some meaning to hold on to and finds alcohol and drugs.

The essence of the story, in all five cases, concerned a family that was not performing the necessary roles to help develop a functioning and happy individual. As Hess and Handel (1974:1) explain:

In their mutual interaction, the family members develop more or less adequate understanding of one another, collaborating in the effort to establish consensus and to negotiate uncertainty. The family's life together is an endless process of movement in and around consensus understanding, from attachment to conflict to withdrawal—and over again. Separateness and connectedness are underlying conditions of a family's life, and its common task is to give form to both.

In the discussion and analysis of each case, the following topics are included: family dynamics; roles of family members; family themes, such as violence and abuse, adjustment problems, loneliness, lack of affection, low self-esteem, promiscuity, the feeling of not being safe, and alcohol and substance abuse within the family; and, finally, the client's search to become a better person by seeking help from the clinic and AA.

#### THE CASE OF MM

MM was born in Puerto Rico in 1955. At the time of the interview, he was 38 years old. He grew up in a large family and was the youngest of ten children. His father was an accountant who worked long hours and was "never home." According to MM, his father had to work long hours to be able to support such a large family; yet, while MM was married, he did not get involved with his family—economically or emotionally. His mother was hardly

mentioned throughout his narration, but he did interject that she was a “saint” who always read the Bible. His father, on the other hand, drank and caroused with women. MM reported that his father is a chronic alcoholic.

At first, MM created an idyllic home setting. Everyone loved and helped one another, he “ had a good childhood.” He proudly stated that his parents were good providers: “We had everything; we all had the opportunity to go to school and become a professional, but I didn't take advantage of it. I'm nobody.” Then MM became very pensive, as if wondering what had happened. He uses every opportunity to belittle himself and feels that because of his addiction he has not accomplished much in life. He compares himself to his siblings and usually comes out short. He says that all of his brothers and sisters are professionals with good careers.

As the interview progressed, MM disclosed that his father was never around “to give love and warmth to his children.” If he was not working, he was out with a woman. MM's mother, who did not work outside the home, was not emotionally available for him. Instead, his sisters took care of him. He rationalizes that his mother was “maybe too tired from having so many babies.” MM was her

youngest child.

MM is not aware of the effects his family has had on him and he says that he holds no resentment towards his parents. He places the full blame on himself: "I am a bad seed." He started drinking and using drugs at the age of 13 and promptly dropped out of school. Asked how his parents reacted to his decision to leave school, he responded: "I was such a troublemaker that by then my parents didn't really care what I did."

MM finally revealed that for four years, starting when he was nine years old, his male siblings sexually abused him. However, in the same breath, he dismisses this profound abuse as not having any connection to his life now. He excused the acts as a fluke that "happens in large families" and as nothing to be concerned with. He continued to claim that he had worked it out and that it had had no influence on his life since he is "not a homosexual." He feels that because he is heterosexual, he has escaped the injury of this experience.

Yet MM's behavior reflects the reality that something has gone wrong in his life. He tries to be and feel "normal," but he is not able to. He states that "things just don't appear right." He cannot put

his finger on what it is, but he does not complete tasks which he starts, and this bothers him. His marriage ended in divorce. He has two children whom he had not seen in over four years. "I was no husband and surely not a good father," he explained, "—always drunk and never home."

MM moved to the United States in 1990 to escape his problems in Puerto Rico. He moved with a woman friend. He was accepted for treatment at the clinic in 1993. He had come as a self-referral, but this was due to the urgings of his girlfriend, who was finding it difficult to live with an active alcoholic and drug user. MM acknowledges that his addiction was becoming unmanageable. He claims that he was not a drug addict, however, because he used cocaine only after he had been drinking.

After attending the clinic for approximately four months, MM asked for permission to go to Puerto Rico over Christmas holiday. Permission was granted; however, he had to promise to maintain his sobriety. MM had some grandiose ideas that while visiting in Puerto Rico, he would repair his relationship with his children and family of origin. This did not happen, however, he had a relapse.

MM dismissed this relapse as insignificant. When he returned to the clinic, he did not report that he had had a slip, but he was willing to discuss how determined he was not to drink. He continued the charade for a month, when he finally admitted what had happened. But after his revelation, he became less willing to attend the clinic, and he started to miss many of the group therapy sessions, until one day he stopped coming.

MM had refused to attend AA while coming to the clinic. He would remark that the people in AA did not understand his problem. Retrospectively, it was difficult for MM to deal with the many consequences of his alcoholism and drug use. Although he was not very insightful about the road he had taken in life, he was beginning to understand that he failed at many endeavors because he lacked confidence in himself and did not trust anyone around him. He later admitted that perhaps the long-term abuse by his siblings contributed to the "insecurities" in his life. He reflected:

I was always timid. It was hard for me to initiate a friendship. I don't believe in people. (Pause) It's very difficult for me. I have never cultivated a really good friendship.

And talking about his marriage he commented:

It was never a marriage--what a marriage is supposed to be; I don't think I

really loved her—they [meaning his wife's parents] made me marry her because she was pregnant; and, anyway, I had so many other women when I was married to her [shrugged shoulders].

#### THE CASE OF CO

CO was born in Honduras. At the time of the interview, he was 28 years old. He is a Black Hispanic who was admitted to the clinic in 1990, suffering from epilepsy seizures induced by alcohol. CO started drinking at the age of 17; his drinking escalated at the age of 20 when he came to the United States. CO is very specific concerning the onset of his problem with alcohol, asserting that his migration to the United States was devastating. He tells of the vast feeling of despair that came over him, a feeling that he had never experienced before. "I felt so alone. [I] had no one."

He described his life in a small Honduran town as wonderful and good, yet another picture emerges. He wanted to attend school but was unable to remain enrolled because his family was poor and could not afford tuition. His mother and siblings were counting on his father, an alcoholic who lived in the United States, to send money. He had left Honduras for the purpose of helping his family to achieve a better standard of living; however, he

did not keep his promise. CO became very resentful towards his father, especially after he was forced to leave school. "He forgot his family," CO said. "I remember –I wrote him a letter, and he sent back a very nasty letter. Who was I to tell him what to do."

In 1986, with the father's help, CO's family came to the United States. CO was so disillusioned with this country that he feels that is one of the causes of his alcoholism. His expectations of what was to happen to him and his family were so high that reality could not measure up. For one thing, CO was not able to attend school and was put to work instead. He started "hanging out with older men who were actively drinking." His drinking quickly escalated and by age 24 he was a chronic alcoholic. "My personality would change; I didn't even know myself." CO described his feeling of being alone:

When I came to New York, I thought I'd be with my family—that I would see them every day. I thought New York was a small place. I actually was better off in Honduras. At least I had friends. That's how I felt when I first came, because the only things I did was work and be alone.

CO at first rented a room in Brooklyn because there was not enough space in his father's place. Later, however, he lived with his parents, despite the fact that he did not get along with his alcoholic father.

As CO continued to drink, the epileptic seizures also

increased. Eventually he was taken to the emergency room at a local hospital, where he was referred to the clinic after detoxification.

CO found that his counselor was extremely helpful. He explained:

I was an arrogant person. My counselor... was very strict with me. She would make sure I went to AA. My ego was so big—*ese machismo*—that I was blind to my own sickness. But now, I thank this woman who helped me.

In AA, CO has found the family he always desired. In the true sense of the word, AA is his primary group. He feels safe there and loved by the other members; he says that he no longer feels isolated from people. His relationship with his sponsor is "great." "We discuss the meaning of spiritual awakening and surrender to a higher power," CO said. "When he sees that I am going too fast, he tells me to calm down." CO feels at peace with himself, and he looks forward to one day being a sponsor himself. Even though his relationship with his father is strained, he is also calm about this: "I'm not going to worry about it. Things will work out."

#### THE CASE OF WR

WR, a second generation Puerto Rican, was born in the United States. At the time of the interview, he was 33 years old. He is

the youngest of three children, speaks fluent Spanish, and considers himself bilingual and bicultural. WR has a long history of drinking alcohol and abusing heroin, cocaine, and marijuana. At the age of nine, he was drinking alcohol and learning from his father how to use cocaine. At this age, according to WR, "I already knew how to get high, but I never did it outside the house—always with my father." His father was also an alcoholic.

At around the age of 10 and a half, WR left home. He said that his father had always physically abused him, and he couldn't take it anymore.

I guess when I was 10 and a half years old, my father got ... fed-up. He told me if I didn't like the rules of the house, that I would have to leave. So I said, "fine."

WR moved across the street from his parents' apartment. He lived in a basement where the gang he belonged to had a club house. He said that because he was the youngest in the gang, the other members adopted him. The leader of the gang would buy him clothes and make sure that he ate. Mothers of the gang members gave him food and allowed him to take showers in their homes.

WR's father—a policeman—appears to be the main influence in WR's life. WR speaks of his mother with anger and resentment, even though, he claims to understand her predicament. "When she tried to help me, he would also beat her." WR's family lived in a world where unpredictability was the only stability. Everyone was afraid of WR's father; he ruled with an iron hand. Weekends were the worst time for WR and the rest of the family, because the father got paid, and this meant a drunk. As WR described it:

My father would get home about 2 in the morning and would wake me up. He would say, "I'm going to teach you a lesson," and would beat me. I was scared of him—afraid he might kill me.

There were many physical altercations and arguments between the father and WR. WR recalls an incident that occurred when he was 13:

One day, I waited for my father. I was going to kill him. My father was looking for his gun in the car when he saw me. Later I found out that my mother had taken the gun from the car. I think he would have killed me.

Despite such scenes, WR now speaks fondly of his father. He explains that his father taught him how to survive in the world by showing him how to steal, take drugs such as acid and cocaine, use a gun, and fix cars. "My father would take me with him to warehouses, and he would tell me what to take. One day we hot-wired a car."

At the age of 17, WR became a father. He now has six

At the age of 17, WR became a father. He now has six daughters, none of whom he has taken responsibility for, either financially or emotionally. He rationalizes this behavior by saying, "I was a street person. I always depended on women to take care of me." He was usually "high all day—acid, marijuana, alcohol; later, PCP and heroin." The women he was involved with were usually prostitutes.

WR had his first contact with the clinic in 1992. "I decided to give myself a chance, he said. "I was just coming out of jail." He was sent to the clinic by his parole officer, and at first he didn't take it seriously, but he liked the people and decided to give it a try. He felt the same way about AA at first: he "hated it." But now he feels it is the only thing keeping him sane. He stated that he was tired of being an addict, and that he understands he must work on himself every day to be able to maintain sobriety. At the time of the interview, he was learning to control his emotions and feelings by learning about himself through AA and the 12 steps. He has a sponsor, whom he admires and respects, who comes to his apartment to discuss (with his girlfriend and with him) AA's Big Book and the 12 steps.

## THE CASE OF JMP

JMP, the youngest of eight children, was born in Guatemala. He came to the United States in 1983 and was 34 years old at the time of the interview. His father died of cancer when he was 11, and JMP explained, "the death of my father changed everything in my life." When he learned of his father's death, the only thing he could think was, "who's going to buy me the bicycle he promised." He has felt guilty about this thought for most of his life.

JMP's mother, who worked and did not have time for the house, put one of her daughters in charge. JMP recalls that when his sister was in charge, she tended to be harsh with him, and at times she even whipped him with a belt. At the same time, he was forced to work in his father's business, a shoe repair shop. Because he was working during the day, he had to attend school at night; hence, he was around adults all the time. His companions, drank, and at the age of 14, he, too, started drinking and smoking. As he put it, "My first beer made me feel good—alleviated the tension I lived with. I hated going home."

JMP's drinking continued and became progressively worse. At age 15, he started feeling guilty about it. His family accused him of stealing money from the business, which was not doing well. At about this time, approximately four years after his father's death, his mother started drinking and coming home late. She fought with him and cursed at him, and these encounters were always painful for JMP.

After his father's business was sold, JMP returned to regular day school. He said he felt vulnerable and shy, and could not talk to girls. He found that alcohol reduced his inhibitions, and he could enjoy himself. But by the time he was in college, he was experiencing blackouts and it became impossible for him to finish the second semester. He dropped out of college, but by now his family had worn tired of his behavior, and they did not allow him to work in the other family business. He tried to stop drinking and joined AA. But he failed and instead signed up for the merchant marine.

In 1983, JMP arrived in Miami and worked on different ships. This was an important transition because he started using marijuana and cocaine, though he never felt that he was an addict; his problem was alcohol. From 1984 to 1988 he was involved with AA

and did not drink, but he continued using cocaine and other drugs. Even while he was receiving treatment in the different centers, he continued to use drugs (though not alcohol).

JMP went through a series of treatments before being accepted at the clinic in 1993. Although he was involved in AA and attended the clinic, he was never substance free. Though he never admitted his use of cocaine and marijuana to his counselor, in a routine blood test, the result was positive. At first, he denied it, and he took the test again. Eventually he left the clinic without completing the program.

JMP seemed to forget why he had come to the clinic. He got involved with other activities –getting a graduate equivalency diploma (GED), looking for a job, starting a new relationship –and lost sight of the fact that he needed all his energy and concentration to recover from alcohol and drug addiction.

#### THE CASE OF AL

AL, an only child, was born in Uruguay and came to the United States at the age of 11. At the time of the interview, he was 35 years old. He had recently married a woman he met in the clinic who

was an active alcoholic and 15 years his senior. People who know his mother have stated that the woman he married resembles his mother.

AL tried to repress his desire to talk about his mother, but he found the urge too great. "I have forgiven her, he said. "What she did was wrong, but not too long ago we talked, and we forgave each other." He then described in detail his mother's many love affairs while she was married to his father.

According to AL, his mother did not love his father and they divorced approximately a year after arriving in the United States. Even though Al and his mother shared a bedroom in their small apartment, his mother brought her many lovers home. AL pretended that he was asleep when his mother came into the bedroom with her lovers, so he could watch his mother making love. When asked what he thought of his mother's behavior, he said, "I wanted to be part of what she was doing."

AL also had a problem adjusting to life in the United States. "I was different, he explained. "They [the other boys in the community] would call me a mama's boy and faggot, but I didn't care. I never cared. I didn't know why, but it didn't bother me." He has also said of that time, "I didn't love myself. I felt bad."

AL said that he had two beers for the first time at the age of 15 and felt good. Having been sad for most of his life, this served as a turning point. "I never drank for pleasure," AL said. "I drank to get out of myself." He perceived that everyone around him was happy and felt good, and this distortion gave him an excuse to drink. His drinking increased to nightly ritual, and he regularly woke up with a hangover. He learned from his drinking buddies to drink in the morning so that he could go to work, but eventually, he lost his job and moved in with his mother, who was now married.

Loneliness was always an issue with AL. It motivated him to marry Maria, an active alcoholic, and although he resents her drinking, he stays with her. "I married Maria because I thought she was mature," Al said. Yet he knew she was drinking at the time of the marriage. He admits that "she would drink in front of me, but I thought she could handle it." He came to feel that the marriage was a mistake, but he conceded that he still feels "empty" and "needs someone."

AL came to the clinic in 1990. He "worked" the program with the help of his counselor, who told him, "You are a sick man—take all you can." So he availed himself of "psychiatry, AA, and

antabuse,” and he became highly involved in AA. He says that as a result of all this, he is “dealing with life's problems without drinking.”

#### COMPARISON

A persistent theme in all the cases is the presence of violence and abuse in the childhood homes of these men. The relationship between the parents was often volatile and unpredictable. WR recalls the fights occurred between his parents because of him. "Only when [my father] was drunk would he hit my mother and me—never sober." According to WR, his father was loving except when he was drunk, and this incongruence was hard for WR to understand. He said that when his father gave him alcohol to drink, he “felt a closeness”—felt a bond”—with him.

Like his father, WR hit the women he became involved with: "I used to beat my women. I thought it was okay. I didn't think there was anything wrong. I know now you shouldn't hit women."

Similarly, MM was also abusive towards the woman he was married to. His marriage, though unstable, lasted 15 years. It produced two children, but MM was never a true father to them, and he laments his failure in this regard. Of the woman he lives with

now, he says: "I have learned to love her." He admits, however, to having hit her more than once during their four-year relationship. Throughout the interview, he interjected the words "immature" and "bastard" to describe himself.

CO also experienced violence and verbal abuse as he was growing up. He recalls getting into fights with his father and brothers, and these incidents increased when they moved to the United States. CO felt like the scapegoat of the family.

While JMP and AL escaped blatant violence in the home, they did have to deal with the unpredictability of their mother's behavior. Both of their mothers had lovers of which the family did not approve. Furthermore, both men lost their father at an early age.

Another theme that emerges is loneliness. Feeling of sadness and isolation are pervasive among these men. AL said, "I always felt sad." Only when he drank did he feel normal. CO commented, "I didn't think I was worth anything....I didn't belong."

Though loneliness touched all the men whose lives are described in this chapter, it played a particularly strong role in shaping JMP's life. The theme that no one cared—his mother was too busy, his girlfriend left him, his father died—is a recurrent one throughout

JMP's life. In AA he found solace, but he still needed to use cocaine and marijuana. He became involved in an intimate relationship with a woman 20 years his senior, but he felt too embarrassed to be seen with her.

AL had difficulties adjusting to a new culture. Similarly, CO found it very difficult living in New York City. JMP, afraid of both success and failure, was never comfortable anywhere. He escaped to different locations, trying to find a cure for his inner turmoil. WR was homeless most of his life, and he moved in and out of prisons.

Of the two men who had children, neither met their responsibilities as fathers. MM was trying to reunite with his abandoned children, and WR thought it was too late for reconciliation. Of these five men, the treatment center has helped define the path that each is currently taking. For CO, AL, and WR, this path is a positive one. They have clearly chosen to change the type of existence they experienced in the past and to create a better life now, and for the future. On the other hand, MM and JMP continue to be too frightened and confused to take the necessary steps to a better life. Just as there are turning points towards becoming an alcoholic, there are also turning points towards recovery. CO, for example, described a critical moment when he

realized the meaning of spiritual awakening as explained in the AA literature: One night I was doing my homework. It was on a Saturday and it was 1a.m. I got up from the chair and got myself a glass of milk and some cookies. When I realized that on such a night I would usually be drinking in some bar, I became very emotional and I almost cried.

## **CHAPTER SEVEN**

### **RECOVERY AND OTHER ASPECTS OF A BETTER LIFE: RESOCIALIZATION AND THE NEW SELF**

This chapter's main objective is to discuss recovery, or change as the client perceives it. The terms used in this chapter to signify change are "resocialization," "improvement in quality of life," and "role change." Recovery is the main goal of each client who goes through treatment at the clinic. But compliance is the criterion for completing the treatment program at the clinic since compliance is measurable.

The process of recovery is interpreted differently by each client. Each was asked, "Do you think you are in recovery?," and each responded positively to the question, even though it was known that some had recently relapsed. The important issue, then, is to discuss recovery with the client and determine the actual level of his recovery. Gorski (1989) writes about six levels of recovery: transition, stabilization, early, middle, late, and maintenance. Most of the clients interviewed fell into the range of transition to early

recovery. The clinic also identifies formal levels of recovery, called the developmental model of recovery (DMR), through which the client moves during his treatment. Similarly, AA has the 12 steps.

A pertinent question is, "When does the alcoholic begin to understand that he needs to change?" Many of the clients questioned answered that they were tired of living by the bottle. Many found themselves in trouble with the law, as a consequence of drunk driving, or drinking at the job. Others lost their job for reasons connected with drinking such as lateness or shoddy work. Clients also had difficulties with relationships at home and at work. Loneliness was often a catalyst for seeking help.

To improve, the alcoholic must be ready to accept help from the treatment program and AA. He needs to integrate fully into the process of recovery and not stay on the periphery of treatment. He has to make up his mind that he wants to change and get better. The decision to change must come from the client, since recovery depends on his own thoughts, emotions, and behavior. It is a radical inner

change, the end result of which is that he sees the world differently.

Bjorklund (1983:10) puts it this way:

**For the alcoholic whose life is being destroyed, the challenge of recovery is to find a new god-like relationship, a new focus for his or her spirituality, a new center. Something must replace alcohol as the center of the person's life. This is the reason recovery does not consist of simply not drinking. Putting the cork in the bottle does not necessarily make something else the center of the person's life. Just to stop drinking without other growth and change would simply frustrate a person who has not learned any other way to meet human needs.**

**The alcoholic drinks because this is how he has learned to meet his basic human needs. The bottle is the answer to all his problems.**

**Alcoholism takes over a person's life and totally controls that life.**

**Therefore, the recovery process must be just as strong if the client is to arrest his illness. Role change is a laborious task. Fein (1990:34)**

**explains:**

**The mechanisms that keep social roles from changing too quickly seem to be built into our nature. They are internal to each of us and help make us social. These mechanisms are none other than our role scripts. Both internal and external scripts give role behavior a persistence and consistency that would not otherwise exist. The cognitions, emotions, and volitions of a person, and the demands of his role partners, guide his behaviors into well-worn channels. They do not permit dizzying shifts of conduct that would make him seem to be someone other than who he is....Even when change is intended, altering a script element can be very difficult. Inner change feels like self-betrayal, no matter if the result is self-enhancement. It represents a loss of self and social position that feels**

intolerable, and is tenaciously resisted. A person's role scripts can exercise an inner tyranny worse than any dictator.

**Resistance is a major block to change for the alcoholic. In the field of alcoholism this is also called denial of the illness of alcohol dependence. But just before the alcoholic makes up his mind to seek treatment—change—he might be in a state of anomie or normlessness. The anomie theory defines alcoholism as a form of deviant behavior that results partly from an imbalance in the social structure of society—a disjunction between approved means and goals. From this perspective, alcoholism can be defined as alcohol drinking that exceeds the established norms of the particular society (Merton, 1938 and 1968).**

**Merton (1938: 672) theorizes:**

**In American society there is a set of common goals toward which everyone in society aspires. Material wealth such as a nice home, a good car and expensive clothes are examples of common goals toward which Americans aspire. Even though everyone wants these things, not everyone has an equal opportunity to achieve them. Due to artificial barriers like race discrimination in education and employment, certain segments of society are systematically excluded from legitimate opportunities to achieve societal goals. Such opportunity blockage creates a condition of social-structural strain. The imbalance between wanted goals and lack of opportunity creates a sense of hopelessness.**

Merton's anomie theory explains the difficulties of making a decision to recover. This sociological approach, as well as Becker's labeling perspective, has dealt with the cause of alcoholism—how a person becomes and remains a deviant in society. The discrepancy between cultural goals and institutionalized means that keeps the deviant in a particular adaptation can be called the "external script."

A client is "delabeled" and "re-labeled" by the clinic and AA. It is through this process that the client decides to give these agents of change a chance. Mandatory treatment can be effective, since the decision is not left to the client. Due to the type of illness that alcoholism is, deciding to seek treatment is not a simple matter.

Once a person is in the world of treatment, his rationalizations, denial, and resistance begin to lessen. Of the clients in this study, approximately 59% had been in treatment in at least one other treatment center before coming to the clinic. Another 41% had only been in the clinic under study, but approximately 36% of these men were not there for the first time. This is important because it indicates

that once the alcoholic enters the world of treatment, he may continue to seek help until he eventually recovers. Time is of the essence in deciding to change, but once the alcoholic makes the decision to get better, this factor is less important, because the alcoholic realizes that improvement is a lifetime process. One client can make tremendous progress in a small amount of time, while another might take longer to achieve the same goal. Once the person is recovering, progress becomes the main focus; compliance is no longer a goal.

A person who suffers from alcoholism may try to manage his illness for many years on his own, yet he may not understand why success and failure continue to pose problems. Bateson (1972) argues that for the alcoholic, alcoholism is not the real problem. The real problem pre-dates his alcoholism. If the alcoholic is to understand his situation, he must look at his socialization. By looking at his past, he will come to some understanding of his present condition. Treatment at the clinic and the 12 steps of AA, guide the client through his past.

**The client can reach a conclusion that will help him stay sober.**

**Sobriety becomes his new way of life.**

**The clinic functions as a bridge connecting clients to AA. Without the help of the clinic, the members of this study population would probably not be aware of AA's existence in the community. Furthermore, even if they were aware of AA, most would probably not go on their own. The clinic, especially for this population of Hispanic males, serves as a preparatory facility before connecting them with AA. Many clients did report that they would never have joined AA if it had not been for the clinic.**

**Relapse—"slips"—are significant on the road to recovery. It would be ideal for clients not to relapse, but the potential of a relapse is part of what the alcoholic must remain conscious of in order to progress in his recovery. This is why acceptance of his identity as an alcoholic is so important. Once a person acknowledges what he is, he breaks through denial and accepts the identity of alcoholic. The identity becomes primary (Denzin, 1987a). Denial is no longer a**

problem, but unless the alcoholic is constantly watching himself, slipping back into old patterns is easy. Frequent AA attendance helps to curtail this, and that is why treatment requires it.

Furthermore, internalization of the sick role or disease concept of alcoholism must occur if acceptance of the identity of alcoholic is to take place. The client must accept the first step of the 12-step program of AA: “We admitted we were powerless over alcohol—that our lives had become unmanageable.” For many alcoholics, denial is a protective cocoon where they can safely stay until they are ready to admit their situation and begin towards recovery. The client might not be drinking during the course of this denial phase. Instead, he might be going through the “dry drunk” syndrome in which he is neither drinking alcohol nor working on his recovery.

## THE RECOVERY PROCESS

For the phenomenon of recovery to be real, and not an abstract concept, it must be manifested through the client's social behavior. One purpose of this study is to try to understand the "definitions of the situation" (Spradley, 1980) that recovering Hispanic male alcoholics have of their world. In other words, the goal is to perceive their social reality as they do.

Moreover, another focus of this study is to explain whether there is improvement in quality of life for the Hispanic male alcoholics who attend the alcoholism program. As previously defined, improvement of quality in life is the enhancement of coping skills in a non-addictive way, development of a sobriety support system, insight into and understanding of the changes occurring in the alcoholic's life (managing without the addictive substance, role change), integration in family life, and a feeling of overall satisfaction with life. Coping skills are taught in the clinic in the form of relapse prevention. These

mandatory relapse prevention groups are attended by all clients, including the DWI.

The value of teaching coping skills is illustrated by the following story: JM was 41 years old at the time of the study. He began using heroin at the age of 16 and started drinking a few years later; however, his drug of choice continued to be heroin. Although alcohol dependence was a secondary diagnosis, JM could not cope with the idea that he was an addict. He refused to attend Narcotics Anonymous(NA) meetings, and it took almost two years of treatment and AA attendance for JM to muster enough courage to go to NA. He realized that he needed to confront issues that he could not address in AA. Thus, JM was able to cope with his situation in a new and positive way and to stay with his decision to continue attending NA.

The necessity of involvement in AA becomes clear since the clinic only requires compliance from the clients to complete the program. Compliance, as the clinic's measure of success, means that the client keeps all counseling and medical appointments, attends all

required AA meetings, and is sober. This means that the client is free from the use of alcohol and any other mood altering drugs. To make sure of this, clients are breathalyzed randomly for alcohol content. Clients are also required to give urine and blood samples for alcohol and drug testing. If a client has complied with all of these requirements, he is given a letter of completion after the required amount of time in the program.

Although the clinic's measure of client success is compliance with treatment, the program goal is personal growth of the client helping him to feel comfortable with himself and confident that he can cope with life without alcohol or drugs. AA speaks of this process as surrendering—giving up the old self and becoming a new self.

Bateson, in "The Cybernetics of Self: A Theory of Alcoholism" (1972), explains the concept of surrendering as a recognition of defeat. According to Bateson (1972:313), "The experience of defeat not only serves to convince the alcoholic that a change is necessary; it is the first spiritual experience. The myth of

**self-power is thereby broken by the demonstration of greater power.”**

**In short, recovery for the alcoholic begins when he can admit that he has been defeated by alcohol. This is the act of surrender. The act and state of surrender induces a state of receptivity to new ideas and approaches to dealing with problems, and these, in turn, make possible recovery and a healthy adjustment by the alcoholic. For Bateson, AA is essential for a person to recover from alcoholism.**

**The Hispanic client who comes to the clinic knows that he is being accepted into a Spanish-speaking program with an Hispanic staff. This knowledge is important because, in many cases, it induces the client to keep his appointment. At least in the treatment situation, acculturation stress is not an issue for the clients, many of whom do not speak English fluently. Indeed, most of the clients remain within Hispanic culture. They speak only Spanish, live in Hispanic communities, and attend mostly Spanish AA. Many of the clients had connections with the old country, and many took time to visit their country during the treatment period. Only two clients in the study**

were experiencing psychological distress due to acculturation stress.

Overall this was not a significant experience among the clients.

The Hispanic alcoholic client redefines his view of reality and how it affects the quality of his life. He redesigns his life by internalizing what he has learned in the clinic and AA. In this way, he is able to restructure his life. However, both internalization and restructuring are time consuming. The client must give himself time to interact in the clinic and AA; to internalize and to put into practice the knowledge he acquires in the clinic and AA. Gorski (1989:8) says that "recovery is a process of growth that takes time. To go from stabilization to maintenance may require from 3 to 15 years."

In addition, the client must understand that he has an alcohol illness which will never be cured but can only be arrested. By incorporating into his life what he has learned from the clinic and AA, the client has an opportunity to change his perception of the world by slowly working on himself to learn to cope with difficult situations without the use of alcohol. In this way the client realizes that he has

the power and potential within himself to change. This is redesigning one's life by learning to use a more adaptive frame of reference.

#### DRY DRUNK SYNDROME

The dry drunk syndrome is a form of denial. This syndrome is revealed in persons who are unaware of the illness of alcoholism. Many Hispanic clients experience the dry drunk syndrome, but only the ones who break through it are likely to recover with the help of treatment and AA. At the beginning of treatment, many of the Hispanic clients think that if they stop, self-will – *fuera de voluntad* – is enough to maintain sobriety. Many become stuck in this phase for years, unaware of the consequences. The dry drunk syndrome is “intoxication without alcohol” (Solberg, 1983:3). “Persons who are experiencing a full-blown Dry Drunk are, for that period, removed from the world of sobriety, they fail, for whatever reason, to accept the necessary conditions for sober living. Their mental and emotional homes are chaotic, their approach to everyday living is unrealistic, and

their behavior, both verbal and physical, is unacceptable” (Solberg, 1983:3).

In Hispanic culture, as previously stated, drinking is an important aspect of being a man, being *macho*. Drinking, per se, is not considered to be a problem for Hispanic men. In addition, if a man is a good provider and takes care of his family, drinking is generally seen as his reward (Aviles-Roig, 1973; Panitz, et al., 1983). This aspect of the Hispanic culture was best demonstrated by the DWI clients, who came to the clinic in the evening. In general, they did not accept the label of “alcoholic.” They all complied with the program and graduated.<sup>14</sup> The image they had of an alcoholic was that of a skid row alcoholic, and they could not relate to this image.

When does drinking in excess become a problem for the Hispanic client? The answer is that drinking in excess becomes problematic when it creates conflict between coexisting value structures (Pittman, 1967). “The ambiguous or inadequate normative

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<sup>14</sup> With the exception of one DWI client, all the others did not adopt the required identity as an alcoholic to be considered in the process of recovery.

guidelines which characterize groups with ambivalent drinking norms are most likely to produce problem drinkers” (Bales, 1946). Both Hispanic culture and American culture are “ambivalent cultures,” in which these important guidelines are not provided. On the other hand, the message is that drinking enhances one’s life and/or image; on the other hand, the message is that drinking causes harm.

#### COUNSELOR’S ROLE

The clinic motivates the client to continue in AA because it views its own therapy as time-limited. It is not considered successful treatment if a client stays in the clinic for a long time. When he comes for treatment, he must learn to verbally communicate what is bothering him within the framework of his problem with alcohol. Learning to talk with the counselor is a difficult matter for most of the Hispanic clients. Even clients who have been in other treatment facilities find it a monumental task to open up to a counselor. It was difficult for the

evening clients, since many were there simply to fulfill a requirement, not because they felt they needed treatment.

The role of the counselor is to encourage each client to become involved in treatment. Trust is a big issue. It is among the concerns that are given focus in group and individual counseling, along with matters concerning the client's connection to AA.

Sometimes the two issues are linked. For instance, a client who had previously attended AA, and was basically familiar with it, informed his counselor that he would not continue attending AA because he no longer felt that it was for him. He had tried more than one AA group, and they made him feel uncomfortable. He was tired of people "snooping" about his life. The counselor listened and, in time, was able to help the client see AA in a different light. The client was not forced to return to AA until he and the counselor felt that he was ready to try again.

Rapport with the counselor was an important part of the client's eventual readiness. Through counseling he realized that he was

keeping secrets and that he felt ashamed of these secrets, since he had kept them for so many years. He needed to give himself time to unravel them, and he did not divulge them to his counselor. He unburdened himself, however, when he worked on the fourth and fifth steps of AA (see Appendix B for a list of the 12 steps of AA). The Hispanic male does not feel comfortable in situations that call for self-disclosure, but in the majority of cases the steps are helpful.

The client trusted his counselor enough to discuss his resentments and anger towards his mother and siblings. There were many indications that he was feeling better when he wanted to discuss returning to AA. Fein (1990) refers to the therapeutic alliance that occurs when the clinician and client work together on behalf of the client.

This therapeutic alliance is vital if the client is to recover. “As George Herbert Mead (1934) discovered many years ago, in order for people to interact meaningfully, they must have some idea of what others are trying to do. Both parties in a social interaction must be able

to put themselves in their role partner's place" (Fein, 1990:120). The counselor aids the client in managing his emotions in relation to the world around him. "Reality is never an individual construction" (Fein, 1990:128), and the client must learn to manage all of its intricacies.

Accordingly, the counselor plays a pivotal role in resocialization. In order for the counselor to enter his client's world, he or she must be able to experience it as if from the inside. To achieve this, the counselor must be a skillful "role taker." "Roles are patterns of interpersonal action that are guided by both internal and external directions. They are shaped by a person's plans, thoughts, and feelings, and by the demands made by others" (Fein, 1990: 4). Among the tools needed are empathy, self-knowledge, and social knowledge (Fein, 1990).

## INTERNALIZATION

Denzin (1987b) describes using Mead's concepts of "I" and "me,"<sup>15</sup> how the alcoholic internalizes the teachings of AA. The "sober I" learns how to be sober by taking the attitudes of sober selves who are members of AA. The AA group becomes a "generalized other" for the member. The significant symbols of the group (the steps) gradually call out, in the alcoholic, consensual self-understandings regarding AA and recovery. The symbolic meanings of the word "alcoholic" similarly come to be integrated into the member's inner dialogues regarding "I" and "me." A self thus emerges that is grounded in the symbols and meanings of self, alcohol, drinking, and alcoholism. As this new structure appears, old meanings of self, alcohol, and alcoholism are pushed aside.

## THE FAMILY: COMPARING TWO CLIENTS

The spouses of clients in treatment who are, themselves, involved in therapy or Al-Anon (groups for family or friends of

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<sup>15</sup> According to Mead (1934) the "I" (myself as I am) is involved in a continual interaction with the "me" (myself as others see me).

alcoholics) tend to do better than spouses who are not similarly involved. In the spring of 1994, for example, a client who had once become violent when drinking was celebrating his one-year anniversary of sobriety. He had been trying to stay sober since 1985, and although he'd had a life of hardship (including abandonment by his parents at the age of 12), he knew that if his hopes and expectations for his three children were to be different, then he had to recover and set his life in order. He loved his wife but would beat her each time he drank. His wife was receiving counseling from a family agency, and she was attending Al-Anon. At the end of 1992, the client noted changes in his wife, and this pushed him onto the road to recovery. He revealed in counseling that he was afraid that his wife might leave him if he didn't pull himself together. Hence, by the spring of 1994, he felt proud that he had been able to stay sober, prepare for the High School Equivalency Diploma (GED), and muster the courage to request a raise and promotion at his job. This combination of events created a happier home life.

On the other hand, a client who complied with all the requirements at the clinic, and who graduated that same spring of 1994, was not in recovery, but rather in a dry drunk syndrome. His wife was receiving public assistance and was not involved with AL-Anon. He attended AA only sporadically, and was seeing another woman.

The first client described above focused on the wellness of himself and his family by attending AA daily, participating in the daily activities of the family, being concerned with his children's health and education, attending church with his family, and caring about his wife's feelings. His success in recovery can be linked to his family involvement

In contrast, the other client had an attitude of indifference towards his family and, he was not involved in the daily activities of the home. He felt that it was a woman's work to care for the home and to be concerned about his children. The likelihood that this client would relapse was very high.

## RELAPSE AND RELAPSE PREVENTION

The clinic informs the client in small increments that time needs to be invested if recovery is to be a reality. It is hard for the client to understand that only when he is ready can he achieve what he so dearly desires.

Slips and relapses are a nightmare for alcoholics who want to enter the world of recovery. The clinic teaches the client to recognize when he is entering the realm of relapse. He is taught to be aware of his feelings and emotions as signs that must be heeded. Relapse prevention groups at the clinic teach an array of techniques and strategies to help clients prevent a relapse.

Relapse prevention therapy teaches the client that

relapse is more than just using alcohol or drugs. It is a process of becoming so dysfunctional in recovery that use seems like a reasonable choice. The process tends to follow an eight-step progression: (1) Getting stuck in recovery; (2) Denying being stuck; (3) Using other compulsions; (4) The trigger event; (5) Internal dysfunction; (6) External dysfunction; (7) Loss of control; (8) Relapse (Addiction & Recovery, August 1990: 40).

Relapse does not occur at the spur of the moment. It is a process that evolves through time, and if nothing is done to prevent it, then that first drink will be taken. The client is given a list of common

warning signs that might lead to a relapse. He is asked to keep this list with him and to read it daily. Some warning signs are: exhaustion (allowing yourself to become overly tired or in poor health), dishonesty (this begins with a pattern of unnecessary little lies and deceits with fellow workers, friends, family), wanting too much (setting goals that are not attainable with normal efforts), and expecting too much (it's always great when good things you were not expecting happen).

AA also deals with relapse issues. It asks the member to call his sponsor, or another AA member, if the urge to drink comes. This telephone call is known as "dime therapy or twelfth stepper." Talk is encouraged in AA, and this talk is focused on the problem of drinking and recovery. Relapsing becomes a problem for the alcoholic who has not committed himself to the identity of a "recovering alcoholic."

Denzin (1987a:88) defines a slip or relapse as

a complex social act that has four phases. In the first phase the alcoholic has a lapse into permissive thinking concerning his or her recovery program. This lapse into permissiveness may involve the alcoholic going into drinking places where old friends are present. In the second phase of the relapse the alcoholic actually buys a drink and drinks it. This signals the beginning of the third phase of the relapse, for drinking ends phase two. In the third phase the alcoholic gets drunk. This is the end of the

relapse. In the fourth phase the alcoholic, it is hoped, seeks help for the relapse. He or she may confess the just completed drinking episode to an AA group or to an alcoholism counselor.

Some clients hid the fact that a relapse had occurred, but they eventually confessed the deed. Others, as indicated in Chapter 2, wanted to stay on public assistance, and hence their relapse was on purpose. For most clients, however, the problem was that they needed to learn relapse prevention. As a client said, "Once you are in the world of treatment, it is hard to stay away. You keep coming back until you finally get it." The alcoholic is in a state of ambivalence. Until now he has rejected the label of "alcoholic." He is engaging in "impression management" to convey an image of who he thinks he is so that he can influence the "definition of the situation" (Goffman, 1959:3-4).

Ideally, the client finally decides to focus on his recovery by committing himself to treatment, and eventually to AA, through the act of surrender. In order to understand the journey of the client to reach this juncture, the meaning of the act of surrender, and the term spiritual awakening, must be understood.

## DEVELOPMENTAL MODEL OF RECOVERY AND THE 12 STEPS OF AA

The clinic adopted the developmental model of recovery (DMR) in 1992. This model which is explained in Brown's Treating the Alcoholic: A Developmental Model of Recovery, is combined with Gorski's work on recovery, and the 12 Steps of AA, to form the clinic's treatment approach. The developmental model of recovery views change as a process that occurs in stages. Each stage must be resolved before going on to the next stage. The basic tenet of the clinic's treatment approach, as well as of AA, is that alcohol addiction is a physical, mental, and spiritual disease. There are no conflicts between the clinic's approach and AA philosophy.

Once the client is accepted into the program, his primary worker gives him a schedule to follow. This schedule includes all the groups that the client must attend. There are four phases that the client needs to complete in order to graduate from the program; the first is orientation. In this phase the client is asked to look at step 1 of AA: "We admitted we were powerless over alcohol—that our lives had

become unmanageable” (Twelve Steps and Twelve Traditions, 1981).

This first step is the act of surrender. The client might not even realize that he has lost control. He admits to being an alcoholic, yet this is not necessarily acceptance. At this point, clients need help in turning their lives around. The client needs to learn that when he is no longer ashamed of his illness, then he is ready to accept not having control.

Many clients speak of controlled drinking in this stage. The belief that this is possible is discussed in the group session. Of the clients interviewed, 60% understood the definition of surrender, and 40% did not understand. At the same time, 70% scored “very good” in the alcohol education category, 30% scored “good,” and none scored “poor.” The orientation phase appears to be effective.

The other phases of treatment are phase I, phase II, and phase III. In phase I, the focus is relapse prevention and education. In this phase, step 2 and 3<sup>16</sup> are introduced in group session and individual

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<sup>16</sup> Step 2: Came to believe that a Power greater than ourselves could restore us to sanity.  
Step 3: Made a decision to turn our lives over to the care of God *as we understood Him* (italics in original) (Twelve Steps and Twelve Traditions, 1981)

counseling. The concept of a “higher power” is discussed. Clients are reminded to keep an open mind, especially if they are uncomfortable dealing with the idea of God. It is emphasized that the higher power is defined according to the clients understanding. Developing faith and trust in oneself and other human beings is the crux of the discussion in the counseling sessions.

After steps 2 and 3 are understood, steps 4 and 5<sup>17</sup> are introduced in counseling. The client is asked to write a “moral inventory”<sup>18</sup> in the form of a list. This is usually very difficult, for the clients; fears and keeping secrets are two of the topics that are discussed. In step 5, the client is asked to act upon step 4. Both of these steps look at loneliness and isolation. The client is encouraged to talk, at first about the most acute and obvious problems, since the steps are a lifetime practice. Later he has the time to deal with

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<sup>17</sup> Step 4: Made a searching and fearless moral inventory of ourselves. Step 5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs (Twelve Steps and Twelve Traditions, 1981).

<sup>18</sup> A moral inventory is a vigorously, soul-searching evaluation of the alcoholic’s past behavior made by the alcoholic in the form of a list.

problems that he is not yet ready to reveal. Here the important concept of “humility” is introduced.

In phase II, clients begin to deal with personal and vocational issues. Therapy becomes more intensive. In this phase, steps 6, 7, 8, and 9<sup>19</sup> are introduced. For Gorski, this is middle recovery, where the alcoholic begins to look at his past damage and starts to put balance into his life. He begins to repair hurt relationships, and action becomes a priority. In the steps, the client is encouraged to look at his “character defects,” such as envy, jealousy and others, and to improve his attitude towards life. In step 7, he is reminded that he is not alone in the world and that it is okay to make mistakes—no one is perfect. Steps 8 and 9 put the client in a position to reexperience pain by requesting that he make out a list of the people he has harmed. Later he is to contact these people and ask for their forgiveness.

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<sup>19</sup> Step 6: Were entirely ready to have God remove all these defects of character. Step 7: Humbly asked Him to remove our shortcomings. Step 8; Made a list of all persons we had harmed, and became willing to make amends to them all. Step 9: Made direct amends to such people wherever possible, except when to do so would injure them or others (Twelve Steps and Twelve Traditions, 1981).

In phase III, the client is taught stress management and how to develop a strong support system. The steps included in this phase are 10, 11, and 12.<sup>20</sup> Step 12 is the step that incorporates all the other steps. This is why AA is called a way of life: these 12 steps are a guide to a better life, and as such they never end.

In Gorski's s recovery schema, steps 10 and 11 are considered "late recovery" while step 12 is referred to as "maintenance." In late recovery, the alcoholic focuses on overcoming obstacles to healthy living. Thus, step 10 encourages the client to put what he has learned into practice: "to put our AA way of living to practical use, day by day, in fair weather or foul" (Twelve Steps and Twelve Traditions, 1953:84). The clients are told, "We need not be discouraged when we fall into the error of our old ways, for these disciplines are not easy.

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<sup>20</sup> Step 10: Continued to take personal inventory and when we were wrong promptly admitted it. Step 11: Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out (italics in the original). Step 12: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs (Twelve Steps and Twelve Traditions, 1981).

**We shall look for progress, not perfection” (Twelve Steps and Twelve Traditions, 1953:91). In step 11, the client is encouraged to pray and meditate. He learns, in this step, to deal with the world as it is, not as he wishes it could be. He learns to help another alcoholic by becoming someone’s sponsor; not to take “another’s inventory;” to find strength in prayer, and to develop a sense of belonging through prayer.**

**In step 12, he realizes that he is able to “do, feel, and believe.” This is a spiritual awakening. It is different for each person, but the common ingredients are having peace of mind and simply liking who you are. In maintenance, the final stage of Gorski’s scheme, the alcoholic learns that he must continue to grow and develop as a person. Alcohol and other drugs cannot be used safely, and the individual must “practice a daily recovery program to keep addictive thinking from returning.” Brown (1985:61) characterizes the phase-specific developmental model of recovery as**

**the integration of Piagetian and dynamic concepts that forms the analogy for the ongoing dynamic process of recovery. That process involves the development of a new structure of the self, based on the new identity as an alcoholic. Within that**

**new structure increasingly mature and complex behavioral cognitive and affective development occurs. This rudimentary explanation sets the stage for understanding the phase-specific developmental tasks of recovery.**

**Brown (1985:61) goes on to explain that the importance of the developmental emphasis in the model of recovery is found in Piaget's idea that as the child develops he becomes more mature and is able to assimilate and accommodate to changes. The process of recovery can be viewed as a progressive interplay between assimilation and accommodation, organizing the development of a new, mature structure.**

**In the final analysis, for a new life to emerge, the seeds of recovery must be planted. This means that the client has accepted his situation in life and is willing to work hard to achieve recovery. He accepts that completing a treatment program is necessary and that AA is a way of life. Brown, Gorski, and Denzin are expressing the same point: that the alcoholic needs both professional help and AA in order to obtain a new and meaningful life.**

## **CHAPTER EIGHT**

### **RESULTS AND DISCUSSIONS**

**In this chapter, data will be presented on scale construction and the demographic background of the respondents. Results will then be presented on the relationships between client participation, on the one hand, and the factors of demographics, social isolation, recovery, and family living situation, on the other.**

#### **PRELIMINARY ANALYSES**

**Table 8. 1 presents the frequencies and distributions of the clients in this study on demographic background variables. Eleven (29.7%) were born in Puerto Rico, eight (21.6%) came from Central America, five (13.5%) came from the Dominican Republic, four (10.8%) were born in the United States, three (8.1%) were Cuban, and six (16.2%) came from other countries (South America and Spain).**

**TABLE 8.1**  
**FREQUENCIES AND DISTRIBUTIONS OF CLIENTS ON**  
**DEMOGRAPHIC VARIABLES (N=37)**

VARIABLE	n	%
<b>COUNTRY OF ORIGIN</b>		
Puerto Rico	11	29.7
Central America	8	21.6
Dominican Republic	5	13.5
USA	4	10.8
Cuba	3	8.1
Other	6	16.2
<b>RELIGION</b>		
Catholic	33	89.2
Protestant	3	8.1
None	1	2.7
<b>MARITAL STATUS</b>		
Single	10	27.0
Married	10	27.0
Separated/Divorced	17	45.9
<b>EMPLOYMENT STATUS</b>		
Employed	14	37.8
Unemployed	23	62.2
<b>LITERATE</b>		
Yes	34	91.9
No	3	8.1

Thirty-three (89.2%) of the clients – the vast majority –  
were catholic, three (8.1%) were Protestant, and one (2.7%) claimed  
no religious

affiliation. Nearly half (45.9%) were separated or divorced, and the rest were evenly split (27.0% each) between never married and married. Nearly all (91.9%) were literate. Almost two-thirds (62.2%) were unemployed.

Table 8. 2 contains the mean, standard deviation, and the range of continuous demographic indicators. The mean age of the participants in the study was 42.24 years ( $SD = 7.05$ , range = 28-59). The mean number of years in the United States was 19.49 ( $SD = 10.97$ ). Participants had been in the United States from 3 to 46 years. Years of schooling ranged from none to college graduate, with a mean of 9.22 years ( $SD = 3.71$ ).

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TABLE 8.2

MEANS AND STANDARD DEVIATIONS OF CLIENTS ON DEMOGRAPHIC VARIABLES (N=37)

VARIABLE	M	SD	RANGE
Age	42.24	7.05	28 - 59
Years in the U.S.	19.49	10.97	3 - 46
Years of Schooling	9.22	3.71	0 - 16

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The sample consisted of Hispanic men, most of whom were born on Caribbean islands but had spent, on average, about 20 years in the U.S. Most had less than a high school education and were unemployed. Most were over 40 years old.

Nearly all were Catholic and nearly all were literate. Most were single or divorced.

#### PROGRAM PARTICIPATION

Table 8.3 presents the frequencies and distributions of the participants on program variables. Nearly three-fourths (73.0%) were in the day program, with the remainder in the evening program. The most common source of referral to the program was family agencies (29.7%), followed by self referrals (27.0). (In reality, there was only one self referral, even though many responded that they were). Court mandated referrals accounted for an additional 18.9%, and the welfare department added 8.1%. Referrals from other sources accounted for another 16.2%.

The majority (56.8%) had previously been in treatment for alcoholism. Sixteen and two-tenths had been in previous treatment once, 21.6% twice, 13.5% three times, and 5.4% four or five times.

Ten (27.0%) had experienced relapses in the program, four (10.8%) of whom stayed, and six (16.2%) of whom left. The other 27 (73.0%) had not relapsed. Among the latter group, 13 (35.1%) stayed in the program and 14 (37.8%) left.

**TABLE 8.3**  
**FREQUENCIES AND DISTRIBUTIONS OF CLIENTS ON PROGRAM VARIABLES**  
**(N=37)**

VARIABLE	n	%
<b>PROGRAM</b>		
Day	27	73.0
Evening	10	27.0
<b>SOURCE OF REFERRAL</b>		
Family Agency	11	29.7
Self	10	27.0
Court	7	18.9
Welfare	3	8.1
Other	6	16.2
<b>PREVIOUS TREATMENT</b>		
Yes	21	56.8
No	16	43.2
<b># OF TIMES IN PREVIOUS TREATMENT</b>		
0	16	43.2
1	6	16.2
2	8	21.6
3	5	13.5
4 - 5	2	5.4
<b>RELAPSE STATUS</b>		
Relapsed/Stayed in Program	4	10.8
No Relapse/Stayed in Program	13	35.1
No relapse/ Did not stay	14	37.8
Relapsed/ Did not stay	6	16.2
<b>DWI</b>		
Yes	12	32.4
No	25	67.6

Table 8. 4 contains the means and standard deviations on length of sobriety and length of time in the program. The mean number of months clients had remained sober was 12.84 ( $SD = 13.06$ ). Clients had been sober between 1 and 48 months. The mean number of months in the program was 13.89 ( $SD = 17.42$ ). The length of time spent in the program ranged from 0 to 72 months.

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TABLE 8.4  
MEANS AND STANDARD DEVIATIONS OF CLIENTS ON PROGRAM  
VARIABLES (N=37)

VARIABLE	M	SD	RANGE
Months Sober	12.84	13.06	1 - 48
Months in Program	13.89	17.42	0 - 72

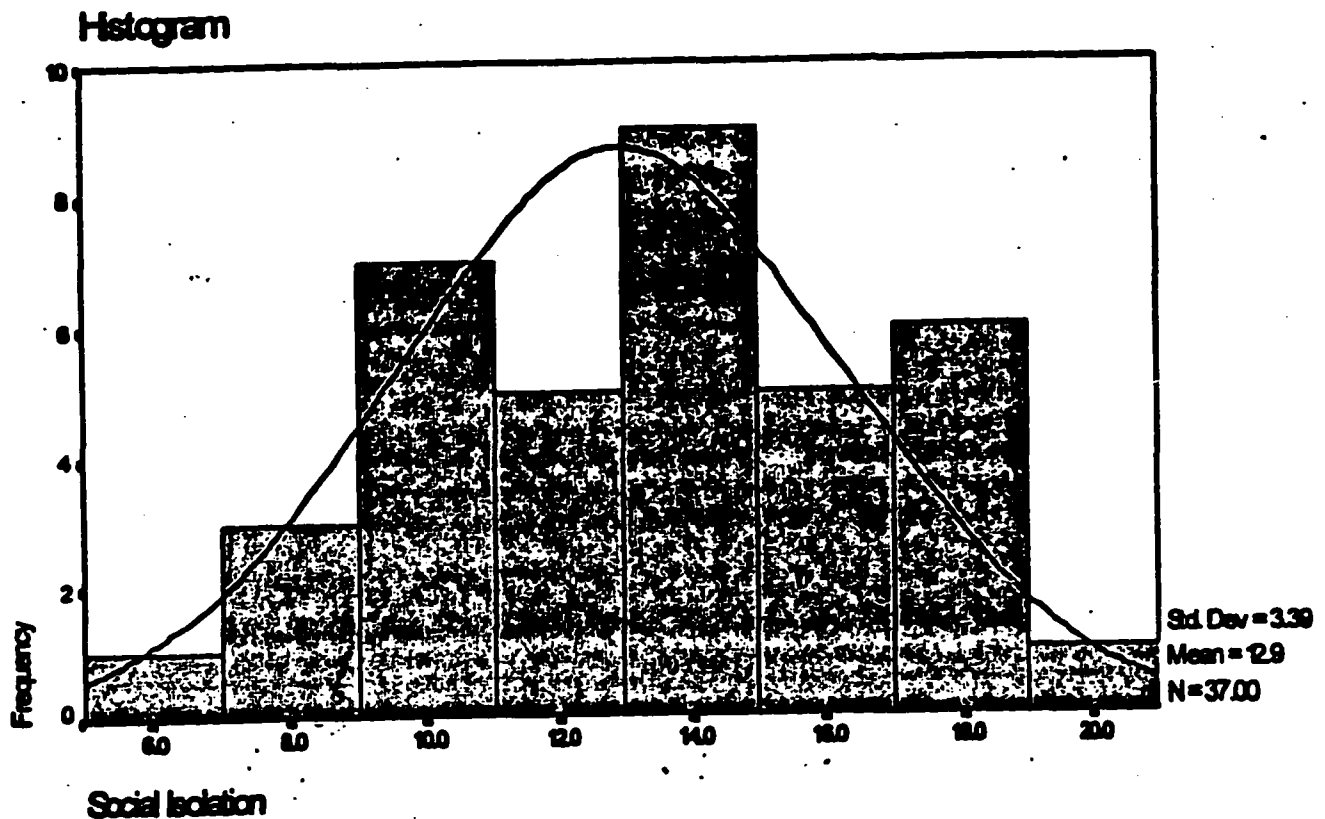
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The program participants had been enrolled in the program for about a year. They had been sober for a similar length of time. Most were in the day program and most had

received prior treatment for alcoholism. Approximately one quarter were self referred (as reported in the survey by the client but as previously mentioned when checked with the clinic's charts, there was only one self-referral); the others were referred by a variety of agencies. About one-quarter had experienced a relapse; slightly less than half of those who relapsed remained in the program after assessment.

#### SOCIAL ISOLATION SCALE

The social isolation scale initially consisted of 10 items anchored to a five-point Likert-type response mode. However, the internal consistency of the scale was low ( $\alpha = .27$ ). Therefore, an effort was made to improve the internal consistency of the scale by removing items in a stepwise matter. Those having the lowest item-to-scale correlations were removed first. Internal consistency reliability was improved to  $\alpha = .53$  for a five-item scale. The scale had a mean of 12.91, with a standard deviation of 3.39. Figure 1 contains a graphical presentation of the distribution of scores around the mean. Scores approximated a normal distribution (skewness = 0.09; kurtosis = 0.68).



**FIGURE 8.1: HISTOGRAM OF SOCIAL ISOLATION WITH A NORMAL CURVE SUPERIMPOSED**

#### PROGRAM PARTICIPATION/DEMOGRAPHICS

In this section, relationships between background variables and program participation are presented. Table 8.5 presents correlations between age and educational background and program participation.

TABLE 8.5			
CORRELATIONS OF AGE AND YEARS OF EDUCATION WITH PARTICIPATION (N=37)			
PARTICIPATION		AGE	YEARS OF EDUCATION
	IN THE PROGRAM		
Attendance		.05	-.08
# of Groups		-.04	.08
# Sessions per Month		-.29*	.18
Attend without Appointment		.02	-.23
Phase		-.13	-.02
Days per Week in Dayroom		-.12	.19
# of Voc/Rehab Groups		-.47*	-.18
# Friends in the Clinic		-.13	.07
Socialize with Friends Outside Clinic		.04	.29
Satisfaction with Treatment		.05	-.20
	IN AA		
Meetings per Week		-.22	.01
Talks per Week with Sponsor		-.31	-.12
Help at AA Meetings		-.17	-.03
# of Times Qualified / stories		-.41**	.07
Socialized with AA Friends Outside Meetings		..34*	-.23
Length of Membership		.18	-.18
# Friends Made in AA		-.18	-.15

\*p < .10; \*\*p < .05

The data in Table 8.5 indicate that educational background has no significant relationship with the participation variables. There are several significant relationships between age and participation. Younger men are likely to have more sessions with the counselors per month than older men ( $r = -.29, p < .10$ ) and to participate in more vocational rehabilitation groups ( $r = -.47, p < .05$ ). They are also more likely to qualify in AA ( $r = -.41, p < .05$ ). However, older men are more likely to socialize outside the program with friends they have made in AA ( $r = .34, p < .10$ ).

TABLE 8.6  
ANALYSIS OF MARITAL STATUS WITH PARTICIPATION IN AA (N=30)

PARTICIPATION	MARITAL STATUS			F
	Single (n = 10)	Married (n = 10)	Divorced (n=17)	
Attendance				
M	2.30	2.50	3.29	2.46
SD	1.16	1.18	1.32	
of Groups				
M	1.80	2.40	3.00	1.88
SD	1.93	1.35	1.46	
# Sessions per Month				
M	2.00	1.60	1.31	1.27
SD	1.49	0.97	0.79	
Attend without Appointment				
M	44.44	40.00	35.29	0.10
SD	5.27	5.16	4.93	
Phase				
M	2.90	2.30	1.64	4.67**
SD	1.29	0.95	0.93	
Days per Week in Dayroom				
M	2.80	1.80	3.20	2.18
SD	1.40	1.75	1.74	
# of Voc/Rehab Groups				
M	3.50	0.75	1.16	2.90*
SD	3.10	0.50	0.98	
Friends in the Clinic				
M	3.40	3.80	3.29	0.89
SD	0.97	0.42	1.16	
% Socialize with Friends Outside Clinic				
M	44.44	25.00	6.67	2.53*
SD	5.27	4.26	2.85	
Satisfaction with Treatment				
M	1.90	1.70	1.94	0.15
SD	0.99	0.95	1.30	

Note, a single > Divorced,  $p < .05$ .

\* $p < .10$ ; \*\* $P < .05$

TABLE 8.7  
ANALYSIS OF VARIANCE OF MARITAL STATUS WITH PARTICIPATION IN AA (N=30)

PARTICIPATION	MARITAL STATUS			F
	Single (n = 7)	Married (n = 9)	Divorced (n=14)	
Meetings per Week				
M	3.14	2.20	1.73	2.90*
SD	1.21	1.22	1.34	
Talks per Week with Sponsor				
M	3.00	2.60	2.00	0.36
SD	0.63	1.94	2.64	
Help at AA Meetings				
M	3.86	1.78	1.93	4.03**
SD	1.57	1.56	1.68	
# of Times Qualified				
M	3.71	2.11	1.84	2.95*
SD	1.60	2.03	1.46	
Socialize with AA Friends Outside Meetings				
M	2.29	2.56	3.58	3.01*
SD	1.25	1.51	1.00	
Length of Membership				
M	4.42	3.44	3.80	0.85
SD	0.79	1.87	1.48	
# Friends Made in AA				
M	3.57	3.22	2.38	2.55*
SD	0.53	1.31	1.39	

\*p < .10; \*\*p < .05

The data in Table 8. 6 indicate that single participants were in later phases of their rehabilitation programs more often than divorced men ( $F=4.67, p < .05$ ). This may indicate that divorced men do not proceed in the treatment program as positively as single men. Also, single men participated in more vocational/rehabilitation groups than married or divorced men ( $F = 2.90, p < .10$ ). Divorced men were less likely to socialize with friends outside the clinic than single or married men ( $F = 2.53, p < .10$ ). It appears that single clients invested more time in their alcohol treatment than married or divorced clients. The reason for this might be that single men have more free time than married or divorced men. Also, single men have fewer responsibilities at home and are able to spend more time socializing with friends. Married or divorced clients may have less need to socialize outside the home since many of their social needs are met by the family. Evening clients, with one exception, were married. And many of the divorced clients were in contact with their family of origin, former spouse, and children, even if they reported (for purposes of public assistance) that they were not.

The data in Table 8. 7 indicate that single men generally participated more in AA than married and divorced men. They attended more meetings per week ( $F = 2.90, p < .10$ ), helped more at meetings ( $F = 4.03, p < .05$ ), qualified more often ( $F = 2.95, p < .10$ ), and made more friends in AA ( $F =$

2.55,  $p < .10$ ). Divorced men were more likely to socialize outside the meetings ( $F=3.01$ ,  $p<.10$ ) with friends made in AA.

TABLE 8.8

## PROGRAM PARTICIPATION FOR DAY AND EVENING PROGRAM PARTICIPANTS (N=37)

PARTICIPATION	PROGRAM		t
	Day (n = 27)	Evening (n=10)	
Attendance			
M	3.11	2.00	4.14***
SD	1.36	0.00	
# of Groups			
M	2.70	2.00	1.97**
SD	1.85	0.00	
# Sessions per Month			
M	1.74	1.11	2.46**
SD	1.20	0.33	
Attend without Appointment			
M	0.46	0.20	1.57
SD	0.51	0.42	
Phase			
M	2.22	2.00	0.86
SD	1.34	0.00	
Days per Week in Dayroom			
M	3.22	0.88	4.14***
SD	1.50	0.99	
Friends in the Clinic			
M	3.41	3.60	-0.54
SD	0.97	0.97	
Socialize Outside Clinic			
M	0.29	0.00	3.08***
SD	0.46	0.00	
Satisf. with Treatment			
M	1.78	2.10	-0.68
SD	1.01	1.37	

\*p &lt; .10; \*\*p &lt; .05; \*\*\*p &lt; .01

The data in Table 8. 8 indicate that day clients were more active in their program participation than those in the evening program. Their clinic attendance was higher ( $t = 4.14, p < .01$ ), they attended more groups ( $t = 1.97, p < .05$ ), they attended more individual sessions per month ( $t = 2.46, p < .05$ ), they spent more days in the day room per week per week ( $t = 4.14, p < .01$ ), and they socialized more often outside the clinic ( $t = 3.08, p < .01$ ) with friends from the program.

TABLE 8.9

## PARTICIPATION IN AA FOR DAY AND EVENING PROGRAM PARTICIPANTS (N=32)

PARTICIPATION	PROGRAM		t
	Day (n = 25)	Evening (n = 7)	
Meetings per Week			
M	2.40	1.42	1.73*
SD	1.41	0.79	
Talks per Week with Sponsor			
M	2.83	1.50	1.10
SD	1.64	0.71	
Help at AA Meetings			
M	2.73	1.25	3.33***
SD	1.93	0.46	
# Of Times Qualified			
M	2.54	1.86	1.00
SD	1.90	1.46	
Socialize with AA Friends outside Meetings			
M	2.67	3.71	-2.51**
SD	1.39	0.76	
Length of Membership			
M	4.05	3.28	1.17
SD	1.39	1.70	
Friends Made in AA			
M	2.95	2.85	0.17
SD	1.29	1.35	

\*p < .10; \*\*p < .05; \*\*\*p < .01

Twenty-five of the day clients and seven of the evening clients were members of AA. As in program participation, day participants tended to be more active in AA than evening participants, although differences were less pronounced. Day clinic participants attended more AA meetings per week ( $t = 1.73, p < .10$ ) and helped more at meetings ( $t = 3.33, p < .10$ ). However, evening participants tended to socialize with AA friends outside of meetings more than day participants ( $t = 2.51, p < .05$ ).

Tables 8.10 and 8.11 present program participation and AA participation for those who have had previous treatment and those who have not had previous treatment. Those who have had previous treatment attended more individual sessions per month ( $t = 1.74, p < .10$ ), spent more days per week in the day room ( $t = 2.16, p < .05$ ), and socialized more often outside the clinic with friends from the program ( $t = 1.78, p < .10$ ). The only significant difference in AA participation was that those who had previously been in treatment had been members of AA longer than those who had not previously been in treatment ( $t = 2.53, p < .10$ ).

TABLE 8.10

## PROGRAM PARTICIPATION BY PREVIOUS TREATMENT (N=37)

PARTICIPATION	PREVIOUS TREATMENT		t
	Yes (n = 21)	No (n = 16)	
<b>Attendance</b>			
M	2.95	2.63	0.77
SD	1.36	1.20	
<b># of Groups</b>			
M	2.47	2.56	-0.17
SD	1.94	1.09	
<b># Sessions per Month</b>			
M	1.80	1.27	1.74*
SD	1.33	0.46	
<b>Attend without Appointment</b>			
M	0.45	0.31	0.83
SD	0.51	0.47	
<b>Phase</b>			
M	2.28	2.00	0.78
SD	1.27	0.97	
<b>Days per Week in Dayroom</b>			
M	3.20	2.00	2.16**
SD	1.57	1.69	
<b>Friends in the Clinic</b>			
M	3.42	3.50	-0.22
SD	0.93	1.03	
<b>Socialize Outside Clinic</b>			
M	0.32	0.08	1.78*
SD	0.48	0.28	
<b>Satisf. with Treatment</b>			
M	1.90	1.81	0.25
SD	1.22	0.98	

\*p &lt; .10; \*\*p &lt; .05; \*\*\*p &lt; .01

TABLE 8.11

## PARTICIPATION IN AA BY PREVIOUS TREATMENT (N=32)

PARTICIPATION	PREVIOUS TREATMENT		t
	Yes (n = 18)	No (n = 14)	
Meetings per Week			
M	2.50	1.78	1.51
SD	1.50	1.05	
Talks per Week with Sponsor			
M	2.00	3.00	1.13
SD	1.58	1.58	
Help at AA Meetings			
M	2.41	2.23	0.27
SD	1.87	1.74	
# of Times Qualified			
M	2.58	2.08	0.74
SD	1.91	1.68	
Socialize with AA Friends Outside Meetings			
M	2.69	3.25	1.11
SD	1.25	1.42	
Length of Membership			
M	4.47	3.00	2.53
SD	0.83	1.79	
# Friends Made in AA			
M	3.06	2.75	0.63
SD	1.24	1.36	

\*p < .10; \*\*p < .05; \*\*\*p < .01

Tables 8. 12 and 8. 13 contain the results of the analyses of participation in the program and in AA, comparing employed and unemployed participants. Unemployed participants had higher rates of attendance in the program ( $t = -2.28, p < .05$ ), spent more days per week in the day room ( $t = -2.79, p < .01$ ), and socialized outside the clinic more ( $t = -3.20, p < .01$ ) than employed participants.

There were fewer differences between employed and unemployed participants in their participation in AA. Employed participants socialized with AA friends outside AA meetings more frequently than unemployed participants ( $t = 1.76, p < .10$ ). The data suggest that unemployed participants socialize with other program participants outside the clinic, while employed participants seem to socialize more with fellow AA members outside the AA program.

TABLE 8.12  
PROGRAM PARTICIPATION BY EMPLOYMENT STATUS (N=37)

PARTICIPATION	EMPLOYED		t
	Yes (n = 21)	No (n = 16)	
<b>Attendance</b>			
M	2.28	3.13	-2.28**
SD	0.83	1.42	
<b># of Groups</b>			
M	2.42	2.56	-0.25
SD	1.56	1.67	
<b># Sessions per Month</b>			
M	1.38	1.70	-0.83
SD	0.87	1.18	
<b>Attend without Appointment</b>			
M	0.23	0.48	-1.53
SD	0.43	0.51	
<b>Phase</b>			
M	2.00	2.26	-0.78
SD	0.68	1.35	
<b>Days per Week in Dayroom</b>			
M	1.67	3.21	-2.79***
SD	1.56	1.57	
<b># Friends in the Clinic</b>			
M	3.64	3.34	0.90
SD	0.84	1.03	
<b>Socialize Outside Clinic</b>			
M	0.00	0.35	-3.20***
SD	0.00	0.48	
<b>Satisf. with Treatment</b>			
M	2.07	1.73	0.88
SD	1.27	1.01	

\*p < .10; \*\*p < .05; \*\*\*p < .01

TABLE 8.13

## PARTICIPATION IN AA BY EMPLOYMENT STATUS (N=32)

PARTICIPATION	EMPLOYED		t
	Yes (n = 21)	No (n=11)	
Meetings per Week			
M	2.09	2.23	0.29
SD	1.38	1.38	
Talks per week with Sponsor			
M	2.83	2.50	0.37
SD	1.47	1.77	
Help at AA Meetings			
M	1.82	2.63	-1.21
SD	1.66	1.83	
# of Times Qualified			
M	1.90	2.63	-1.12
SD	1.52	1.92	
Socialized with AA Friends Outside Meetings			
M	3.50	2.61	1.76*
SD	1.08	1.38	
Length of Membership			
M	3.50	4.06	-0.93
SD	1.51	1.48	
# Friends Made in AA			
M	3.10	2.84	0.51
SD	1.20	1.34	

\*p &lt; .10; \*\*p &lt; .05; \*\*\*p &lt; .01

## SOCIAL ISOLATION SCORES

Table 8.14 contains the results of the correlations of social isolation scores with participation indicators. The data indicate that those participants who had higher social isolation scores were more likely to attend the program without appointments ( $r = .41, p < .05$ ) and were enrolled in more vocational/rehabilitation groups ( $r = .43, p < .01$ ). Participants with higher isolation scores tended to talk more often with their sponsor ( $r = .47, p < .10$ ). These data suggest that one of the latent functions of the program is to provide a hangout for persons who are socially isolated.

TABLE 8.14  
CORRELATIONS SOCIAL ISOLATION WITH PARTICIPATION

PARTICIPATION	SOCIAL ISOLATION
IN THE PROGRAM(N=37)	
Attendance	.10
# of Groups	.07
# Sessions per Month	.20
Attend without Appointment	.41**
Phase	.00
Days per Week in Dayroom	.08
# of Voc/Rehab Groups	.43***
# Friends in the Clinic	-.23
Socialize with Friends Outside Clinic	.16
Satisfaction with Treatment	.27
IN AA (N = 32)	
Meetings per Week	.24
Talks per Week with Sponsor	.47*
Help at AA Meetings	.02
# of Times Qualified	.23
Socialize with AA Friends Outside Meetings	-.06
Length of Membership	.34
# Friends Made in AA	.13

\*p < .10; \*\*p < .05

## RECOVERY STATUS

As described above, respondents were classified in terms of their recovery and program status. These two variables provided four categories of recovery status: (a) relapsed/stayed in the program, (b) no relapse/stayed in the program, (c) no relapse/ did not stay, and (d) relapsed/did not stay. The four groups were compared on their participation levels in the program using oneway analyses of variance with Scheffe range tests for post hoc comparisons. The results are presented in Table 8.15.

The data in Table 8.15 indicate that those who relapsed had higher levels of attendance than those who did not ( $F[3,34] = 5.49, p < .01$ ). Those who did not relapse and stayed in the program were in higher phases of treatment than other participants ( $F[3,34] = 3.45, p < .05$ ). Those who relapsed tended to spend more days in the day room than those who did not relapse ( $F[3,34] = 2.52, p < .10$ ).

Table 8.16 presents the results of the analyses of variance for AA participation for the 32 participants who were in AA. There were no significant between-group differences on any of the AA participation variables.

TABLE 8.15

## COMPARISON OF RECOVERY GROUPS ON PARTICIPATION (N=37)

PARTICIPATION	1 Relapse/ Stayed (n = 4)	2 No Relapse/ Stayed (n = 13)	3 No Relapse/ Did not Stay (n = 14)	4 Relapse/ Did not Stay (n = 6)	t
<b>Attendance</b>					
M	4.00	2.23	2.50	4.00	5.49***
SD	0.82	0.93	1.40	0.63	
<b># of Groups</b>					
M	3.25	2.15	2.21	3.50	1.46
SD	2.75	1.57	1.31	1.22	
<b># of Sessions</b>					
M	1.75	1.92	1.46	1.00	1.12
SD	1.50	1.32	0.88	0.00	
<b>No Appoint.</b>					
M	0.67	0.46	0.36	0.17	0.82
SD	0.58	0.51	0.50	0.41	
<b># Visits per Week</b>					
M	1.50	1.15	1.07	0.83	0.10
SD	2.38	1.72	1.81	2.04	
<b>Phase</b>					
M	1.75	2.85	2.00	1.33	3.45**
SD	1.50	1.21	0.78	0.82	
<b># Days used Dayroom</b>					
M	3.50	2.50	2.00	4.00	2.52*
SD	1.73	1.24	2.08	0.63	
<b>In Voc/Rehab</b>					
M	0.50	0.38	0.29	0.17	0.48
SD	0.58	0.51	0.47	0.41	
<b># Friends</b>					
M	3.00	3.84	3.21	3.50	1.35
SD	1.41	0.37	1.25	0.55	

Notes. aScheffe Ranges 4 > 2.

\*p < .10; \*\*p < .05; \*\*\*p < .01

TABLE 8.16  
COMPARISON OF RECOVERY GROUPS ON AA PARTICIPATION (N=32)

PARTICIPATION	1 Relapse/ Stayed (n = 4)	2 No Relapse/ Stayed (n = 10)	3 No Relapse/ Did not Stay (n = 13)	4 Relapse/ /Did not Stay (n = 5)	F
<b>Attendance</b>					
M	2.75	2.50	2.08	1.40	1.00
SD	1.71	1.18	1.55	0.55	
<b>% Homegroup</b>					
M	66.67	66.67	88.89	50.00	0.87
SD	5.77	4.92	3.33	5.47	
<b>% Sponsor</b>					
M	66.67	58.33	44.44	16.67	0.83
SD	5.77	6.69	5.27	4.08	
<b>Help at Meetings</b>					
M	2.33	2.58	2.00	2.33	0.17
SD	2.31	1.93	1.41	2.16	
<b>Qualification</b>					
M	1.33	2.58	2.88	1.83	0.75
SD	0.58	2.02	1.81	1.72	
<b># of Friends</b>					
M	2.67	3.17	3.37	2.00	1.67
SD	1.52	1.11	1.06	1.54	
<b>Socialize</b>					
M	4.00	2.91	2.62	3.00	0.55
SD	0.00	1.16	1.51	1.67	
<b>Time in AA</b>					
M	4.33	4.00	4.25	2.25	2.13
SD	1.15	1.61	0.89	1.70	

## FAMILY LIVING SITUATION

Respondents were categorized on the basis of whether they were living with their family. Of the 37 participants, 22 did not live with another family member, and 15 did. The two groups were compared on the participation variables using t-tests.

Table 8.17 presents the results of the comparisons for program participation. Those living with their families tended to attend more individual sessions per month than those who were not living with family members ( $t = -1.69, p < .10$ ). A greater percentage of those living with family members socialized with other program participants outside the clinic than those not living with their family ( $t = -2.19, p < .05$ ).

The data in Table 8.18 indicate that those not living with their family were more likely to socialize with AA friends outside AA meetings ( $t = 2.19, p < .05$ ). This suggests that those who live with their family are more likely to socialize with other program members, while those who do not live with their family are more likely to socialize with friends made in AA.

**TABLE 8.17**  
**PROGRAM PARTICIPATION FOR PARTICIPANTS WHO DO AND DO NOT LIVE WITH THEIR**  
**FAMILY (N=37)**

PARTICIPATION	LIVE WITH FAMILY		t
	No (n = 22)	Yes (n=15)	
<b>Attendance</b>			
M	3.00	2.53	1.09
SD	1.34	1.19	
<b># of Groups</b>			
M	2.59	2.40	0.35
SD	1.76	1.40	
<b># Sessions per Month</b>			
M	1.33	1.93	-1.69*
SD	0.97	1.16	
<b>Attend without Appointment</b>			
M	38.10	40.00	-0.11
SD	4.98	5.07	
<b>Phase</b>			
M	1.95	2.47	-1.35
SD	1.09	1.19	
<b>Days per Week in Dayroom</b>			
M	2.80	2.53	0.45
SD	1.82	1.60	
<b>Friends in the Clinic</b>			
M	3.36	3.60	-0.73
SD	1.05	0.83	
<b>Socialize Outside Clinic</b>			
M	10.00	41.67	-2.19**
SD	3.08	5.15	
<b>Satisf. with Treatment</b>			
M	2.05	1.60	1.21
SD	1.21	0.91	

\*p < .10; \*\*p < .05; \*\*\*p < .01

**TABLE 8.18**  
**PARTICIPATION IN AA FOR PARTICIPANTS WHO DO AND DO NOT LIVE WITH THEIR FAMILY**  
**(N=32)**

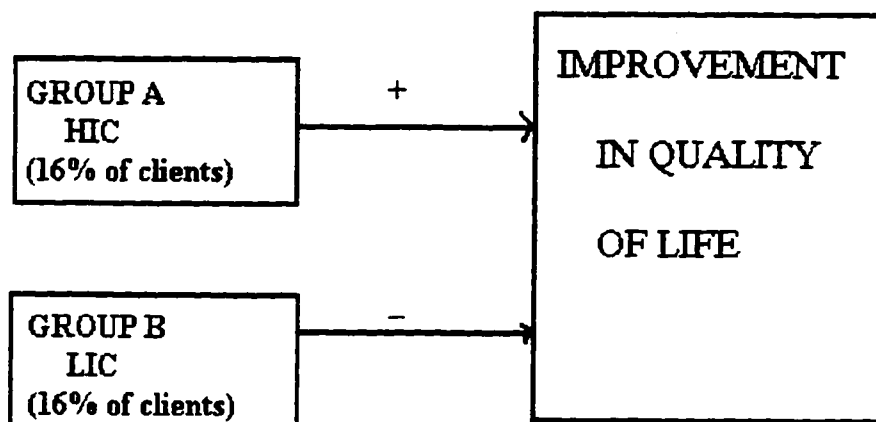
PARTICIPATION	LIVE WITH FAMILY		t
	No (n=18)	Yes (n=14)	
<b>Meetings per Week</b>			
M	2.11	2.28	-0.36
SD	1.45	1.27	
<b>Talks per Week with Sponsor</b>			
M	2.42	2.86	-0.49
SD	1.71	1.57	
<b>Help at AA Meetings</b>			
M	2.39	2.25	0.21
SD	1.91	1.65	
<b># of Times Qualified</b>			
M	2.29	2.50	-0.30
SD	1.72	1.98	
<b>Socialized with AA Friends Outside Meetings</b>			
M	3.38	2.33	2.19**
SD	1.14	1.37	
<b>Length of Membership</b>			
M	3.79	3.91	-0.21
SD	1.31	1.73	
<b># Friends Made in AA</b>			
M	2.71	3.25	-1.13
SD	1.36	1.14	

\*p < .10; \*\* < .05; \*\*\*p < .01

## COMPARASION OF THE HIGHLY INVOLVED CLIENTS (HIC) WITH THE LEAST INVOLVED CLIENTS (LIC)

This section compares the highly involved clients (HIC) with the least involved clients (LIC) by creating two groups: Group A is the HIC and Group B is the LIC. The following model can be applied:

**FIGURE 8.2 MODEL COMPARING HIC AND LIC**



The two groups were created by reviewing all the treatment program participants, based on their participation in the clinic and AA, and applying the definition of improvement in quality of life. Improvement in quality of life, for the purposes of this study, has been defined as enhancement of coping skills in a non-addictive way, development of a sobriety support system, insight and understanding regarding the changes occurring (managing without the addictive substance, role change), integration in family life, and a feeling of overall satisfaction with life.

Six clients out of the 37 were chosen for Group A because they met the above criteria, and six clients were chosen for Group B because they did not. Clients in Group A had eight months or more of sobriety, had made at least one friend in the clinic and AA, had an average of at least one weekly visit to the clinic without a formal appointment, had a good attendance record in the clinic, had attended five or more AA meetings per week, and had a sponsor. They were considered to be in recovery.

In contrast, clients in Group B had less than eight months of sobriety, had made no friends in the clinic and AA, had attended the clinic only with an appointment, had a fair to poor attendance record,

had attended fewer than four AA meetings per week, and had no sponsor. They were not considered to be in recovery.

Clients in Group A were either in school or in a training program. Their goal was to return to the work force. Meanwhile, they were learning to cope with returning to a meaningful life without alcohol or drugs. For example, when a client in Group A registered at one of the city colleges, he was told that he needed to take a remedial course in mathematics. At first, he was disappointed with himself, but soon he was able to understand why he needed to take the course. He analyzed the situation and concluded that it was the right thing to do. He discussed his feelings with his counselor and his sponsor. He also reported that he did not have an urge to drink. He felt very good about himself after exploring his feelings on this issue. He no longer saw it as a problem to take a remedial course.

Conversely, when the opportunity to apply for a training program presented itself to a client in Group B, the client relapsed and did not return to the clinic. Later, he informed the counselor that he was not ready to commit, but the truth was that he was really afraid to fail. This client had run away from his wife and children many years before, and he had not made a commitment to his recovery. He was

in fact a college graduate and capable of handling the training, but running away continued to be his style of “coping.”

On the whole, the clients in Group A learned that life has no guarantees and that it was up to them to change and to maintain their recovery. On the road to recovery, these clients tried to understand their upbringing, not to put too much blame on their parents, and to reconcile with family members. They attempted to follow the rules of probation and parole and maintain a good perspective on the priorities in their lives. Although they understood that the road to recovery is very hard, they were willing to risk making mistakes, because they also understood that the only way to a better life is being willing to take a chance.

These men were also very lonely and shy, and the clinic and AA helped in reducing both. The clinic and AA are like shields that protect the person as he gradually becomes strong enough to deal with life's hardships on his own. This is one of the reasons that these men became so connected to the clinic and AA.

In contrast, clients in Group B spent much of their time dealing with relapse. All clients in Group B, with one exception, left the clinic due to drinking. These men were all on welfare and their

futures were very bleak. One client left the clinic because he was returning to his home country. He had been accused of molesting a young girl while under the influence of alcohol, and he was afraid of doing time in jail. Three other clients left the clinic because they could not stop drinking, even though they had been sent to rehabilitation. Two other clients stayed in the clinic but were having difficulties staying sober. One of these clients was eventually transferred to the mental health clinic; the other eventually began a training program, but, due to his drinking, he was unable to complete it.

The question of whether to reconcile with family members was a problem for many clients. Many times the client was either an outcast from the family or he perceived himself as such. Hence, an indication that the client was on the road to recovery was his willingness to talk about his family. An important question concerned how to return into its midst and deal with the situation. For example, a client in Group A who had been estranged from his mother for many years, decided to visit her after being in the clinic for a year. He has since visited his mother once every week, and he reported that he understood why his mother acted the way she did when he was a boy.

He stated that he no longer carried any resentments towards her.

Many events converged for the clients in Group A to bring them to the decision that they needed to change. Perhaps the decision would have come sooner if they had understood the influences shaping their path to adulthood. An indicator of wanting to get better is that the client is willing to tell his life story.

#### DISCUSSION OF RESULTS

The symbolic interactionist perspective, together with the resocialization approach, is the framework within which data were collected and analyzed. Both approaches emphasize the importance of the subject's way of perceiving his world.

In this study, involvement and the degree of participation in the clinic and AA are independent variables that were hypothesized to have a positive effect on the client's life. Two related hypotheses were explored: (1) the more socially involved the client is in the alcohol treatment program and AA, the greater the improvement in the quality of life of the client, and (2) the more anomic the life situation of the client, the less socially involved the client will be in the alcohol treatment program and AA, and the less improvement there will be in

his quality of life.

The findings have supported the hypotheses. As indicated above, clients in Group A were highly involved in the clinic and AA. These clients had more effective lives, as a result of their involvement, than Group B, who were less involved. The men in Group B had chaotic lives and were not willing to invest the time necessary to create change.

Most clients who came to the clinic for treatment were mandated. This was true of all the clients in Group A and B. When the data were divided into subgroups, such as day clients versus evening clients, and employed versus unemployed, the day clients were found to be more involved in the clinic than the evening clients. In actuality, Group A was composed of day clients. The evening clients, as previously explained, did not view themselves as alcoholics. Many felt that they had been unlucky in being stopped by the police while under the influence of alcohol. This incident caused them to be mandated by the criminal court to complete an alcohol treatment program as one of the conditions of probation. Most had two or more violations for driving while intoxicated, which suggested at least an alcohol abuse diagnosis.

It was anticipated that the unemployed would participate in the clinic more than the employed. Most of the day clients were unemployed, unlike the evening clients. This is consistent with the finding that the more isolated the client was, the greater was his participation in the clinic.

Day clients also participated more in AA than evening clients. Day clients appeared to be more intense in trying to attain recovery. The day clients were mostly on public assistance and separated from their family or spouse, while the evening clients were usually employed, covered by health insurance, and living with their family or spouse.

For the day clients, the clinic and AA became a quasi-primary group. These clients knew that they were welcomed in the clinic at any time during its regular hours and, of course, AA was always there for them.

The clinic and AA did a good job of de-labeling and re-labeling (Trice & Roman, 1970) the clients, especially the clients who attended during the day. The clinic is best at teaching clients how to follow routines. The daily routine of keeping appointments and being on time was very important in teaching clients stability. The clinic also

prepares the client to accept AA, whose rituals of fellowship are central to clients' recovery. Indeed, it has been said that AA is a "therapeutic cult" (Galanter, 1989). It insists that the person stay away from people, places, and things that make him want to drink again. It also demands a confession and a belief in a higher power. Yet because AA is compatible with the attitudes of the greater society, this support and acceptance has allowed it to flourish.

On the whole, the clients who were willing to invest the necessary time in treatment did recover from their addiction. Time is an important factor in creating an effective treatment plan. Individuals who were considered to be in recovery had been in the clinic for over a year and a half. It appears that one year might not be enough for effective treatment. In order for treatment to be effective, it must be accepted by the client. Often the client needs to be educated and confronted; then treatment begins. The clients in Group A all took approximately a year to come to a decision that they were serious about recovery. After a decision is made to recover, recovery becomes a person's life. Growth is the only measure of continuing recovery.

## **CHAPTER NINE**

### **SUMMARY AND CONCLUSION**

This study explores the essence of alcoholism treatment and recovery by looking at a group of 37 Hispanic male alcoholics in a treatment center. The sociological methods used to collect the data were participant observation, in-depth interviews, chart reviews, and a questionnaire. All methods were conducted in English or Spanish.

The treatment program has great influence on all the clients participating in treatment because it not only educates the client on alcohol and alcoholism, but it is also involved with the most intimate parts of the client's life. The clinic influences the beliefs and attitudes of the client through the implementation of cognitive therapies and cognitive behavioral strategies (Vaillant, 1995). The clinic is not extreme, however, in the message it expounds. Indeed, there is no "extreme" method that works. When clients are told, for example, that they are committing slow suicide because of their excessive drinking, they do not immediately stop drinking, even though audio and visual information have been provided. Clients do not comprehend the finality of death in terms of themselves, so fear of death does not motivate them to stop. The clinic is subtle in the way it

presents to the client what he must do in order to achieve recovery.

For example, relapse by a client is not considered a failure but part of the process of recovery. The clinic understands, as does AA, that for many, recovery is not attained without setbacks. At the same time, it teaches the client that failure is not the end of the world, but being unwilling to try again is. Since many alcoholics suffer from perfectionism, this attitude helps the client to develop coping skills.

The main theoretical perspective in this study was symbolic interaction. The importance of the role played by the individual in this setting was addressed. The way in which the client perceived his situation influenced his progress in recovery. The relearning of roles and behaviors through resocialization gave the client the chance to improve his life. For example, WR had internalized the dichotomy of his father's behavior (being a loving parent when he was sober and a violent parent when he was drunk). He was confused. However, he learned at the clinic, and with help from AA, that his father's way was wrong, and this understanding allowed him to change and become a better person, free of alcohol and drugs.

Insight, as well as understanding what is involved in recovery, were strategies that took time to learn. "Change involves

movement over time” (Prochaska, 1991:807). Knowing how to use time made the process of recovery less tedious and harsh. Time usage was important because the client did not know how to manage time in the past. He wasted time or used it to drink. The realization that only through time does recovery become real, forced many clients to learn to plan and budget their time. Improvement was measured by the level of positive satisfaction the client attributed to his life; for example, his interest in the future, the status of his family life, his AA attendance, and his interest in work or school.

The social structure of the clinic and AA positively affected the progress made by the client. The clinic was able to help clients who thought they would not be able to change; who were unable to connect to other people due to their drinking. The clinic provided the time that many of these clients needed in order to lessen their fear about living without alcohol or drugs. It also provided the structured space that was necessary for “self-healing.”

Vaillant (1995:384) remarks that

alcoholics recover not because we treat them but because they heal themselves. Staying sober is not a process of simply becoming detoxified but often becomes the work of several years or in a few cases even a

lifetime. Our task is to provide emergency medical care, shelter, detoxification and understanding until self-healing takes place.

Although Vaillant, makes an important observation, he does not stress the importance of the treatment facility. For many of the clients in this study, the clinic was a significant place to spend time. The treatment program created a physical and emotional space in which the client was forced to think about his predicament. This included the availability of the day room for clients to use as their own space. This resulted in creating and maintaining norms and trust through the process of informal social interaction among the clients. The client became aware that he could change, and this awareness of empowerment impelled some clients to reach for recovery and not compliance. One client explained that “once you’re in the treatment process, you don’t get out. You feel uncomfortable and eventually you get it.” This client had started alcohol treatment in 1985, and nine years later he was celebrating one year of sobriety. It took him nine years to move into action, but he never gave up.

Recovery is a slow process and most cannot do it alone. One indication that a person is on the road to recovery is his willingness to ask for help. The clinic and AA are social structures that compel the

client to examine why he needs to be part of them. They create an “awareness context” (Glaser and Strauss, 1972) for clients who want to achieve recovery. The individuals referred to the clinic, even though many are mandated, have some awareness of their problem with alcohol and drugs. By the time a man comes to the clinic, many things have gone wrong in his life. “Hitting bottom,” according to AA, is different for each person. This was evident in the clinic, where the day clients knew they were in need of help, but the evening clients had the attitude that there was nothing wrong.<sup>21</sup>

Alcohol treatment is about acceptance of past behaviors and learning to live with yourself without alcohol. The clinic, together with AA, gives the client the tools to bring this about. For the initial phase of treatment, the clinic is very important because it provides the client with a structured environment. This way, the clinic helps the client prepare to make decisions about the path his recovery will take; it helps him to get unstuck from the stage of pre-action. The developmental model of recovery (DMR) promotes the use of therapeutic approach that is most effective with alcoholic clients. The

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<sup>21</sup> Alcoholics who attend AA on their own have already made the decision that something is wrong.

concept of efficacy is important in the clinic, and the staff strive for it on a daily basis through organization, planning, and empathy for the client.

The clinic and AA are equally effective; however, the clinic is best for the initial phase of treatment, and AA is used for maintenance. A client who stays too long in the clinic is not considered to be successful in treatment. The clinic seeks to motivate the client to want to go to AA, without being forced to attend. When the client enters the clinic's environment, he understands his predicament. He realizes that he is not alone and that he no longer needs to hide his real situation. He is encouraged to form relationships with other clients in order to develop his social skills. Loneliness is chipped away as his involvement in the clinic increases.

When the client is asked to attend AA, his immediate reaction is negative. He is afraid to attend for many reasons, but the most common reason is that AA is a social organization, and this elicits a fear of what might be expected of him. Once the client understands that, initially, he is there just to listen to what is being said, he is more apt to go without resistance. In many cases, the client begins to attach himself to AA.

Teaching members not to forget the pain of their existence is what AA does best. Both the clinic and AA support the survival of the alcoholic who wants to improve. The client is made to understand, however, that the clinic offers time-limited therapy and that AA will be there for the long haul. The clinic prepares the client to accept AA by integrating the history of AA, the literature of AA, and AA attendance into the orientation phase.

#### CONCLUDING REMARKS

Length of time in treatment is very significant. As DeLeon (1986) states in his review of therapeutic communities, the longer the length of stay, the better the outcome. This is also true for clients in an outpatient alcohol facility. A finding of this study is that persons who had had previous treatment experienced better outcomes than those who had not. It appears that 18 months is sufficient for alcohol treatment with an extension of four months if necessary.

However, too much time in treatment might be detrimental to the client. Allowing a client to stay longer than is necessary could create a dependent situation. A client might find it difficult to separate from the treatment program.

The day group included some clients who were highly involved in treatment, as well as others who were minimally involved. There were more clients attending the day program than the evening program, and the evening clients generally refused to label themselves alcoholics.

The refusal of the evening clients to accept the label of alcoholic is interesting, since these clients were diagnosed as alcoholics. The image they had of an alcoholic was that of a skid row bum, and not even participating in the alcohol education group changed this. They were well dressed, employed, and supporting a family, and they had a social life. They did not like to be compared to the day clients, who they felt were inferior to them. Their self-image may have blocked them from the process of recovery. Many of the evening clients were in trouble with alcohol but had not hit bottom. Although people do not have to lose themselves in order to come to a realization that they need help, these individuals had not penetrated their facade of superiority. The evening clients complied with all the rules and regulations of the clinic and were able to graduate. With only one exception, however, they were unable to capture and internalize the process of recovery.

The one exceptional client in this group admitted that he was a recovering alcoholic and spoke very eloquently to the group of his past life as an alcoholic. He had been sober for the last four years, and gave AA credit for helping him to maintain his sobriety. However, he had stopped attending AA in the last two years and had become a member of an evangelical church. He is said he felt comfortable at the church and that it gave him plenty of emotional and social support. This client had been separated from his family for over ten years, and there had been no attempt to reconcile with his children. He did admit, however, that he understood why his children had not accepted him back into their life.

The group missed the message of the story and could not identify with the situation. Their only response was that the children were behaving poorly. The group, as a whole, understood that excessive drinking could get you into trouble, but they perceived their trouble as being very unlucky: the day they drank too much was the day a policeman stopped them.

The evening clients appeared to be suffering from all the ramifications of denial. These clients needed more time in the clinic to develop informal aspects of treatment. Since they only attended two

nights a week, and treatment was focused on the fact that driving and drinking do not mix, there was not enough time to educate them or allow them to develop friendships. None of the evening clients was highly involved in the clinic or AA, thus proving the importance of client participation in the informal aspects of treatment.

The social isolation scale indicates that the more a client feels socially isolated, the more likely it is that he will attend the clinic. For a few hours each day, these individuals feel connected to other individuals. Social isolation appears to be higher among the day clients.

The connection between alcohol treatment and public assistance is detrimental to the process of recovery. Many times, clients who were progressing in treatment relapsed when they realized that by completing the program and graduating, they would no longer qualify for public assistance. There were some clients who were terrified of the idea of not being taken care of, since they had not worked in over five or ten years. This is a difficult problem which the clinic has not fully addressed. Although a transition stage has been implemented so

client, upon graduation, is given employment counseling and assistance in attaining employment.

The advent of managed care appears to be changing how alcoholism services are provided, because of the focus on short-term treatment and cost-effectiveness. This situation raises serious questions concerning treatment outcome. Particularly troublesome is the issue of individuals who are not ready to work.

A significant finding that can aid the therapist in treatment and treatment planning is that the client's willingness to get involved in treatment is concretely evidenced by his daily participation in the clinic. Incremental increase in involvement in the clinic is seen through the informal aspects of treatment. As the client becomes more socially involved, he becomes more interested in improving his life. To recover, the alcoholic must be ready and willing to change. There is no way around this fact, and recovery is hard work. The alcoholic in treatment learns that the bottle has to be replaced and that readiness is the first step. Then, in time, he will be able to confront and cope with life without alcohol and drugs.

## APPENDIX A

### SEMI - STRUCTURED PRE-CODED INTERVIEW GUIDE

#### I PROGRAM KNOWLEDGE AND INVOLVEMENT (DEGREE OF PARTICIPATION AND SOCIAL INVOLVEMENT)

1. How long have you been sober?

0-1 month  2-6 months  7-12 months  13+ months

2. How many times a week do you attend the program? \_\_\_\_\_

3. How many groups per week? \_\_\_\_\_

4. How many individual sessions per month? \_\_\_\_\_

5. Do you come to the clinic even when you do not have an appointment with your counselor or group?

Yes  No

If yes, how many times per week? \_\_\_\_\_

6. What phase are you in? \_\_\_\_\_

7. How many days per week do you use the day room? \_\_\_\_\_

8. Do you participate in the vocational rehabilitation groups?

Yes  No

If yes, how many groups? \_\_\_\_\_

9. How many new friends have you made in the clinic?

0  1  2-5  6+

10. Do you socialize with these friends outside of the clinic?

Yes  No

If yes, how often do you socialize?

Often  Sometimes  Rarely  Never

11. Are you satisfied with the treatment you are receiving in these programs?

Very Satisfied  Fairly Satisfied  Satisfied

Not Satisfied

12. What has been your general reaction to and experience with the program? Write answer.

II AA KNOWLEDGE AND INVOLVEMENT  
(DEGREE OF PARTICIPATION AND SOCIAL DEVELOPMENT)

1. How many meetings do you attend per week?

0  1-2  3-5  6-7  8+

5. How many times have you qualified in the last 6 months?

0  1-2  3-5  6-7  8+

6. How many new friends have you made in AA?

0  1  2-5  6+

7. To what extent have you socialized with friends from AA, outside of AA meetings?

Often  Sometimes  Rarely  Never

8. How long do you consider that you have been a member of AA?

Less than 1 month  1-2 months  2-6 months

7-12 months  12+months

9. What has been your general reaction to experience with AA? Write answer.

### III FAMILY INTEGRATION AND INVOLVEMENT

1. Do you live with your family?

Yes  No

(If yes, go to question 5; If no, go to question 2.)

2. How long have you been separated from your family?

Less than 1 month  1-2 months  2-6 months

6-12 months  12 months

2. Do you have a home group?

Yes  No

If yes, name of group \_\_\_\_\_

3. Do you have a sponsor?

Yes  No

If yes, how many times per week do you speak with your counselor?

0  1-2  3-5  6-7  8+

4. How many times have you volunteered to help with the coffee, literature, newcomers at AA meetings?

0  1-2  3-5  6-7  8+

3. To what extent are you in contact with your family (children)?

Frequently  Occasionally  Rarely  Never

4. Do you give child support?

Yes  No

5. How would you describe your relationship with your spouse or closest person?

Very positive  Positive  Somewhat positive

Neutral  Negative  Somewhat negative

Very negative

6. How would you describe your relationship with your children (if any)?

7. What kind of chores do you do around the house?

Child care  Clean-up  Laundry

All of these  Some  None

8. What ages are your children? (If none, go to question 13.) If children are school age, continue.

9. What is the name of the school?

\_\_\_\_\_

10. What is the name of the teacher?

\_\_\_\_\_

11. Have you met their teacher?

Yes  No

12. Do you help them with their homework?

Yes  No

13. To what extent does your spouse or person closest to you approve of your coming to AA?

Somewhat supportive  Supportive

Very supportive  Not supportive

Negative support

14. Does your spouse (close person) attend Al-Anon?

Yes  No

If yes, how many times a month? \_\_\_\_\_

15. Do any of your children attend Alateen?

Yes  No

If yes, how many times a month? \_\_\_\_\_

16. Does your spouse/children/closest person participate in the program?

Yes  No

How active is he/she?

Not very  Moderately  Very

17. Is your spouse a social drinker?

Yes  No

18. If yes, to what extent do you feel pressure to drink?

Frequently  Occasionally  Never

19. How are decisions such as school choices, paying bills, vacation made in your house?

Family  You and your mate  Mate alone  You  
alone

#### IV. SOCIAL ISOLATION

(LIKERT FORMAT WITH FIVE CHOICES RANGING FROM STRONGLY AGREE TO STRONGLY DISAGREE.)

1= Strongly agree

2= Agree

3= Undecided

4= Disagree

5= Strongly disagree

1. I can always count on my family for help when I need it.

\_\_\_\_\_

2. I have many friends who will help me.

\_\_\_\_\_

3. I was very lonely during the past month.

\_\_\_\_\_

4. I often feel alone in the world.

\_\_\_\_\_

5. I can tell my troubles to my spouse/closest friend and she/he will help me.

\_\_\_\_\_

6. I worry about the future facing today's children.

\_\_\_\_\_

7. Sometimes I have the feeling that other people are using me.

\_\_\_\_\_

8. Real friends are easy as ever to find.

\_\_\_\_\_

9. The only thing one can be sure of today is that he can be sure of nothing.

\_\_\_\_\_

\_\_\_\_\_

10. The world in which we live is basically a friendly place.

\_\_\_\_\_

## V. ECONOMIC STABILITY: WORK HISTORY

1. Are you employed?

Yes  No

If yes, how many hours per week are you working? \_\_\_\_  
If no, go to question 4.

2. How long have you been working in this position?

Less than 1 month  1-2 months  2-6 months

6-12 months  12+ months

3. Are you satisfied with your present situation at work?

Very dissatisfied  Moderately dissatisfied

Moderately satisfied  Satisfied  Very satisfied

4. Are you ....(check if applies to you)

Collecting unemployment  In school

On public assistance

## VI. LEGAL STATUS/ HISTORY

1. How many times have you been arrested? \_\_\_\_\_

2. What was the legal problem?

DWI  Order of Protection  Family Court

Other- Please state \_\_\_\_\_

3. Are you currently involved in any legal matters?

Yes  No

## VII. IMMIGRATION STATUS

1. Are you a U.S. citizen?

Yes  No

If yes, skip questions 2 & 3.

2. Do you have a green card or work permit?

Yes  No

3. When did you obtain this card/ work permit?

Less than 1 month ago  1-6 months ago

6-12 months ago  12+ months ago

## VIII. ALCOHOL EDUCATION (TRUE OR FALSE) \*\*

1. Alcoholism is a disease

T F

2. Most alcoholics experience denial

T F

3. Alcohol is an addictive drug

T F

4. Most alcoholics are skid row bums

T F

5. Alcohol is a factor in violent crimes

T F

6. People suffering from Alcoholism can be cured

T F

7. Four drinks a day is a safe level of alcohol use

T F

8. A wine cooler has less alcohol in it than a shot of  
whiskey

T F

**\*\* RATING SCALE**

0-1 = VERY POOR

2-3 = POOR

4-5 = GOOD

6-8 = VERY GOOD

**IX. THE PROCESS OF RECOVERY**

1. Do you consider yourself in recovery?

Yes  No

If yes, have you experienced significant events or  
changes in your life?

- Job changes
- Back to school
- Death
- Separation from spouse/loved ones
- Divorce
- Other \_\_\_\_\_

If no, have you had a relapse recently?

Yes  No

2. It has been said that one of the reasons that a person drinks is a lack of willpower; they don't feel capable of doing things.

Do you think this is true or false?

\_\_\_\_\_

3. What does surrendering to a higher power mean to you?
4. Do you believe that a spiritual awakening can only be achieved after many years of sobriety?

Yes  No

If yes, how many years? \_\_\_\_\_

5. When was the last time you had a craving for alcoholic beverages?

- Less than 1 hour ago  
 Less than a day ago  
 Less than 1 week ago  
 Less than 1 month ago  
 2-6 months ago  
 6-12 months ago  
 13 + months ago

6. Do you have a sponsor or are you currently a sponsor?

Yes  No

7. If you are a sponsor, do you enjoy being a sponsor?

Yes  No

**APPENDIX B**

## THE TWELVE STEPS (AA)

1. We admitted we were powerless over alcohol -- that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as *we understood him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and mediation to improve our conscious contact with God *as we understood him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

## **APPENDIX C**

### **THE TWELVE TRADITIONS**

1. **Our common welfare should come first; personal recovery depends upon AA unity.**
2. **For our group purpose there is but one ultimate authority---a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.**
3. **The only requirement for AA membership is a desire to stop drinking.**
4. **Each group should be autonomous except in matters affecting other groups or AA as a whole.**
5. **Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.**
6. **An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.**
7. **Every AA group ought to be fully self-supporting, declining outside contributions.**
8. **Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.**
9. **AA., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.**
10. **Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.**
11. **Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.**
12. **Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.**

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