

**Alcoholism: Group Factors in Etiology and Therapy**

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Despite the many factors involved in alcoholism, one basic characteristic distinguishes the problem drinker from the remainder of the drinking population. He is unable to control his drinking. Once he has begun to drink, he continues until some external force interrupts him. Thus, he may "pass out," become ill, find himself in jail, be deprived of his "supply," or injure himself on some way. The basic criterion of alcoholism is not what is done while sober, but whether there develops an irresistible "yen" to keep on drinking once it has been started. The problem drinker experiences this as a strong desire that asserts itself upon the resumption of drinking. Whether this compulsion is a physiological peculiarity, a conversion hysteria, or some other factor is a wide-open question. Less debatable is the definition that the alcoholic is one who deviates from the drinking limits accepted by most of those around him. Where the non-alcoholic accepts standards that define when he has had enough, the developing alcoholic continues to drink beyond these limitations until controls outside himself intervene to stop him. It is this uncontrolled drinking that constitutes the core of the syndrome termed alcoholism.

**Research Interests of Various Disciplines**

Historically, the problem drinker was either "born that way," "lacked willpower," or was a moral degenerate. Adding to these widespread historical stereotypes is an ambivalence in American society toward alcohol itself. On the one hand its anaesthetic properties are extolled and included in the daily affairs of life. On the other hand, its ether-like results are fiercely denounced as a major source of debauchery, carnal pleasures and social

irresponsibility.

As research efforts have intermingled with this traditional turmoil, they have, despite resistance, exercised a clarifying influence. Many persons have come to look upon alcoholism as a natural phenomenon, something that can be studied as a process and treated without regard for the historical confusion that has existed. But even the research-minded have been unable to escape the general societal confusion regarding the alcoholic. In a sense, the confusion over the alcoholic has moved from the moral to the scientific arena with different disciplines actively debating over how to explain and treat the uncontrolled drinker. The clinical psychologists have talked in terms of "emotional instability" as a predisposing force. The psychoanalysts have poisted an unresolved complex or a fixation (usually oral) as an etiological explanation. Those of biological persuasion have emphasized a nutritional deficiency. Anthropologists and sociologists insist that the absence of social controls covering alcohol usage sets the stage for compulsive drinking.

Therapy has reflected this variety of explanations. It has ranged all the way from the most esoteric psychoanalyses, through various chemical sensitizers, to Alcoholics Anonymous. As yet no well-developed verification of the effectiveness of these techniques has appeared. Each therapist, on the basis of his own etiological persuasion, has proceeded to treat accordingly. Some trend has developed toward the combination of psychotherapy, vitamin therapy and group therapy. But, generally speaking, therapy, like etiology, remains fractured into the different disciplines.

### **The Research Problem**

Before an effective therapy can emerge, it is necessary to clarify a further etiological problem. Even if the predispositions to loss of control assumed by the various disciplines do exist, there remains the question of how these were translated into an uncontrolled use of alcohol. The mere possession of an unusual genetic difference in nutritional needs does not automatically mean uncontrolled drinking. Neither is it logical to believe that "emotional instability" or "oral fixation," assuming they exist, are inexorably linked to alcoholism. Nothing in the nature of these predisposers inevitably leads to a loss of control. Something has to serve as a selective device, centering the predispositions with alcohol. The basic etiological problem in alcoholism

today is the question of what forces act to join a predisposition to alcoholism with the actual use of alcohol.

In order to point up this basic question it is necessary to summarize prominent hypotheses concerning the etiology of alcoholism. These can be subsumed under three classifications: 1) Physiological deficiencies, 2) Psychological - emotional maladjustments and 3) Lack of effective social controls.

### **The Physiologists**

Various physiologists conclude from their research that nutritional deficiencies in the form of vitamin-poor diets increase the consumption of alcohol. The impairment of nutrition leads to an impairment of the food selection mechanisms in the body. In turn, a poor food, alcohol, is selected disproportionately. An heredity factor is often coupled with this. Not only can this nutritional deficiency develop environmentally, but it can be the result of genetic differences in nutritional needs. Thus, "Loss of control" may not in its origin be greatly different from other innate cravings such as a dehydrated individual has for water or an herbivorous animal has for salt. The main difference is that alcohol craving leads to harmful rather than beneficial results. According to this view, the alcoholic has an in-born, unusually high requirement for certain nutritional elements. This produces a "metabolic individuality" that predisposes toward addiction.

Since this research is based largely on rat reactions it is difficult to learn exactly where the predisposition might be in humans. Furthermore, there has been no demonstration that these assumed deficiencies existed prior to alcoholism. That they exist after loss of control is a widely accepted fact. Whether they existed in an etiological sense before loss of control remains to be demonstrated.

However, the important consideration lies in the "even if" acceptance that the deficiencies are demonstrable and were present prior to loss of control. There is nothing in the predisposition itself that compels an attachment to alcohol. There are "poor foods" other than alcohol that could be selected. Food choice is just as culturally determined as it is biologically determined. Social norms, taboos, traditions operate in a potent manner to

guide food selection. Further, even if alcohol were culturally emphasized, it may be defined in such a manner that it is brought under effective social control. Thus, the Cantonese Chinese of New York City, the Orthodox Jews, the Northwest Coast Indians all use alcohol frequently, yet loss of control is extremely rare among them. It is difficult to believe that these people would not possess their expected quota of persons with the alleged physiological predisposition.

The absence of a link between this assumed predisposition and loss of control is realized by this school of thought. "....environmental factors are potent and indispensable for bringing about alcoholism, but they do not do so unless the person involved possesses the type of metabolic individuality which predisposes toward addiction." The research need is to illuminate those "Environmental factors."

### **The Psychologists and Psychiatrists**

Those who explain loss of control via the "emotional instability" route are in the same enigmas as the physiologists. Many clinical psychologists, psychiatrists and psychoanalysts assume an automatic linkage between alleged "unstable emotions" and the excessive use of alcohol. How the problem drinker learned to use alcohol in the first place is not considered.

And, like the physiologists, there is a tact assumption that neurotic trends existed prior to loss of control. This has not been demonstrated. Despite the widespread research efforts to show that the alcoholic is a neurotic, it has not been clearly demonstrated that he possesses introversion, or mother fixation, or narcissistic responses, or a host of other neurotic manifestations in significantly greater amounts than nonalcoholics. And, it should be emphasized, these research comparisons were made after the subjects had become alcoholic. It seems only natural to assume that the end result of the alcoholism process would be the production of neurotic behavior. However, even this "after the fact" evidence is meager.

For example, those of more Freudian persuasion often conclude that "in alcohol he (the problem drinker) discovers a way to relieve his tensions in the same way that nursing and oral gratification did when he was a baby." However, the writer goes on to state that these fixations are not peculiar to

the alcoholic, and that "a certain combination of circumstances must play a part in the onset of drinking." In short, some third force had to link the neurosis to alcohol usage. Another psychoanalyst sees the linkage between loss of control and neurotic trends as an "accident." Some speak of a "discovery" of alcohol as a means of resolving neurotic tension and anxiety. The content of these "accidents," "discoveries," and "combination of circumstances" is, however, left unexplored.

The testing psychologists have failed to show that emotional maladjustment is necessarily linked to loss of control. Years ago Bowman and Jellinek concluded that "no personality constellation leads of necessity to addiction. Certain forces must act on the terrain to bring about addiction or abnormal drinking." Little evidence has accumulated since to change this conclusion. Rorschach specialists have concluded that "definite similarity was demonstrated between alcoholic psychopaths and social psychopaths." This means that, emotionally speaking, the psychoneurotic symptoms were common to both alcoholics and non-alcoholics. A similar conclusion is possible from Thematic Apperception Test results. Again, "certain forces" were, as in the case of the psychoanalyst, left unexplored.

When it comes to demonstrating clear-cut differences between "normals" and alcoholics on test results, no data are convincing. Sutherland, after an intensive review of test data, confirms the conclusion of Wexberg that "there is no alcoholic personality prior to alcoholism." Recent claims that Rorschach patterns can be ascertained that differentiate "alcoholics from corresponding non-alcoholics" suffer from the fact that the "normals" were widely different from alcoholic subjects in age and sex distributions. And, the etiological implications of emotional maladjustment is made from cases who had already developed alcoholism. No effort is made to emphasize the fact that these psychological deficiencies are shown to exist after the onset of uncontrolled drinking, not before it. The same observations hold for the claims accorded to the Minnesota Multi-phasic Personality Inventory. The psychopathic deviate scale is claimed to differentiate between addicts and non-addicts. However, no effort appears to be made to decide whether this psychopathy was present before the onset of loss of control or after. The results show it present after; no logical inference can be made that it was there before uncontrolled drinking started.

Again, however, the important research consideration lies in the "even if" acceptance that the emotional instabilities are demonstrably present prior to a loss of control. Even if this were the case, we are still faced with the problem of showing what process acted to connect these emotionally inclined persons with alcohol usage. Why was alcohol selected as the way out? What accounts for this union between excessive use of alcohol and neurotic trends, or, between excessive drinking and nutritional deficiencies?

### **The Sociologists and Anthropologists**

An answer, couched in broad generalizations, has been stated by those researchers who emphasize the effect of cultural forces on drinking behavior. Societies, or subcultures, set up over-all definitions of what perceptions should mean. The anaesthetic effects of alcohol on the body is readily perceivable by users. The social milieu gives a normative meaning to this perception. At the same time, the society has brought this meaning under the social controls that are a natural part of its structure, or it has not. Thus, those social structures that have defined the depressant effects of alcohol as "the" adjustment technique to use in managing anxiety are building a union between individual predispositions and uncontrolled drinking. If to this is added the fact that alcohol usage does not come under the control of the internalized inhibitions fostered by the society, predisposed persons are not equipped to exercise control.

The major data in developing these points derive from a comparison of alcoholism rates among Irish and Orthodox Jews. The rate among the Irish is unusually high. The Irish are described as defining the biological effects of alcohol as the way to manage individual tensions to the exclusion of other adjustment techniques. Furthermore, this normative use of alcohol is not related to the moral patterns or religious rituals that constitute the social controls of the Irish. Drinking is separated from the system of internalized inhibitions. It is allowed free reign in individual conduct, under the influence of the normative definition just described. Thus, loss of control becomes more possible since drinking groups encourage members to drink their troubles away and, at the same time, isolate the use of alcohol from the general pattern of inhibitions. In contrast, Orthodox Jewish subculture

orients its members toward a ritualistic use of alcohol that relates it to moral symbolism and sacred religious practices. Thus, drinking is included as an integral part of the socialization process, becoming, for individual members, a part of their inhibitory behavior. In this manner the predisposed are not vitally connected to excessive use of alcohol, even though it is widely used. Anthropological studies of drinking in pre-literate and semi-acculturated cultures have been in general agreement with this interpretation.

In summary, the coupling between those inclined toward alcoholism and its actual use in the cultural encouragement to drink that exists in the social milieu, plus the absence of effective social controls that would set up individual limitations.

The main objection to this answer to the linkage question lies in its broad generalizations. What is the group process that executes these over-all, societal definitions? To a marked degree we have had to rely on overgeneralized data from such wide categories as religious, occupational, social class, or "sub-cultural." Interaction studies of specific, face-to-face, drinking groups have not been systematically attempted. Although the specific phenomena of spontaneous group behavior has been implied, it has not been spelled out in research data. The research needs of the future center around an investigation of the primary drinking group experiences of the alcoholics. In one way or another all research viewpoints have acknowledged this research need. The terms "environmental factors," "certain forces," "combination of circumstances," "discovery," indicate a realization of the learning process going on within drinking groups. In addition, it is an accepted fact that the bulk of alcoholics have gone through a long period of development. What drinking group experiences were occurring during this time to effect an attachment between predispositions and alcohol? It is the basic hypothesis of this paper that a vigorous effort to explore these face-to-face drinking group experiences of the alcoholic will provide us with new etiological insight with which to design more effective therapy.

### **Individual vs. Group Therapy**

Such suggested research is consistent with the fact that alcoholic group therapy is often regarded as superior to individually-oriented treatment. For

example, in the opinion of numerous therapists, Alcoholics Anonymous surpasses the treatment success of other types of therapy. Jellinek states that "as far as the rehabilitation of the alcoholic is concerned, there is no therapeutic activity which comes near to the success this extraordinary group has achieved." Lemert declares that "whether their records are, or can be, accurate is debatable, but of the general superiority of its methods over other methods in use there can be no doubt." Kersten regards it as a "mainstay" of treatment. Bird describes it as having "better success than any other method." Maxwell concludes that skepticism has given way "to the pragmatic fact that the program works."

These opinions are not to be taken lightly. Even those effective rehabilitation programs that do not utilize A.A., use group therapy that is similar in principle. The highly effective program of the Consolidated-Edison Company has used group psychotherapy as one of its basic techniques. "In the group, he (the alcoholic) has the opportunity of observing similar problems in others, permitting increased insight into his own problems and gradual establishment of relationship with others."

Why is Alcoholics Anonymous effective where individual therapy would fail? The core of the matter is simply that the alcoholics become the therapists. Out of this basic emphasis there arises a network of group controls for sobriety that is not present in the usual doctor-patient situation. As Bales indicates, in the latter instance the alcoholic "never initiates controlling activity...(In A.A.) there is a structural framework in which each member has the opportunity to act as moral authority toward others who are acting as moral dependents, whereas (in other therapies) he is confined to the status of the moral dependent as a 'patient.' To be recognized and respected are strong supports to motivation, needed by the patient more than by the doctor."

Other factors seem to be related to its success. The permissiveness of the group acts as a means of reducing the extreme defense barriers erected to protect the alcoholic personality from moral condemnation and exhortation. Moreover, the void created by abstinence is filled by activities and persons who emphasized the norm of sobriety, rather than alcoholic indulgence. A.A. is an emotionally satisfying alternative to chronic drinking. It acts to give the member of feeling of group support. Clinard concludes that in A.A. "the individual is given a feeling of group incorporation, and group-oriented goals

rather than individualistic and materialistic goals are furnished....Such organizations represent, in part, the restoration of many of the characteristics of a folk-society in the modern urban world." Further, the "twenty four hour" program acts to relieve tension, blotting out the past and deemphasizing the future. The typical alcoholic regards lifelong sobriety, which is his only hope, as an intolerable existence. When told he can never drink again his whole world is threatened. But by emphasizing being sober only a small period of time, this threat is reduced. In this manner the A.A. member focuses upon one small chunk of time after another until he amasses enough sober time to feel the rewards of a "dry" world.

Finally, group participation in A.A. activities provides a new status based on new roles to play. This new status and recognition acts to change prior self-conceptions of himself. Prior to this experience, his reference points for self-definition were gleaned from drinking group supports that emphasized his loss of control. Now there is a status that emphasizes sobriety.

### **The Therapy Problem: Non-affiliation**

But many problem drinkers cannot voluntarily align themselves with an A.A. group despite the fact that one is available and they are exposed to it. Specific barriers prevent their affiliation. If a problem drinker does not think of himself as a person who can share his emotional reactions with others he has an obstacle to affiliation. If he has associated closely with an esteemed friend or relative who, he thinks, has quit drinking by his own will power, he will choose to act like this "behavior model" rather than join A.A. If he has inaccurate expectations of what membership involves, or if he is sensitive to social class symbols, he faces barriers to affiliation.

Additional impediments to affiliation exist in the receiving A.A. group. Unless there is forthcoming from the A.A. group itself a constructive relationship involving sponsorship and close contact with numerous members, further stumbling blocks will be added to his affiliation. If the newcomer does not become incorporated into the informal cliques that form before and after meetings, new obstructions are added. Much of the ego-involvement lies in these spontaneous grouping. Should the newcomer be emotionally unable to

interact with these intimate groupings, he faces trouble in affiliation. On the other hand, the group itself may unconsciously practice a selectivity that acts to exclude him. A final hinderance to affiliation lies in competition from his immediate family. This can take the form of a wife who continues her own controlled drinking, forcing him to choose between her and A.A. Or, it can take the form of blood relatives who provide moral and financial support for the problems that ensue from his drinking.

Given these barriers, many alcoholics approach A.A. but do not join. Although this is a guess, it is probable that two out of three cannot "get on the program." Thus, what is regarded as one of the most effective therapies we have is often vitiated by social-psychological drawbacks. Those elements that account for attraction to the group are lacking in all too many cases.

### **Research Strategy: Etiology**

So far we have seen that face-to-face group patterns play a vital role both in etiology and therapy. A prominent research problem for the future lies in clarifying the role of this group factor. Where etiology is concerned, the task is to show the group process whereby alcoholic predispositions are joined to alcohol usage. Where therapy is concerned, the task is to determine how the barriers to group therapy can be reduced.

First, what research strategy can be suggested regarding etiology? Too often it has been assumed that the chief motivation to use alcohol excessively is the need to manage persistent and chronic anxiety. This exclusive attention to the role of psychic tension in uncontrolled drinking overlooks the positive rewards present in face-to-face drinking groups. These groups accord status to drinkers on the basis of expected drinking behavior. Like any other spontaneous, natural group, a drinking group assigns status on the basis of the particular group definition of what alcohol should mean, i.e., the goals of the group. A hierarchy of status comes to regulate the drinking group behavior, with each member receiving group recognition on the basis of how well he fulfills the group definition of why they drink alcohol.

For example, tavern drinking groups studied by the author, drank for the purpose of demonstrating virility. Alcohol was a means of showing you were a "two-fisted drinker." Consequently, "holding your liquor," was a status-giving

feat. Those who could drink their comrades "under the table" were fulfilling the goals of the group more fully than others. Their group recognition was higher than the ones who "passed out" or got sick or just went to sleep. The fact that this esteemed high tolerance for alcohol was a sign of imminent loss of control was irrelevant to the status-awarding process.

In such a situation alcohol is joined with reward stimuli. Those with a predisposition are, through such experiences, forging a link between their inclination toward loss of control and its realization. As Conger has pointed out, "the basic assumption of a reinforcement story of learning is that the association between a stimulus and a response requires the presence of some sort of reward or reinforcement...If we are to be consistent in applying a drive-reduction hypothesis, we must maintain that in those cases where the drink response is learned, it is learned because it is rewarded." The "some sort of reward" may readily lie in the prestige accorded drinking behavior in drinking groups. If drinking group acceptance is forthcoming to a drinker on the basis of his drinking performance, he has been given the reward of "being included." A learning relationship between alcohol usage and group reward is cultivated. The learning link is even stronger if his drinking behavior is accorded status beyond mere group acceptance. Latent tendencies to loss of control are encouraged and slowly brought to active expression by these group influences.

Implicit in this discussion are two facets of drinking group dynamics. First, there are expected drinking behaviors, i.e., acceptable kinds of behavior. They are merely the norms of the drinking group, those drinking expectations generally conformed to by all members before affiliation is completed. Second, there are status-giving drinking behaviors. Certain behavior is not only acceptable, it is looked upon as desirable, as emulative. It is given group recognition in the form of deference; leadership arises from the accumulation of this group status.

A third facet is present. Drinking groups have standards of what constitute unacceptable drinking behavior. Not only can acceptance and reward drinking-group membership; rejection by the group for "going too far" is also possible. Drinking groups have subtle limits that define unacceptable drinking behavior. Certain acts become "disgusting," "out of line," "too high," or "he is a nuisance," "he doesn't know when he has had enough." Within the drinking

expectations of the group there is a "cut-off" point beyond which status rapidly declines rather than increases. And so the problem drinker can receive group exclusion as well as group recognition for his drinking conduct. When his drinking becomes inconsistent with group norms, when it has gone "too far" for group recognition, he feels both the group pressure to remove himself and a rejection, on his part, of his drinking associates. Whereupon he realigns himself with another drinking group with more compatible drinking patterns. Since a learning link has been forged between reward and alcohol usage he shifts to a group of people who drink as he does to continue the rewarding experience. In this manner he continues to find drinking group support for the symptoms of alcoholism he is developing, i.e., high tolerance, "blackouts," poor eating, etc.

But guilt feelings about "drinking different" have now become active and intermingled with anxiety from other sources. Latent predispositions now become more manifest. More alcohol, plus the continued reward from a new drinking group, provide a ready solution. Soon, however, the rejection experience reasserts itself and migration to another drinking group takes place. This shifting from intolerant drinking groups to more tolerant ones provide him with a continuous network of group supports. In this way he is given an ever-enlarging definition of what constitutes acceptable drinking behavior. Since "loss of control" is a relative matter, measured against modal drinking patterns, he soon reaches affiliation with those drinking groups where the expectation that you will drink until some outside force intervenes to stop you. "Loss of control" is the group norm. The more group shifting takes place, the more isolated from the modal drinking pattern he gets. This serves to accentuate the extreme drinking expectations of the most lenient groups. An in-group vs. out-group psychology enhances for him the drinking patterns of loss of control.

This hypothesis has been supported by field interviews results conducted by the writer with both hospitalized alcoholics and active A.A. members. Excerpts from these interviews follow. (Since this work is still in the exploratory stage, even the minimum of identification will be eliminated.)

"My former friends ostracized me as my problem got worse. It was a little bit of both you rejecting the group and group rejecting you: they would be a bit resentful that you did not drink like they

did - and you wouldn't want them to acknowledge you had a problem - that you couldn't drink in the same manner that your friends did - this was one reason you went to lower-type bars. They rejected me because I was going overboard, becoming a nuisance - after a while people get fed up with this sort of thing and do not care to have you around - when this happened I said, "To hell with them. I will show them"- so I found a bunch who would still look up to me."

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They did not drink right along with you - you would leave them and go to someone else who would continue to match you drink for drink - got so people wouldn't even go with me - my own sisters would say they would go with me if I would have only a few. I promised but after I got in there I would just stay - so next time they just wouldn't take me with them.

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As my problem got worse the old gang I drank with got more and more fed up with me. That's why I dropped down to a lower level all the time. Every time I got drunk I would seek out a lower level because I had the feeling I would be accepted there. The old drinking buddies didn't come right out and say I wasn't accepted. I wanted to be, but in my own way of thinking I wasn't. I just got the thought in my mind that I can't kid these people any longer. I have to get some drinking partners I can put it over on and still keep that feeling that I'm higher than they are and better than they are.

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The reason I went to the lower places is because the other guy, although I wouldn't admit it, was beginning to look down on me. The better class, the class I had slipped away from because I had become miserable and mean, were beginning to say I couldn't manage the

stuff. Because I had to step over the deep end, I looked for the other guy who had stepped over the deep end too, because I wanted to make myself believe I really wasn't so bad. I always had to feel superior. If someone looks down on you, and you can't cope with it, you're going to go somewhere where you can cope with it.

They were happy to see me come in there for quite a spell - I liked to be the life of the party - and they seemed to like it too. It was wonderful until I got half-loaded and then I started getting mean. It always happened when I was about half-way gone. They'd get angry at something I said, and, the first thing you knew I'd be in a fight and I'd end up by busting up something. That was my trouble, somebody would say something I wouldn't like and then I would paste 'em. Same old story. They got so they hated to see me come in.

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I think any alcoholic has a feeling of superiority especially when he is half-shot. You want to get with a group that looks up to you, and if you go in a place where everybody has on overalls and you have on a half-way decent clean shirt and shoes shined, stroll up to the bar, people look up to you. So I started going to places where they still wanted me. If you have some money they start crowding up waiting for you to buy 'em a drink and you feel superior. That's what I was looking for.

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More research should be aimed at testing these formulations. The first step in such a research effort is to investigate the reward-giving aspects of drinking in specific drinking groups. The second step is to attempt to determine what constitutes acceptable, usual drinking behavior within such groups. What is expected? What do the norms say you should do as far as drinking is concerned? Third, at what point does unacceptable drinking behavior develop? How does the rejected drinker react? Is there a pattern of shifting from intolerant to tolerant groups?

By posing such questions as these we can illuminate more clearly the etiological puzzle of what forces act to join predispositions with excessive drinking. In such investigations we will find those motivational influences that will precipitate a latent tendency toward alcoholism into the full-fledged product. This insistence is not without support. Diethelm states a similar point. "The dependence of an intoxicated person's behavior on prevalent attitudes and expectations of the social group is also little understood and deserves careful investigation by the integrated efforts of psychiatrists and cultural anthropologists."

On the other hand, it should be emphasized that such a research orientation is not intended as all inclusive. In all probability there are those cases who become alcoholics without this process. There is the "lone" drinker who apparently reaches a loss of control without these group experiences. He may be deficient in those social skills that would have enabled him initially to be a part of drinking groups. He is the symptomatic type of drinker who has come to express his underlying maladjustment through alcoholism. Female alcoholics seem to fit into this mold. In short, there seems to be a type of schizoid personality that has taken readily to alcohol without any group tutelage.

However, the contention here is that this type is relatively infrequent. Furthermore, it is quite possible that "lone drinking" is an end result of the group process. Before isolated drinking is too quickly regarded as purely an individual matter it is desirable to explore the history of the case. Too often it has been assumed that the "lone" drinker was an isolate from the start. This may be the case, and undoubtedly often is. But it is equally probable that he may be a "group-processed" type who arrived at lone drinking due to the absence of a compatible drinking group.

### **Research Strategy: Therapy**

Research relative to effective therapy needs to concentrate further on the pitfalls to affiliation with therapeutic groups such as A.A. The high regard with which the writer holds A.A. is a well-known fact. From this position of respect and sympathetic support, however, it is possible to see that as a group A.A. possesses the features of any other interacting unit. And so it seems

justified to raise the research question: does a screening process go on that selects certain newcomers for inclusion while others are cultivated less intensely? To what degree does hearsay communication about a prospective member set up an adverse reaction in the group? Even more important is the question: are some potential members more readily included in the informal clique pattern of the group than others? Are some provided with closer, overall contact with the group, while others are limited to contact with a few members?

The research problem is to study the induction process used by various groups. A provocative hypothesis is that the rate of affiliation is higher among those groups who exercise a reasonable aggressiveness toward the newcomer. Rather than allowing the newcomer to decide independently concerning his behavior, do successful groups use, during the first few encounters with a prospect, a pattern of high interaction with him? In this manner, perhaps, the group controls are activated quickly and the newcomer is relieved of individual decision making. A variation on this hunch would be the hypothesis that this kind of induction is accorded to some new members but not to others. Those newcomers who receive it affiliate readily, those who do not, face an uphill battle. The findings relative to such a research hypothesis would enable various groups to critically appraise their reception techniques.

Do those who affiliate with A.A. have a higher affiliation motive in their personality make-up than those who do not? This is a second relative research question regarding the barriers to affiliation with A.A. The hypothesis is that a significant difference does exist. The measurement of such differences could be attempted by means of the Thematic Apperception Test. Stories from this test have been scored to provide an index into the strength of the affiliation motive (in affiliation). Further refinements on this technique have been made. With these tools at hand a comparison of affiliates and non-affiliates relative to the intensity of the affiliation motive would be fruitful. Exploratory efforts along this line have been made by the author. These indicate the feasibility of such a research effort. If the hypothesis is substantiated, it would provide a device for detecting those who have a personality barrier to affiliation with A.A. Therapeutic efforts could be adjusted accordingly. If the hypothesis is rejected, the induction techniques of receiving groups would be indicated as a more determinative factor for affiliation than personality predispositions.

Although not as clear-cut as these two research questions and hypotheses, a third research area is suggested by the fact that the dynamics in etiology and therapy are, at bottom, often the same process. Many of the group phenomena present in drinking groups are also present in the dynamics of Alcoholics Anonymous. Only their content varies. Thus, group reward in the form of recognition and status is present in both. Group norms are operating in both. Self-definitions are provided in both. In both, specific group controls define who will be a member and who will not. The question that emerges from this fact: at what point in the group experiences of the alcoholic is he most susceptible to affiliation with a new "dry" group instead of a new "wet" one? One hypothesis that is suggested is that he can affiliate with a "dry" group when he has exhausted the possibilities of affiliation with a "wet" one. The research hunch is that affiliation with A.A. can take place only after drinking group supports have been removed. Exploratory interviews by the writer with many active A.A. members tends to support this position. Another hypothesis is that affiliation susceptibility is enhanced during the period of drinking group realignment. Following rejection from one group there is a readjustment period. The hypothesis would be that attachment to a "dry" group such as A.A. is more probable during this time than after a new "wet" group attachment has taken place.

A methodological problem involved in all of these suggestions can only be touched on lightly. The questions and potential answers require field work. The rapport problem in such efforts is a difficult one. Time, frustration, money, and a source of alcoholic subjects, present obstacles. But it is the slow, pedestrian accumulation of acceptance by research-suspicious persons that constitutes the major research difficulty.

### **Summary**

A basic research problem in the etiology of alcoholism lies in spelling out the group dynamics that can unite alcoholic predispositions to alcohol usage. Despite widespread awareness that a "linkage" process is missing from etiological considerations, little effort has been made to illuminate its nature. It is contended here that the coupling often takes place through the status-reward present in face-to-face drinking groups. Within the reference

points provided by these groups, predisposed persons are tutored to use alcohol excessively. Group rewards provide positive motivation to use alcohol. However, group exclusion also develops and the budding alcoholic seeks out new drinking groups that will continue to reward his drinking behavior. In this manner, he reaches groups where "loss of control" is the expected norm.

A basic research problem in therapy lies in how to detect and reduce the barriers to affiliation with therapeutic groups such as Alcoholics Anonymous. The induction practices of a receiving A.A. group may act selectively to deter affiliation. Research is needed to clarify this hypothesis. Or, on the other hand, the affiliation motive may be weak in those who cannot affiliate. Research questions and hypotheses were presented relative to this barrier.

### **Conclusion**

These considerations are not intended as a polemic against the physiological or psychiatric viewpoints. The time is long over-due when researchers in the alcohol field will look upon alcoholism as a process, not a single factor, one-way, cause and effect result. The physiological and psychiatric are not ruled out, but small group factors are ruled in with them.

In short, these considerations are intended to call more sharply to attention the role of the "wet" group in etiology and the "dry" group in therapy. The conclusion that can be reached is that exclusive consideration of physiological and psychiatric forces has only limited explanatory power. It is essential that the learning influence of the primary face-to-face drinking group be included if a more complete explanation of loss of control is to be realized. It is equally important that impediments to affiliation with group therapy such as A.A. be studied and reduced so that therapeutic efforts will be more successful. Finally, specific research orientations, questions, and hypotheses concerning the role of the groups both in etiology and therapy await our attention.

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