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ALCOHOL ABUSE AND ALCOHOLISM

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For those sociologists who have had the motivation and opportunity to study alcohol-related issues, the topic can prove compelling, often capturing the commitment of an entire career. Despite these implicit attractions, an examination of sociology journals and of the major emphases of academic departments of sociology suggests that the corpus of sociological work on alcohol use, alcohol abuse, and alcoholism is quite small. Indeed, Robert Straus (1973), an early and multigenerational contributor to the specialty, observed that relatively few social scientists are attracted to studying alcohol issues because of the stigma associated with the subject matter. The measure of "how much" sociological interest of effort is concentrated on a particular subject matter is more elusive than it might appear. Thus, an alternative view is that there is a substantial influence of sociological theory and research design within alcohol studies, but it is in many ways "hidden" in places other than sociology departments because of the peculiar organization of scientific research in the United States. For example, as an indirect result of sociological research on the behavior of what they are labeled "problem drinkers" (Room and Cahalan 1974), the medical definition of alcoholism is fundamentally sociological. Within official diagnostic manuals, alcohol dependence (alcoholism) is almost exclusively defined in terms of individuals' social role performance and others' definition of the extent to which this performance, due to repeated episodes of drinking, fails to meet social expectations. The centrality of a sociological model within a medical definition would seem to be an indicator of notable influence, yet most sociologists are probably unaware of the content of the definition or the sociological research that helped shape it.

The status of alcohol studies within sociology is a question within the sociology of science and a more complex challenge than it might appear (Wiener 1981). This issue is not limited to alcohol studies and converges on contemporary concerns about the importance of interdisciplinary research versus the "silos" within which academic disciplines tend to operate. The central assertion in this chapter is that there is great opportunity for the application of sociological theory and methods to issues around alcohol and the problems that its use creates. The location of both past and ongoing work of this nature is not highly visible within what might be called the sociological mainstream.

In this chapter, a sampling of some of the work in this specialty is provided, together with an analysis of how this specialty has developed and been shaped over time. The discussion here is largely limited to the United States. Although there is a range of sociological activity worldwide, the patterns of scholarly interaction tend to stay within national borders, largely because of the unique policies, service delivery systems, and research support structures that guide sociological work in different nations. The worldwide sociological study of alcohol issues is of great importance but is beyond the scope of the present discussion.

The chapter opens with an overview of the historical emergence of sociological interest in alcohol issues, and three different themes are described. This is followed by several examples of research that characterize each of the three thematic areas and a discussion of possible directions that may occur in the future.

THE ORGANIZATION OF THE SOCIOLOGY OF ALCOHOL-RELATED ISSUES

Since the early 1990s, the American Sociological Association (ASA) has had a section on the Sociology of Alcohol and Drugs, recently renamed to include research interest in tobacco use. More notable as a hub for sociological activity over the long term, the Society for the Study of Social Problems (SSSP) launched a Committee for Research on Drinking Behavior in 1955. This has since been modified to include research interest in drugs. Finally, a small but vibrant organization involving a range of international social science interests, including sociology, the Kettil Bruun Society (named in honor of the research contributions of a deceased Finnish sociologist), meets every other year at rotating venues that include the United States.

Despite these organizational structures, the actual scope of research and writing activity directed toward alcohol issues that is identifiably within sociology is relatively minimal. In a review article in an outlet central to alcohol studies, a sociological leader in the specialty (and cofounder of the ASA section), Helene R. White (1993), observes that the specialty has

> a low status in the discipline of sociology. An examination of three major journals in sociology (*Social Forces, American Journal of Sociology* and *American Sociological Review*) revealed that out of 1,600 articles published during the 1995-2004 period, there were three, none and three articles, respectively, that dealt with alcohol use or alcoholism. Thus, less than one percent of all articles published in these major sociology journals in the entire decade were directly related to drinking behavior. (P. 8)

One might add more data to this observation by noting that relatively little of the underlying research activity occurs within settings that are explicitly identified with sociology. A review of the research grants funded between 1972 and 2005 by the National Institute on Alcohol Abuse and Alcoholism (NIAAA, a part of the National Institutes of Health [NIH]) reveals fewer than 20 investigators who have been based within academic departments of sociology.

Sociologists' involvement in research and writing on alcohol issues is, however, partially masked by the organizational contexts in which it occurs. Much of the research and writing about alcohol (and drugs) takes place in interdisciplinary centers that are commonly based in medical centers or schools of public health. Notable are centers such as those at Rutgers University, University of Michigan, University of Washington, University of Texas, University of California at Los Angeles, University of Georgia, University of Kentucky, University of Connecticut, the University at Buffalo, and the University of Oklahoma. There is also a substantial amount of research activity that occurs in independent free-standing organizations, both nonprofit and for-profit, such as the Research Triangle Institute, RAND Corporation, Pacific Institutes for Research and Evaluation, and Westat, Inc.

Those with sociological backgrounds working in settings as members of interdisciplinary teams are not readily identified as sociologists, nor is their work usually published in sociological outlets. Instead, it appears in numerous specialty outlets focused on substance abuse or in journals more broadly focused on psychiatry, general medicine, public health, or health services research.

Some of these publication outlets in turn represent specialized research organizations such as the Research Society on Alcoholism, the College of Problems of Drug Dependence, the Academy of Health Services Research, the American Society of Addiction Medicine, and the American Public Health Association. Participation in these organizations keeps sociologists involved in alcohol studies in contact with peers from other disciplines, who may be studying similar issues. Such interaction is important in building and sustaining reputations and prestige, as well as providing access to new research and publishing opportunities.

These networks in turn include persons selected as peer reviewers for research grant applications by the NIAAA, the National Institute on Drug Abuse (NIDA), and other funding agencies within the NIH. Sociologists and other network members also sit on the editorial boards of the specialty journals, such as *Addiction, Journal of Studies on Alcohol, American Journal of the Addictions, Journal of Substance Abuse Treatment, Substance Abuse and Misuse,* and many others, publication in which is central to peer interaction and part of the expectations associated with receiving grant and contract awards. Moreover, the funding agencies, principally within the NIH, are oriented toward alcoholism and the health and social consequences of alcohol abuse and are thus unlikely to provide favorable reviews or high priority to research aimed at fundamental sociological questions.

THE EMERGENCE OF THE SOCIOLOGY OF ALCOHOL-RELATED ISSUES

Alcohol issues became prominent in American culture in the 1830s, with the launching of the Temperance movement, substantially predating the emergence of American sociology. The social and organizational activity swirled around alcohol issues into the first quarter of the twentieth century, culminating in national Prohibition (Clark 1976; Rumbarger 1989). While the prohibition of alcohol manufacture and distribution in the United States would seem to have offered sociologists a great opportunity for commentary and perhaps criticism of this social policy, as well as opportunity for analyzing the emergence of the policy despite popular ambivalence, an examination of the content of the *American Journal of Sociology* and the *Journal*

of Social Forces, the two extant sociological journals published during the period of Prohibition (enacted in 1918, enforcement began in 1920, repeal in 1933), finds almost no interest in the topic.

The sociological study of alcohol issues in the United States had its origins in the repeal of Prohibition in 1933. The enactment of Prohibition in 1920 marked the culmination of an 80-year period of prominence for a two-pronged set of efforts to remove drinking from American society, the Women's Christian Temperance Union and the Anti-Saloon League (Gusfield 1963; Clark 1976; Rumbarger 1989). The fundamental ideology of these overlapping but separate movements was that the manufacture, distribution, and use of alcohol are destructive to both social structure and social order. Drinking was said to have especially undermining effects on the family and the workplace through adult male drinking habits, highly visible in the relatively short-lived social institution of the saloon.

The development of two streams of sociological study can be traced back to the post-Prohibition period. Each of these flowed "naturally" from other events involving changes in social policy. A third stream was launched quite deliberately several years later but has developed in a quite limited fashion and at present appears to be dormant. These three streams can also be characterized by their typical foci: (1) alcohol abuse, or behavior which produces social costs and problems; (2) alcohol dependence and alcoholism; and (3) normative drinking behavior and the roles that the use of alcohol plays in social structure and social institutions.

The first stream is easily understood for its continuity with portions of the ideology of Prohibition and the Temperance movement in its focus on the problematic consequences of alcohol use. This research includes the relationships between drinking and a variety of undesirable social outcomes such as crime, unemployment, and family instability. This stream of research also focuses on the problematic drinking patterns of certain social groups, such as college students or the elderly.

Researchers aligned with this perspective rarely advocate a return to Prohibition but are strongly identified with both supply and demand reduction in the form of preventive education about the risks associated with drinking and increased controls on the availability of alcoholic beverages. In a traditional sociological sense, this is the "social problems" perspective on alcohol. From a broad perspective, this orientation today is closely aligned with the field of public health.

The second stream flowed from fascinating social changes that began in the 1930s and continue to evolve until the present day. Temperance ideology was coupled with the notion that alcohol consumption offered the potential of unmanageable habituation to anyone who drank. The best analogy to understanding is contemporary ideas about heroin use in American culture, namely, that the drug's effects are so potent and seductive that any user is at high risk of becoming an addict. The repeal of Prohibition occurred for a complex set of political, economic, and social reasons that did not include a social "embrace" of alcohol as the "Good Creature of God" as it had been labeled in the eighteenth century. Drinking in American society is not seen as an expectation or a right but as a privilege or a necessary evil. However, repeal effectively undermined the perspective that alcohol use created a marked risk of loss of control and addiction. Another conception was needed.

Although some changes were almost immediate, the 20 years following the repeal of Prohibition led to a greatly modified vision of the social location of the alcohol problem, namely, the rejuvenation, rearticulation, alteration, and attempted widespread diffusion of the idea of the disease of alcoholism (Levine 1978; Schneider 1978). This was the first and central ingredient of this stream of research, and it opened the way for American society to reaccept the legal presence of alcohol because alcoholism occurs among relatively few people. Specifically, this disorder, characterized by a progression to loss of control over one's drinking, is posed to affect a relatively small proportion of alcohol users. Its definition specifically excludes the excessive use of alcohol as a cause of alcoholism and draws a distinction between this disease condition and deviant drinking behaviors. The deviant drinker has chosen to break laws and social norms and may be punished for this behavior, whereas alcoholics are driven by a compulsion that is supposedly out of their control.

The disease model could not be nurtured in a vacuum. The available organizational context was centered on the replacement of the "moral" approach to alcohol by a scientific or "rational" approach. The debate over right and wrong involving alcohol was to yield to objective and comprehensive understanding of the substance's nature and effects. This in turn would guide social policies based on reason instead of emotion. Through happenstance or predestination, the rapid success of this transformation was greatly enhanced by the emergence of the first scientific center of studies on alcohol at one of the most distinguished and respected centers of thought in the United States, Yale University.

The Laboratory of Applied Physiology, established many years earlier, included eclectic leaders such as Dr. Howard Haggard and Dr. Yandell Henderson, the latter having authored scientific articles about the relative harmlessness of beer consumption, data that may have added impetus to the repeal movement. Following repeal, a section on Alcohol Studies appeared in the Laboratory and eventually emerged as a full-scale Center of Alcohol Studies.

The scientific orientation was attractive to a number of prominent scientists outside Yale, who had been repelled by the Prohibition experiment and its irrational features. They formed the Research Council on Problems of Alcoholism as a means of garnering interest and support for the emerging specialty of scientific alcohol studies and were closely

aligned with the activities at Yale. This council enhanced its linkage with scientific imagery by becoming affiliated with the American Association for the Advancement of Science (Beauchamp 1980). This group initially received some modest support from the alcohol beverage production industry, as well as from other sources, but it did not attract governmental support for research.

Almost simultaneous with the disease model and the superceding of moralism by the scientific approach was the rise of a fascinating solution to the newly defined disease, namely, the invention, codification, and diffusion of the fellowship of Alcoholics Anonymous (AA). Originally defined as a "cure" for alcoholism (later the ideology shifted to "once an alcoholic, always an alcoholic"), AA evolved from the Oxford Group concepts popular in the 1920s and 1930s. In order to open the way for full reentry into society, AA essentially embraced the disease model of alcoholism, although its referent has always been that the loss of control is traced to an "allergy."

While working informally and without a name for several years after its founding in 1935, AA came to national attention with an article in the then popular magazine the *Saturday Evening Post.* The AA program came to be articulated into a series of 12 steps. These steps include experiences of surrender to a higher power, self-examination, repentance, confession, meditation, and finally, service to others attempting to deal with their drinking problems. Membership in the fellowship requires only a sincere commitment to stop drinking. Passage through the steps, which is not mandatory and does not confer status, is reinforced by peer support, by attendance at regular meetings where members shared their "stories" of alcoholic defeat, and by sponsorship of an experienced AA member, who is available around the clock to provide advice and support.

The scientific approach, the disease concept, and AA constituted a mutually supportive and interdependent system that gave impetus to a substantial amount of research and promotional activity that brought the notion of alcoholism as a treatable illness into mainstream American culture. An illustrative capstone event of this integral process was the offer in 1954 of an honorary doctorate by Yale University to William G. Wilson, the cofounder of AA. Wilson refused the honor on the basis that it would set a precedent for individuals receiving personal recognition for the activities of AA (Hartigan 2000).

This core of the disease model of alcoholism, nested in a scientific approach, and the treatment of alcoholism with a logical, inexpensive, lay-based yet supportive of the disease concept is the home of the second stream of sociological research. It is notably interdisciplinary, and the unique contributions of sociology are not always clearly evident. This stream might be seen as a subfield of medical sociology, although it is not organized as such within sociology. The stream embodies social psychological studies, epidemiology, and health services research. It is, however, more closely aligned with medicine than with public health.

The third stream was intended to be within the sociological mainstream, but its development has become minimal and marginal to the mainstream of sociology. More than 60 years ago, a sociologist laid out a plan for using alcohol as the platform for a major endeavor in advancing sociological understanding of groups, communities, institutions, cultures, and societies (Bacon 1943). Selden Daskam Bacon was a Yale Ph.D. in sociology who studied under Albert Keller, who had been a student of William Graham Sumner. From the platform of the Yale Center and its emphasis on the scientific approach, Bacon saw distinctive roles for the social sciences assuming that the moral perspective on alcohol was relegated to the past.

In this treatise, Bacon saw both the history of alcohol in human societies and its pervasive presence in many realms of social institutional life as descriptive of its interconnections with the formation and deterioration of social norms and values. He recognized the fact that the apparent control of a potent drug flowing freely in adult society offered the potential for understanding the workings of basic processes of social control. Bacon's call included attention to all the "normal" and integrative uses of alcohol, in addition to expected sociological concerns with alcohol-related and alcohol-fueled conflict and deviant behavior.

While Bacon's plan never came to fruition, or is yet to be discovered by those who will develop it, he himself became a mainstream figure in the interdisciplinary research field of alcohol studies and, clearly identifying himself as a sociologist, became the first Director when Alcohol Studies achieved Center status at Yale. It should be noted that the relationship of the Center with Yale ended in 1962, when amidst a swirl of controversy, Yale president Kingman Brewster terminated the Center on the grounds that its interests were outside the University's central stream of basic research and education (Wiener 1981). With support from the only philanthropist who has ever given substantial resources to the field of alcohol studies and practice, R. Brinkley Smithers, and with support from the National Institute of Mental Health (where the minimal federal interest in alcohol-related research was located prior to the establishment of NIAAA), the Center on Alcohol Studies was successfully relocated to Rutgers University, where it remains today.

The remainder of this chapter reviews examples of sociological ideas and research about the broad notions of alcohol abuse and alcoholism. Rather than offering an abbreviated catalog of the entire body of this work, focus is on several illustrative samples in each stream.

THE FIRST STREAM: SOCIOLOGY, ALCOHOL ABUSE, AND SOCIAL PROBLEMS

Beginning with what has been referred to as the first stream of sociological research, the definition of alcohol abuse is distinctively sociological, based on deviation from

the norms of acceptable drinking. If one's drinking is deviant in the eyes of another, then it may be said that an event of alcohol abuse has occurred. This becomes consequential when the defining other is more powerful than the drinker and decides to take action. Thus, a 12-year-old caught drinking a tiny amount from a bottle in her parents' liquor cabinet would likely be defined as an alcohol abuser by an observing parent. Later in her life, when she is a college student, the same female may be observed by her peers drinking a copious amount of beer through a funnel, and the behavior is not defined as abuse.

A narrower definition emerges when social reactions are considered, for there are far more incidents of alcohol abuse than there are incidents that generate significant social reactions. These reactions may include screening for people whose drinking exceeds legal levels, such as that which occurs commonly on highways and less commonly in workplaces. Or the reactions may be triggered by social impacts, costs, and damages that are associated with the presence of alcohol abuse. In some such situations, the alcohol use is defined as abuse regardless of its level, with the consequences being the determining factors.

An illustration of this approach to analysis is a social problem that is the result of technological change, namely, the emergence of motor vehicles of all types as primary modes of human transportation. There has been a highly effective diffusion of the idea that alcohol consumption is the leading cause of highway accidents and related injuries and fatalities. In many respects, this logic is continuous with the "demonization" themes so common during the Temperance movement. Importantly, motor vehicles had not achieved prominence in the period from 1840 to 1918, when the gradual movement toward alcohol prohibition was under way. Thus, the theme of drinking's impact on highway safety had no relevance to the Temperance and Anti-Saloon movements.

The alcohol linkage may be seen as "ecological (Roman 1981b)." Five "ingredients" are present when a drinking-driver casualty occurs: alcohol in bloodstream + driver + automobile + highway + crash event. Testing for alcohol in the bloodstream and/or other evidence of alcohol consumption is at the forefront of the investigation. If alcohol is found to be present in an adequate amount, it is typically concluded that it was the "cause" of the event. It takes precedence over other possible causal explanations that may not be considered.

As examples, the possibility that other conditions affecting the driver could have "caused" the accident, such as lack of sleep, physical exhaustion, or emotional preoccupations, are ruled out by default. Only recently has there been awareness that "groups drive cars," although resulting regulations about the composition of the passenger population in a given vehicle are limited to those under age 21.

Likewise, unless blatantly obvious conditions are observed, defects in the physical functioning of the automobile itself are not considered as a possible cause of the accident.

Similarly, while sometimes considered as a contributing factor, highway conditions are rarely, if ever, attributed as a primary cause of an accident when alcohol is found to be present.

Sociological studies have advanced four interrelated factors that account for the dominance of drinking-related explanations. First, there has been a well-organized social movement, Mothers Against Drunk Driving (MADD), that forcefully and effectively brought this linkage to public attention (Reinarman 1988) and led to spin-off organizations such as Students Against Drunk Driving (SADD). Rather than using scientific evidence about the linkage between drinking and vehicular accidents, MADD adopted two icons that were prominent in the Temperance movement, the innocent child and the irresponsible drunken male adult. The founders of MADD were mothers of children who had been killed or injured by a driver who had been found to be drinking. The meaning of the group's acronym lies in maternal anger over the light penalties imposed on the drunken drivers, and the all-too-common stories that these individuals had retained their driver's licenses. Thus, MADD pushed for heavier penalties and more extensive enforcement of drinking and driving laws, all based on the causal linkage between drinking and highway crashes.

A second contributing factor is the relative ease of generating explanatory evidence. Blood alcohol levels detected through breath or blood tests are objective indicators that are relatively easily measured and understood. By contrast, the location of other causes may involve subjectivity and set the stage for conflicting interpretations.

Third, along with much of the industrialized world, the causal linkage in the United States between drinking as a cause of vehicular accidents is an institutionalized explanation that goes without challenge. In the United States, such causal statements appear on every container of alcohol sold through a retail outlet. Another institutional marker of this causal belief is a set of "dram shop laws," which can hold individual servers or retail outlets responsible for the material consequences of intoxication. The alcohol production and distribution industry does not challenge this explanation and in fact cooperates in campaigns to promote nondrinking "designated drivers" and to make servers of alcohol sensitive to the potential driving-related consequences of excessive alcohol consumption.

Fourth, alternative explanations that focus on defects in cars or on highway design may be seen as challenging vested interests and creating liabilities that may prove problematic for manufacturers and/or public officials who design and maintain highways. By contrast, there are no defenders of drunk drivers. Persons who desire to drink and drive or who do so routinely have not organized themselves into interest groups to promote these opportunities. To argue in today's society that it is a person's right to drive with a blood alcohol level of .08 or greater is patently absurd on its face.

It is of interest that this singular causal theory has not been diluted by a parallel movement to impugn illegal drug

use as a significant contributor to highway accidents. Considering the elements reviewed above, there is no trace of a social movement to address drugs and driving, and it is clear that measurement of drug use in an "onsite" fashion as is done with alcohol offers considerable technical challenges. The highway and the motor vehicle are, however, part of a different drug-related drama that echoes the Prohibition era, namely, the pursuit and apprehension of "suspicious" drivers and vehicles that are found to be carrying quantities of illegal drugs.

A similar set of social constructions can be found to prevail in a very different circumstance, namely, the consumption of alcohol by pregnant women (Armstrong 2003; Golden 2005). Drinking during pregnancy is imputed as the cause of a set of psychophysiological impairments observed in childhood known as the fetal alcohol syndrome (FAS), with milder forms of the symptoms referred to as fetal alcohol effects (FAE). The linkage of maternal drinking to these outcomes is ambiguous, as are the diagnoses of the disorders. Nevertheless, warnings about the effects of drinking on developing fetuses are universally diffused in the United States, including warning labels on alcoholic beverage containers and posted warnings in retail settings where alcoholic drinks are sold. Presumably, a woman who is noticeably pregnant and observed to be drinking would be stigmatized as irresponsible, perhaps in the extreme.

There are a number of problematic implications of this emergent normative structure (Armstrong 2003). First is the fact that when cases of apparent FAS and FAE have been closely examined, there is a strong association with poverty and general disorganization in the lives of the mothers. It appears likely that the outcomes of FAS and FAE stem from combinations of behaviors resulting in malnutrition, negligence of prenatal care, and heavy drinking. By focusing exclusively on maternal drinking behavior as the etiological agent, broader social conditions and life chances of the mothers and their offspring are effectively ignored.

Second, the ambiguous association between maternal drinking and FAS/FAE is used to impose social controls on pregnant women while effectively ignoring the drinking behaviors of fathers. Fathers' drinking may lead to the conditions of negligence and poverty that are important agents in the outcomes that have been labeled FAS/FAE. Likewise, the powerful indictment of drinking as a harmful agent draws attention away from nutritional factors and maternal behaviors such as tobacco smoking.

Third, the causal linkage is a mechanism for attributing blame solely to the mother and her behavioral choices. This may be seen as another mechanism whereby women's control over the reproductive process is curbed by the imposition of rules via simplistic interpretation of scientific data and through reasoning that easily crosses the border from science into morality.

Proscribed maternal drinking is remarkable in its simplicity in that it parallels the rules surrounding drinking and driving. Warning labels and signs are used to remind not only pregnant women of possibly damaging behavior but also bystanders of what pregnant women should and should not be doing. As with drinking and driving, there is no counteradvocacy group suggesting that pregnant women should be allowed to drink in moderation or that the research evidence about this linkage should be challenged.

That ambiguous data have been accepted as the basis for institutionalized rules that affect a significant portion of the population is another indicator of the lack of positive support for alcohol consumption in American culture and the absence of advocacy for the privilege of drinking. The overall attitude toward drinking during pregnancy, as with drinking before or during the experience of operating a motor vehicle, is "better safe than sorry," despite the possibilities that the causes of the adverse outcomes lie in something other than drinking.

Sociologists have long been attracted to the association between alcohol and crime, a direct heritage from the Temperance and Prohibition ideologies. One of the most thorough investigations has centered on alcohol and homicide (Parker 1996). It is clear that there is no direct causal linkage between drinking and violent behavior, but that the presence of drinking can be a facilitating factor in crime (Roman 1981a). This possibility is especially underlined when it is established that the victims of crime have frequently been drinking as well as the perpetrators, or that drinking by a crime victim created a particular vulnerability to victimization by a nondrinking perpetrator. This association has recently been examined extensively surrounding the issue of "date rape," of particular concern among college students (Abbey 2002).

There are a multitude of other social problems where data indicate an association with drinking, but where causality is difficult to discern. An example is homelessness, where drinking and alcohol abuse are complex correlates but hardly a singular cause. An emergent issue of the past decade has been "binge drinking" among college students, supposedly a set of risky and destructive behaviors affecting students who are naive about alcohol's dangers, their nondrinking peers, and the communities in which colleges are located. The imagery of risks associated with binge drinking by college students has been painted in broad strokes (Perkins 2002a) and, in the case of one highly effective moral entrepreneur, has been escalated to be associated with frequent fatalities (Wechsler and Wuethrich 2003). On the other side of the risk model, several sociologists have been active in the effort to develop interventions that will curb these behaviors (DeJong 2002; Perkins 2002b).

THE SECOND STREAM: SOCIOLOGY AND THE CAUSES OF ALCOHOLISM

Turning to the second stream of research, the overview now turns to studies that are primarily concerned with the

disease of alcoholism and its treatment. Research in the twentieth century had strong suggestions of social factors in the etiology of alcohol dependence. Trice (1966) offered a theory of individually rewarding drinking experiences followed by selective and sequential associations with drinking groups within which increasingly heavy and chronic alcohol use was socially accepted. Individuals who became alcoholic were surmised to "drift" through structures of social tolerance, where they found social acceptance but eventually ended up at "the bottom," or on skid row.

Building on the work of other researchers who had examined homeless and disaffiliated alcoholics, Wiseman (1970) uncovered social patterns and social structure in the lives and interactions within these groups rather than anomie and normlessness. Later, the same author (Wiseman 1991) documented patterns of social interaction in couples where the husband was a recovering alcoholic, strongly suggesting that social role relationships could develop around a spouse's chronic alcoholism and can serve to prolong it; by contrast, the adjustments necessary for the couple to relate in the context of sobriety is more complex than might be assumed.

Bacon (1973) used role theory to describe how individuals used alcohol to "ease" their entry into social situations where they felt uncomfortable with their performance. This in turn was seen as creating risks of thwarted role learning when alcohol became an agent of "pampering" accompanied by a broader repertoire of alcohol use in conjunction with potentially uncomfortable social performances. This was later developed further into an explanation for why "social stars" seem at high risk for developing alcohol and drug problems (Roman and Blum 1984).

Akers (1992) developed a straightforward model based on learning theory, describing patterned rewards in social interaction wherein alcohol dependence could develop. Mulford (1984) used both data-based observations and experience as an alcoholism treatment program director to develop a theory of how the process of recovery from alcoholism actually begins during periods of one's heaviest drinking, looking closely at responses to the reactions of one's social audience. Norman Denzin (1987) developed a detailed and complex description of the construction of the alcoholic self, which followed an earlier monograph that described the emergence of a transformed self through the processes of alcoholism treatment and recovery (Denzin 1986). An outstanding ethnography by a sociologist provides a rich description of processes associated with the struggle for recovery within AA (Rudy 1986).

Despite considerable promise, these studies did not lead to programmatic research, largely because they did not attract research support. This lack of interest is largely explained by the intense support that came to surround the explanation of etiology within a biomedical model of causation, indicating possible variations in alcohol metabolism across individuals and often including suggestions of genetic origins of these behavior patterns.

THE SECOND STREAM: SOCIOLOGY AND THE TREATMENT OF ALCOHOLISM

Within the second stream of sociological research and writing, a new generation of sociologists has moved away from criticism of the disease model and attempts to supplant it with models based on social interaction and has instead implicitly embraced it through treatment and health services research. Following is an example of such sociological analysis, tracing the macroorganizational forces that affected growth and change in the alcoholism treatment industry.

Contemporary alcoholism treatment has its most direct lineage from the postrepeal social movement discussed earlier. Launched by enthusiastic members of AA, who recovered through its program during its first decade of existence, the National Council for Alcoholism Education (later the National Council on Alcoholism [NCA] and now the National Council on Alcoholism and Drug Dependence [NCADD]) was founded in 1943, its mission being to "mainstream" into the health care system the treatment of the disease of alcoholism. The fledgling organization was originally based at the alcohol studies center at Yale University, and thus attempted to build its image via a symbolic association with science and medicine.

Public treatment for inebriates has a long history, with several large-scale asylums established in the second half of the nineteenth century (Baumohl and Room 1990). These centers could accomplish little except to keep their patients away from alcohol for the duration of their stay. By the early twentieth century, they were largely abandoned and replaced by drunk farms and county poorhouses, where little in the form of treatment was attempted. NCA's first departure from this model was the "Yale Plan Clinics" (Bacon 1947). These clinics were based on the AA approach, administered independently from the state hospital system, and their suggested design implicitly pointed toward inclusion of middle-class alcoholics, a notable departure from the caricature of drunkards at the bottom of the social class pyramid within Temperance ideology.

These clinics did not diffuse widely, and thinking shifted by the 1960s toward the idea that structured inpatient care for a brief period of time is necessary for successful treatment of alcoholism. Furthermore, inpatient care was more consistent with medicalizing alcoholism as a serious disorder. What emerged was an approach eventually referred to as "the Minnesota Model"; the inpatient treatment regimen was designed to last four weeks, and was expected to be followed by lifelong affiliation with AA. In addition to group AA experiences, patients also received individual counseling and education about the impact of alcohol on the human organism.

Parallel to these developments, NCA leadership undertook a major campaign for the decriminalization of the public inebriate. This symbolic change was seen as necessary for elevating the status of alcoholism to "a disease like

any other." The transformation of the alcoholic from "bad" to "sick" through the legislative process was viewed as highly significant at the time. NCA was successful in promoting this legislation. Inadvertently, perhaps, this accomplishment tended to reify the image of the alcoholic as a socially marginal, nonproductive public inebriate, a stereotype persisting from the Temperance movement. Thus, decriminalization was a limited and perhaps limiting organizational achievement relative to the movement's mainstreaming goal. It was especially limiting in that it did not build either advocacy or an appropriate constituency to promote NCA's goals.

Through the 1960s, NCA leadership slowly evolved the vision of locating alcoholism at all levels of social strata (Roman and Blum 1987). If alcoholism was a biological disorder, it should be widely dispersed within the population. Thus, the target of concern in the mainstreaming campaign moved from the highly visible, socially marginal public inebriate to the nearly invisible, socially integrated "hidden alcoholic."

Responding to its own definitions, NCA leadership became focused on the mechanisms to most effectively reach the vast bulk of American alcoholics who were not on skid row. In retrospect, a four-pronged campaign can be inferred (Roman and Blum 1987).

First, the public must be convinced that alcoholism was pernicious and pervasive and could be found anywhere in the social structure, from which it follows that the majority of alcoholics are indeed "hidden" and not receiving treatment.

Second, mechanisms must be made available for treating these "respectable" alcoholics, facilities clearly not represented by those that had been envisioned to serve the goal of decriminalization.

Third, to make treatment for alcoholism accessible, its costs must be covered like the costs for treatment of other disorders, leading to the clear need for the extension of health insurance coverage to include alcoholism.

Fourth, means must be established to identify and motivate the vast group of hidden alcoholics in the direction of treatment. Given the contrast in the apparent level of social integration between hidden alcoholics and the public inebriates that had previously been the primary target of treatment, it was clear that the workplace had great potential for serving this purpose. Workplace interventions, ultimately refined into employee assistance programs, were visible in a small but distinguished set of American corporations and were promoted as the mechanism that would provide the patients for a new system of treatment (Roman 1981a).

These goals came to be implemented through the establishment of NIAAA (see Wiener 1981; Olson 2003 for a detailed analysis of the political processes preceding NIAAA's emergence). As a new organization desiring to build a constituency, NIAAA worked closely with NCA. It moved on each of these four fronts to promote the idea that everyone was at risk for alcoholism, that a new system of privately based treatment should be established and supported by health insurance coverage. The NIAAA also enthusiastically embraced workplace interventions, which had been previously developed and promoted by NCA (Roman 1981a).

Entrepreneurs from many backgrounds, including AA recovery, were attracted to build a national network of private alcoholism treatment centers. These centers enjoyed growth, development, and apparently substantial income approximately from the late 1970s to the late 1980s. The centers opening during this period almost universally followed the Minnesota Model. Local, regional, and national advertising emerged to diffuse the concept of inpatient treatment, and the mass media gave considerable attention to the experiences of alcoholism and recovery among celebrated personalities.

However, during the decade of the 1980s and into the 1990s, two major and interrelated challenges to the centers' financial and organizational health emerged. First was a challenge to the relative efficacy of the residential treatment services that were the sole or central activity of most of these centers. A federally commissioned study (Saxe 1983) indicated that there was no evidence of advantages of this mode of treatment over other types. The eventual conclusion was that the residential experience was far more elaborate and expensive than was needed to produce the rate of successful client outcomes that could be inferred from research data.

The second challenge supported the first, namely, the costs of alcoholism treatment. Beginning in the early 1980s, most employers were experiencing rising costs of health insurance coverage for their employees. Employers' concerns were also the concerns of third-party insurers, whose profits and competitive positions were adversely affected by rising costs. The combination of concerns by employers and insurers eventually spread to managers in the public sector responsible for managing public payments for eligible clients receiving private health care. All these factors accumulated toward the health care reform crisis of the early 1990s and the rise of managed care.

Residential inpatient care services provided by the relatively new set of private alcoholism treatment centers were thus under attack from two directions, and each attack was more or less bolstered by the other. On the one hand, it was argued that less expensive services (e.g., community-based outpatient care) could produce the same or better results in treating alcoholism. Furthermore, these treatment centers were especially vulnerable to strong and severe challenges to reduce the costs of services. Several features of private alcoholism treatment centers describe their weak buffers to these challenges to organizational survival.

1. The costs of inpatient care for alcoholism for 28 days were not large relative to the costs of care in a general hospital setting. But private residential alcoholism treatment was a new arrival on the health care scene, and employers and insurers had not had these costs previously. Because of

its newness, this system of treatment was far from being institutionalized within the larger culture's expectations and norms about appropriate medical care. There is little evidence of widespread acceptance of the importance or even the propriety of this treatment within the surrounding public culture.

2. Because of their newness, uniqueness, and tendency to be freestanding, alcoholism treatment centers had not established interdependent relationships with other parts of the health care system. Such interdependencies could act as buffers in the face of environmental challenges, with other service units that either sent or received referrals from alcoholism treatment centers coming to their aid and advocating for their value. Such potential interfaces include primary care physicians and hospital emergency rooms, but partly because of the short organizational life of these centers and other aspects of the "liability of newness" (i.e., the essentially nonmedical nature of alcoholism treatment), there is very little evidence of the development of such interdependencies.

3. Also related to newness, the treatment centers had not developed a collective identity that was manifest in a trade association or other lobbying group that could defend its unique interests. This is in part due to the variation in organizational sponsorship from which the centers were established (i.e., general hospitals, emergent nonprofit boards, and profit-making companies).

4. Most alcoholism treatment centers have little in their regimen that can "mystify" the external observer. The apparent simplicity of their core technology, as well as the strong spiritual emphases, made them especially vulnerable to external challenges to their value. The processes that go on in residential treatment programs appear as "just talk" readily comprehensible to the external observer, bearing no resemblance to medical care. This encourages criticism by outsiders of the "unnecessary" extent of group meetings or the "luxurious" nature of recreational facilities.

A field research study focused on 126 private treatment centers initiated in 1986 (Block 1990; Roman, Blum, and Johnson 2000) revealed that within a sample of these private centers, almost perfect isomorphism could be found, following patterns of 28-day inpatient treatment, using 12-step principles as the foundation for treatment design, and targeting services toward clienteles with appropriate health insurance coverage (Block 1990; Roman et al. 2000). Just as the growth of the population of these centers was spectacular, their transformation has occurred with almost equal rapidity. As the first study moved toward completion, a dramatic number of closures in the original population of centers were documented, with these organizational deaths clearly indicating environmental conditions that were failing to support the centers' existence. There was a nearly a 20 percent fatality rate in the sample of centers between 1989 and 1991 (Roman et al. 2000).

Continuing research indicates that inpatient care and the "Minnesota Model" have become increasingly rare as treatment facilities have been forced to expand their services and modify their treatment ideologies in an effort to adapt to the turbulent environment created by managed care (Johnson and Roman 2002; Roman and Johnson 2002). What were initially separate systems for treating alcohol and drug problems have become integrated. Survival of treatment programs appears increasingly dependent on diversification and seeking new markets for care, such as providing services to special population groups and integrating treatment for co-occurring disorders such as psychiatric illness, eating disorders, and compulsive gambling.

This analysis of a portion of the treatment system for alcoholism is typical of health services research on alcohol issues conducted by sociologists. It makes use of organizational approaches to understanding the growth and development of social systems. Related studies are focused on the adoption of innovations in substance abuse treatment systems and the role of specialized occupations in treating substance abuse problems. Other research has focused on the use of the workplace for identifying employees with alcohol problems and providing them with constructive assistance via the structures available in work organizations (Roman 1990).

THE THIRD STREAM: SOCIOLOGY AND SOCIAL INTEGRATION

The third stream examines an array of "normal" drinking and considers the potentially integrative role of alcohol in multiple sectors of society. There is an extensive anthropological record of the worldwide variations in the social patterns of alcohol use (Heath 2000), much of it emphasizing the socially integrative functions served by alcohol consumption. Several sociological studies follow in this tradition, although most of them tend to include questions about alcohol abuse and alcoholism as well.

Early in this tradition was a study by Robert Freed Bales (1946) of Irish drinking behavior. Looking at drinking in rural Ireland, Bales linked the observed patterns with social and cultural organization. The rules of primogeniture resulted in the oldest son inheriting the farm, with the remaining brothers staying on as farm laborers, but without the wherewithal to marry and raise their own families. Bales argued that heavy drinking had emerged as a functional substitute for sexual outlets among these men in puritanical Irish society and that it eventually diffused as a social acceptance of heavy drinking by men.

Charles Snyder (1958) completed his doctoral work at Yale with an extensive study of drinking among Orthodox Jews, attempting to understand how a culture could have a near-zero rate of abstinence and yet have few problems with alcohol. His conclusions centered on the social

meanings of drinking as symbolic and supportive of family and religious life, with drinking typically present when at ceremonial events underlining the importance of family and of religion. Excessive drinking also had a negative association with non-Jewish outsiders, including memories of events when drunken anti-Semites would attack Jewish communities, particularly in Eastern Europe.

This work was revisited by Glassner and Berg (1980), who conducted research to establish the resilience of the minimal level of alcohol problems as Jewish communities moved away from Orthodox isolation and became more integrated with non-Jewish cultures. Their research revealed four factors: the continuing cultural association of alcohol abuse with non-Jews, the integration of moderate drinking into family-based rituals, tending to drink with other moderate-drinking Jewish family members and friends, and developing repertoires for avoiding the common pressures to drink heavily in social settings.

Other research that has considered the integrative effects of alcohol has suggested that drinking may be an important socialization rite of passage for youth and young adults (Maddox and McCall 1960). This conclusion is, of course, in sharp contrast to the current obsession with drinking among college students, and the symbolic association of death and injury with "binge drinking," a term effectively invented and diffused to precipitate a degree of moral panic (Wechsler and Wuethrich 2003).

Other studies have examined the settings of drinking and have generated some fascinating ethnographies of cocktail lounges, bars, and after-hours clubs (Cavan 1966; Spradley and Mann 1975; Roebuck and Frese 1976). One such ethnography provides a rich examination of the lives of blue-collar men in one community who centered much of their social life surrounding tavern-based drinking (LeMasters 1976).

However, not only is there no sociology of drinking in the mainstream of contemporary sociology, but also it is quite clear that relatively few sociologists include the use or misuse of alcohol in their research or writing. There can be little doubt that in the United States as well as around the world, alcohol issues are marginal to mainstream sociology. Perhaps this attention will change during the twenty-first century.

Robin Room (1976), a polymath sociologist who has explored and written about nearly every aspect of alcohol social history, policy, and epidemiology, wrote a brilliant but neglected essay on American ambivalence toward alcohol and its consequences. Within the social and historical context of American society, it is easy to see how the appreciative stance on alcohol could wither away from lack of social support. The current cultural context has been characterized as a "drug panic," and in such a setting, receptivity to discussions about the virtues and values of alcohol is likely to be low. However, in line with Room's observations, this does not mean that drinking will disappear or even significantly diminish. What it does mean is that talking about drinking and addressing deviant drinking in families or social settings through direct confrontation will both continue as taboo topics and taboo behaviors within this culture.

Looking only at American society, there is, however, little on the horizon to suggest that change in the pattern of sociological attention and investigation will occur. Despite the potential for their development, there are few tensions or conflicts to be observed among the constituent groups surrounding alcohol, these including consumers, the specialized medical care system's for alcohol dependence, the criminal justice system management of alcohol-related deviance, and the alcohol production and distribution industries.

Alcohol use is, however, an increasingly global phenomenon, and alcohol manufacture and distribution is an aggressively growing worldwide industry, replacing in many locations systems of indigenous alcohol production that have usually been accompanied by socially and culturally integrated customs of drinking. For example, the spread of alcohol availability is accompanied by the introduction of Western-style systems of work organization (Roman 2002). This presents two sets of potential problems. First are those where much more extensive use of alcohol develops among those with the newly acquired wherewithal to obtain it, coupled with employed persons' responses to advertising that much more extensive drinking than was known in the past is part of the new normative order. Second are the effects of wider availability of alcohol and attractive promotions in settings where the intermingling of drinking and work has been casually tolerated for centuries. In either case, the problems are not likely to be easily tractable, and an understanding of how to effectively deal with normative and organizational change emanating from sociological research could be potentially valuable. Thus, direct sociological attention to alcohol issues could come to flourish in the twenty-first century and beyond.