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"A Power Greater than Ourselves":
The Commodification of Alcoholism

A Thesis

Presented to the

Department of Sociology and Anthropology

and the

Faculty of the Graduate College

University of Nebraska

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

University of Nebraska at Omaha

by

John S. Rice

March 1989

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THESIS ACCEPTANCE

Acceptance for the faculty of the Graduate College, University of Nebraska, in partial fulfillment of the requirements for the degree, Master of Arts, University of Nebraska at Omaha.

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Chair

3/23/89

Date

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I owe my principal debt of gratitude to the members of my thesis committee, Drs. Littrell, Lamanna, and Gillespie. Each was of invaluable assistance in the writing of this thesis, and this work is stronger for their advice and guidance. None, however, imposed a point of view upon me. The argument, as written, is mine, and I take full responsibility for its oversights and shortcomings.

Formal acknowledgments too-often only acknowledge formal contributions and inspirations. The members of my committee also inspired me indirectly through the quality of their own work and, not incidentally, by their integrity, humor, and commitment to scholarship as a way of life, rather than as an official assemblage of merely "professional" characteristics. In short, during the course of conducting this research and writing the thesis, I have had the honor of working with fine scholars _and_ fine human beings; a rare and deeply appreciated privilege.

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I gratefully acknowledge, as well, the members of Alcoholics Anonymous, and the staff and patients at General Treatment Center, whose willingness to talk with me (and/or in my presence) lent much to my understanding of the present state of the alcoholic role and of alcohol treatment.

Finally, that portion of the title which appears in quotation marks is taken from the second of AA's twelve steps to recovery:

> "[We] came to believe that a power greater than ourselves could restore us to sanity".

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CHAPTER 1

ALCOHOLISM: PAST AND PRESENT

Hospital-based treatment of alcoholism and other, so-called "chemical dependencies", has become common practice in the U.S. In 1983, 4,465 facilities, including hospitals, halfway houses, and outpatient treatment programs and agencies, provided chemical abuse treatment (Denzin 1987: 17). This increase in facilities is mirrored by the increase in people receiving treatment:

> The growth in treatment facilities since 1977 and the increase in A.A.'s [Alcoholics Anonymous] membership since 1977 suggest that in 1985 perhaps over 800,000 individuals a year in the United States are receiving direct hospitalization or indirect A.A. and outpatient treatment for alcoholism (Denzin 1987: 17).

Often, observations such as Denzin's are presented with a curious matter-of-factness, as if the annual treatment of a million persons, more or less, for alcohol, drug, or other dependencies is an unproblematic indicator of America's mounting alcohol and drug problem. Yet, the following page, Denzin (1987: 18) observes that,

> The existence of such a large number of treatment facilities for alcoholism and the expanding membership in A.A. suggest that "treatment" for alcoholism is becoming a big business in the American health care and insurance system.

Some of the growth of both America's problems with addiction and of the facilities devoted to this treatment can be traced to the greater public acceptance and awareness of

the disease model of alcoholism, and an accompanying conviction that medical attention is the necessary and appropriate solution for problems rooted in disease.

However, a more critical interpretation of the increasing numbers of people being treated for alcohol problems issues from Denzin's observation that "'treatment' for alcoholism is becoming a big business". In 1972, Trice and Roman noted the development of a treatment "industry" (cited in Conrad and Schneider 1980: 87), both devoted to and dependent upon the definition of alcoholism as a disease of epidemic proportions. Although prevalent therapies are based upon this disease model, unless one assumes that alcoholism is a contagious disease, the treatment of so many people suggests that something larger than "personal troubles" is afoot: indeed, perhaps a more reasonable conclusion to reach is that alcohol problems are a "public issue", to use Mills' (1959) vital distinction. In short, the context of alcohol problems is often obscured by a focus upon individual disease. The present argument will focus upon that larger context. In the following pages, I will illustrate the social reality of alcoholism treatment. I will argue that the growth in the number of treatment centers, and in the prevalence of treated alcohol and drug abusers, issues from the commodification of the alcoholic role and of alcoholism treatment. The analysis is based upon my ten weeks as a participant-observer at one

hospital-based treatment agency and current, published research on the topic.

MEDICALIZATION AND HOSPITALIZATION

The classification of behavioral problems as medical in nature, and the assignment of the responsibility for and care of these problems to the medical profession has been called "medicalization" (Conrad 1975; Schneider 1978; Pfohl 1977; Conrad and Schneider 1980). Conrad lists several points of concern regarding medicalization, especially its tendency to individualize social problems and depoliticize all norm-violating behaviors. Certainly, the "rise of corporate medicine" (see, for example, Starr 1982) raises the possibility that at least part of the explanation for the medicalization of alcoholism and the development of the treatment industry lies with the profitability of providing alcohol treatment.

Indeed, the profit-oriented character of American medicine must be considered when examining any aspect of the health care system. Alcoholism's medicalization is a necessary condition underlying the process with which the present argument will be concerned: the widespread <u>hospitalization</u> of alcoholics.

In 1985, the U.S. membership of Alcoholics Anonymous (AA), a voluntary self-help group, was 500,000. A recent U.S. Department of Health and Human Services study (1987: xx)

observed that "more than half a million persons were reported to be in [alcoholism] treatment in late September 1984". The entry of hospitals into the alcoholism treatment business, then, is associated with a significant change in the size of America's alcohol problems: AA, after fifty years of existence, had 500,000 members. In 1984, more people than that were in treatment for alcoholism in a single month. The perspective underlying this thesis asserts that after years of studied disinterest in alcohol problems (see Rosenberg 1987), hospitals have taken a deep interest in those problems and have recruited half a million people into treatment in a remarkably short time.

Weisner and Room (1984) report a 48.2 percent increase in the provision of private, for-profit alcoholism treatment in the three years between 1979-1982; 2) a steady expansion of problems defined as alcohol-related; and, 3) the diversion of a sizable proportion of less-serious criminal offenses into alcohol treatment programs. These findings have been supported by researchers in the field (Room 1982, 1983; Morgan 1983; Weisner 1983; Fillmore and Kelso 1986).

The striking increases in treatment populations cannot be explained solely as a result of a sudden explosion of alcohol abuse in America. Although the treatment industry proffers this explanation, this view blames individuals and obscures the social context of the treatment explosion. The social

context of treatment focuses attention upon the relations among the rise of corporate medicine, the medicalization and hospitalization of alcoholism, and the comparatively recent introduction of third-party reimbursement for alcohol treatment.

> From 1978 to 1984, state and local government control of hospital inpatient treatment declined by 16 percent, and for-profit ownership of such units increased by 392 percent [from 199 to 851; see Appendix, Table 3.1]. The apparent heterogeneity among alcoholics is attracting considerable interest in the field. Efforts are being made to understand and measure this heterogeneity for possible application of the concept to individualized treatment planning (Health and Human Services 1987: xx) [emphasis supplied].

The treatment explosion, involving hospitalization for alcoholism, is equally well understood as the corporate hospital's quest for new sources of revenue. This concern for revenue helps to account for hospitals' new-found interest in alcoholics, as well as the consistent refusal to acknowledge the disparity between the treatment industry's assertions that alcoholism is a disease and the very large body of objective research which contradicts those claims (see, for example, Peele 1985, 1986; Fingarette 1988; Vaillant 1983) (1).

---

1. Peele (1986: 66) succinctly summarizes such research: "[I]t simply strains scientific credulity to imagine that the same factors which act in a socially mediated way to determine alcohol misuse also operate through separate genetic paths to influence alcoholism".

The primacy of revenue generation leads to a formal statement of the thesis: the hospitalization of alcoholism is a form of commodity-production which demonstrates the characteristic social relations of that economic process. Commodity production involves an exploitative social relation which assumes the appearance of a relation between "things"; in this case, a disease and a service one may purchase to recover from the disease. Commodification, then, requires a particular set of relations, and a particular way of explaining those relations; the subjects of Chapters 3 through 5.

The development of commodity relations has demanded a changed definition and understanding of the nature of addiction and of the most efficacious solutions to that problem. The following pages will illustrate current commonsense understandings of alcohol abuse and alcoholism, and demonstrate the manner in which we have come to our present understandings.

CURRENT PERCEPTIONS

Those who view alcoholism as epidemic in American life adduce a plethora of inferential and indirect evidence which routinely correlates alcohol use with serious social problems. Endless studies report the magnitude and diversity of problems in which alcohol use is involved. In each case, however, the extent of alcohol's role is a matter of

interpretation or conjecture. In the language of social science, the simple correlates of alcohol use do not demonstrate the causal efficacy of alcohol use.

The correlation between alcohol use and traffic fatalities, for example, consistently hovers around 50% (Health and Human Services 1987: 8) (see Appendix, Table 1.1). This relationship makes intuitive sense: impaired judgment and slowed reflexes are clearly less than optimal states for the operation of a heavy machine at high speeds. But several problems with this view exist. Such figures do not substitute for a direct or indirect measure of alcoholism. There is no support for the assertion that the intoxicated person behind the wheel, even in fatal accidents, was an alcoholic (2). Nothing is said about the 57% of the fatally injured drivers in 1984 who were killed without drinking or being drunk. Nor do these data measure the number of drunk and alcoholic drivers who drink and live.

Crime is another well-documented correlate of alcohol consumption. In 1983, 54% of the violent crimes, 40% of the property crimes, 29% of drug-related offenses, 64% of public order offenses, and 40% of the generic, "other" offenses, involved prior alcohol use (Health and Human Services 1987:

---

2. Alcoholics are conventionally differentiated from other drinkers on the basis of behavior. That is, the primary means of differentiation is said to be alcoholics' loss of control over their behavior. They are said to be "one drink away from a drunk" and cannot predict with any certainty what they will do upon taking a first drink.

13) (see Appendix, Table 1.2). This, too, is an intuitively reasonable chain of causes. Alcohol's disinhibiting effects impair the judgment upon which one makes decisions to walk away from insults without taking a sledgehammer to an enemy's car or head.

Not surprisingly, the highest percentages of prior alcohol use appear in "non-skill" offenses, crimes that require only the suspension of normal judgment. Public order and violent offenses are often heat-of-the-moment transgressions. Proponents of the simple intuitive view conclude that intoxication simply turns up the heat. Crimes which depend upon surreptition, or which may be forms of livelihood, are reflected in their relatively lower percentages of alcohol use. That one does not drink on the job apparently holds true for criminal occupations, as well as more skilled ones. The statistics for 1983 (see Appendix, Table 1.2) bear these observations out.

The data confirm the commonsense disinhibition hypothesis. Yet, as with the data on alcohol and traffic deaths, there are important omissions. If the independent variable "alcohol use" is dichotomous, one must explain the 52% of convicted persons who had <u>not</u> used alcohol prior to their offense. In short, the data demonstrate that the association between alcohol use and crime is, in most instances, about a fifty-fifty proposition. Such data do not

disprove the alcohol abuse hypothesis, but they do not support it, either. The correlates of alcoholism, then, cannot be adduced to explain the sudden growth of private treatment programs.

ALCOHOL AND ECONOMIC COSTS

Another commonsense view of the magnitude of alcohol problems in the U.S. derives from estimates of alcohol's role in economic losses. Harwood et al. (1984), for example, have estimated that in 1983, alcohol problems cost American society nearly $117 billion, while the costs of crime and traffic accidents/fatalities for both offenders and victims amounted to just over $9 billion (Health and Human Services 1987: 23) (see Appendix, Table 1.3). Very importantly, the Harwood (et al.) study attributed sixty-eight percent of the total economic costs of America's alcohol problems in 1983 to the variables of "lost productivity" and "treatment" of those problems. They do not explain how "lost productivity" is measured, in spite of his claim that the loss of productivity is more than three times as costly as any other single aspect of alcohol problems.

Although alcohol use may be related to major social problems, clear causal evidence is very difficult to find. Even more important, attempts to estimate the number of alcoholics from the correlates of alcohol use must fail. Alcohol consumption is not equivalent to alcoholism. To the

contrary, current wisdom regarding alcoholism holds that a clear line of demarcation exists between alcoholic and non-alcoholic drinking patterns. In short, unless we assume that alcohol-related trouble is equivalent to alcoholism, the prevalence of alcoholism is impossible to know. Assertions and speculations to the contrary are based upon incorrect and overly-simple readings of the available data.

CHANGES IN THE CONCEPTION OF ALCOHOL PROBLEMS: THE EMERGENCE OF THE DISEASE MODEL, COLONIAL AMERICA THROUGH 1933

Alcohol use has, historically, been normatively governed. The general consensus is that one should neither drink too much nor too frequently, although how much is too much or how often is too often may be a matter of the company one keeps or loses. There is a loosely-defined understanding that a moderate loosening-of-the-tongue together with customary propriety makes for a better social gathering.

At many social gatherings someone crosses the invisible boundary between acceptable and unacceptable drinking. They may break things, spill their drinks, proposition someone else's companion, get sick, or pass out in the middle of the living room floor. There is a limited tolerance even for such boorishness. The embarrassment and physical pain of the next day are generally seen as sanction enough. But those who drink too much as a regular practice have often been another matter.

Persistent violation of normative drinking practices was, until quite recently, widely viewed as the drinker's choice.

In colonial New England, the chronic inebriate's intransigence was commonly regarded as sinful or criminal, and was met with "excommunication, public degradation, fines, ostracism, whippings and imprisonment" (Conrad and Schneider 1980: 78).

Public views of alcohol abuse have consistently blended moral and medical opinion. In the same, largely punitive atmosphere of 1785 New England, Benjamin Rush concocted a theory of intemperance as a "disease of the will", and devised a chart which catalogued the alcohol abuser's moral and physical decline, at the hands of "Demon Rum". Rush focused upon both "bodily and behavioral effects of alcohol and distilled spirits" (Conrad and Schneider 1980: 79), thereby building the moral-medical foundation upon which the predominant understanding of alcohol problems rests today.

Generally, the behavior of the drinker, rather than the drink itself, has generated concern. Indeed, both "Increase and Cotton Mather called alcohol 'a good creature of God'" (Conrad and Schneider 1980: 78), and taverns were often important social centers in colonial towns. Rush reasoned that problem drinkers must be different from moderate drinkers: the former "lost control" of themselves. Inductively, Rush concluded that the problem drinker was somehow addicted to alcohol. Addiction and loss of control remain the central explanatory mechanisms for problem drinking today.

Rush's thesis led to few substantive changes in public

opinion in his time. However, in the late 19th century the medical-moral model reemerged, in the service of the temperance movement. Conrad and Schneider (1980) observe two important dimensions of the medical-moral model's reappearance. First, the medical consequences of heavy and continual alcohol consumption provided a foundation for the temperance argument, which included a strongly moral component: many of the consequences were behaviors brought about by alcohol's disinhibiting effect. Second, these medical consequences called attention to the irrationality of the problem drinker. Echoing Rush, temperance advocates insisted that no reasonable person would persist in the abuse of alcohol despite the medical "facts".

The consequences faced by the problem drinker remained distinctly punitive at the turn of the twentieth century. Although disease was invoked by way of explanation, it did nothing to mitigate the tone of moral disapprobation. Alcohol abusers were routinely treated poorly in the emerging American hospitals, and physicians did not as a rule share the view that chronic inebriation was either the symptom or the cause of a true disease entity (Rosenberg 1987). Thus, asylums were constructed solely for the moral reconstitution of the problem drinker, and "by 1900 there were more than 50 such special facilities operating in the United States" (Conrad and Schneider 1980: 84). Inebriety may have been a disease, but it

was a disease of the moral indulgence that preceded it. This, at least, was the reasoning of the emerging medical profession and of the temperance movement.

In 1919, the temperance movement began its moment in the sun. Although the 18th amendment made alcohol drinking illegal, the law was widely ignored. Prohibition did, however, temporarily suspend research on the disease concept. Problem drinkers continued to face moral or criminal sanction for their transgressions.

The repeal of Prohibition in 1933 signalled the waning force of the moral crusade against alcohol, although not against alcohol abuse. Sanctions against alcohol abuse remained harsh. The disease model of alcoholism resurfaced in the mid-1930s. Since then -- due to the efforts of the so-called "alcoholism movement" (Room 1980; Fillmore and Kelso 1986) -- the disease model has become the basis for public policy.

THE ALCOHOLISM MOVEMENT AND THE MEDICAL MODEL OF ALCOHOLISM: 1933 TO THE PRESENT

The prime mover behind the contemporary conception of alcoholism was the Yale (now Rutgers) Center for Alcohol Studies, an assemblage of physicians and researchers devoted to uncovering the biological origins and consequences of chronic, heavy alcohol consumption. Under the tutelage of Howard Haggard and E.M. Jellinek, the Yale Center formed a more-or-less identifiable syndrome out of the diverse

behaviors of alcoholics. Following Rush, they developed a chart which chronicled the progressive and fatal course of alcoholism, as well as the necessary steps and signs of "recovery" from the disease. This became the so-called "phase model" of alcoholism (see Appendix, Figure 1.1).

The legacy of the Yale Center includes not only the "borrowed [and loaned] prestige" (Mills 1951) of biomedical opinion, but two other crucial components of the alcoholism movement: The Quarterly Journal of Studies on Alcohol, founded by Haggard in 1940 (and changed, in 1975, to The Journal of Studies on Alcohol), and the National Council (formerly "Committee") on Alcoholism (NCA), formed in 1944 (and directly linked with the Yale Center until 1950). The journal remains the primary American source on the issue of alcohol problems, and the Council endures as "perhaps the most forceful nonpublic voice supporting the idea that alcoholism is a disease" (Conrad and Schneider 1980: 88).

In the same year, the Center developed the Yale Plan Clinics. These early prototypes of modern treatment centers were created with an eye towards the eventual development of general public policy. With the formation, in 1971, of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a sprawling federal bureaucracy devoted to drawing "the treatment of alcoholics into the mainstream of our nation's health care delivery system" (Conrad and Schneider 1980: 87),

these policy goals neared realization.

AA has been another important, and quite different, voice in the alcoholism movement. Begun in 1935 by a stockbroker and a physician, the AA "program" is based upon a twelve-step recovery regimen. These steps emphasize the powerlessness of alcoholics over their disease (said to be an allergic reaction or predisposition to addiction to alcohol), and stress abstinence from alcohol, the reparation of strong social bonds, and the reconstruction of one's personality -- all within a profoundly (though non-denominational) spiritual context. AA has grown principally because of the mandate of the last of its twelve steps, which exhorts members who have experienced "a spiritual awakening as a result of these steps" to help other alcoholics who are still suffering. As of 1985, AA counted a U.S. membership of 585,000, in some 59,000 groups, and a worldwide membership of 1.2 million (Denzin 1987: 17).

The American Medical Association's (AMA) recognition, in 1956, of alcoholism as a disease, greatly assisted the success of the alcoholism movement, as did the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act of 1970 (revised in 1976). With the passage of this act, alcoholism became an officially recognized disease, effectively placed within the jurisdiction of the American health care system. It is in this sense that

Schneider (1978) speaks of the disease concept as an "accomplishment" of the alcoholism movement.

Public opinion has followed the lead of the alcoholism movement. The general public is increasingly inclined to accept alcoholism's definition as a disease. Peele, for example, cites a series of Gallup polls designed to measure belief in the disease model of alcoholism. Between 1946-1951, 20 percent of American respondents agreed that alcoholism is a disease; by 1955-1960, 60 percent agreed. As of 1982, 80 percent of the respondents viewed alcoholism as a disease (Peele 1985: 28). The same 1982 poll reported that "fully one-third of U.S. families believed that one of their members had a drinking problem, a figure that had doubled over the previous six years" (Peele 1985: 146).

The NCA periodically estimates the prevalence of alcoholism in America. These estimates underscore the changing public understanding of the nature of alcoholism, and the growing conviction -- fueled by the treatment industry -- that alcohol problems are disturbingly widespread. For example, the NCA claimed that there were 3 million alcoholics in America in 1943, 5 million in 1956, 6.5 million in 1965, 15 million in 1983. The treatment industry views alcoholism as a "family disease", an assertion that substantially broadens the possible population said to be in need of treatment:

> By reckoning that the relatives of alcoholics need treatment as urgently as alcoholics

> themselves, the treatment industry now considers perhaps one in three or four Americans a potential beneficiary of therapy for alcoholism (Peele 1985: 146).

THE BUREAUCRATIC-CORPORATE CONSTRUCTION OF ALCOHOL PROBLEMS

Vaillant's _The Natural History of Alcoholism_ (1983) is widely respected and often cited to support the disease model. But persons who cite Vaillant in this way have either not read or not understood his book. After conducting the most comprehensive longitudinal study of alcoholism to date, Vaillant (1983) (3) drew several crucial conclusions about alcoholism: 1) it occurs along a continuum which includes a wide array of behaviors not easily amenable to reduction into a single, identifiable syndrome; 2) it regularly reverses itself without medical, AA, or treatment intervention; 3) its genetic origins are, at best, speculative; and, 4) alcoholics are frequently able to drink without jeopardizing an overall commitment to sobriety (4). Each of these conclusions directly contradicts the assertions of the treatment industry, whose spokespersons routinely claim that alcoholism is unproblematically identified, that without intervention alcoholics will drink themselves to death, that the disease is genetically transmitted (and that discovery of the source is

---

3. Vaillant is the Raymond Sobel Professor of Psychiatry at Dartmouth Medical School and Director of Adult Development for Harvard University's Health Services.
4. Cahalan's _Problem Drinkers_ (1970, Jossey-Bass) also noted the "spontaneous remission" of drinking problems, as well as the widespread, _transitory_ nature of such problems.

imminent), and that total abstinence is essential to recovery from the disease.

The treatment industry steadfastly ignores objective research findings, such as Vaillant's, which contradict their own interpretations of alcoholism. The continuing growth of the industry, and the increasing diversity of patient censuses and referral sources, despite these contradictory findings, recalls Thomas' (1928: 572) classic observation that "if men define situations as real they are real in their consequences". Thomas' remark highlights a principal theme underlying the present argument: the "social construction of reality" (cf., also, Berger and Luckmann 1966). This thesis will demonstrate that current understandings of alcoholism have been constructed to serve the administrative interests of corporate hospitals and the corporate consumers of their alcoholism treatment services.

It is in this sense that the redefinition of alcoholism has been described as an accomplishment (Schneider 1978). It is the context of the accomplishment that is of importance. AA has spoken of and contended with alcoholism as a disease for the last fifty years. But AA has had in mind only the assistance of those who seek help. Similarly, the decriminalization of alcohol abuse issued from a fundamentally humanitarian impulse. Drawing upon a model which has been described by objective researchers as, essentially, a useful

metaphor, the alcoholism movement sought a more benign response to people who seemed inexplicably unable to help themselves. In the following pages, I will demonstrate that one corporate hospital has adapted the alcoholism movement's efforts to its own purposes: specifically, the creation of a market for its treatment services.

In Chapter 2, I will discuss the methods -- primarily participant observation -- which guide this thesis, and the field work upon which my findings have been based. The limitations of participant observation and the crucial ethical considerations which accompany field research inform this discussion. I will also discuss the field work setting: the authority structure of the agency, key personnel, and make general comments upon patient census characteristics.

Chapter 3 takes up the development of the institutional social relations necessary to commodity production. Drawing upon the seven significant relationships (Littrell 1983a; see Chapter 3) between and among the actors in a bureaucratic social structure, I will illustrate that through the effective manipulation of its institutional environment, General Treatment Center (see Chapter 2) has created a reliable network of referral sources, which serves as the market for the agency's services. I will argue that this network shapes the social reality of alcohol treatment.

Chapter 4 will discuss that social reality, and the social

relations of treatment as a form of commodity production. Focusing upon administrative, counselor, consumer, and patient interactions, I will argue that the treatment process is designed to bring the patients into line with the social realities of the elites and consumers of the treatment system, and that this process of identity-construction is molded by the quest for revenue, and corporate definitions of social control.

The final chapter will discuss the practical and theoretical implications of commodification. The limiting conditions imposed upon the treatment process by the social reality of market relations is reflected in the agency's exaggerated success rates. These relations also determine the evaluation of "successful treatment". I will examine the practical consequences of these limiting conditions. Finally, I will address the implications of allowing a corporate, bureaucratic agency to set normative standards of behavior, and to define social reality. Treatment, in corporate-bureaucratic hands, is a behavioral modification technique informed by excessively narrow interpretations of psychological well-being. I will demonstrate that these interpretations bear remarkable correspondence with traditional bureaucratic standards -- particularly, unquestioned adherence to rules, an overemphasis upon the importance of predictable and manageable behavior, and an overarching stress upon submission to authority.

CHAPTER 2

SETTING AND METHODS

Most of the material in this thesis is based upon my participant- observation at General Treatment Center (hereafter General or GTC) (1). Both qualitative and quantitative data are presented. Observations of patient or staff remarks and interactions among them were culled from my field notes. Numerical data, such as prices or referral sources, are drawn from information given to me by agency administrators or staff. Importantly, quantitative data was provided to me only because of my presence at the agency and my familiarity with administrative personnel. This underscores the importance of field work as a method. The agency, as with most bureaucratic organizations, is not accustomed to readily handing out information. The information contained in referral, discharge, and census data allow for inference; field work, for verification of those inferences. My research at General was undertaken to at least partially verify the hypothesis that the chemical dependency treatment industry was driven by profit rather than the corporate hospitals' sudden benevolence towards alcoholics (see Chapter 3).

My prior research, as well as the findings of others, had demonstrated the changing nature of both the alcoholic role and of social perceptions and treatment of alcoholism. These historical and structural changes seemed to

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1. GTC is a psuedonym, as are all other organizations and individuals named in this thesis.

parallel the earlier American transition to an industrial economy. Indeed, Trice and Roman (1972) had described these changes as "the development of a virtual 'industry' of professional and lay persons charged with the identification, treatment, counseling, and study of [alcoholism and alcoholics]" (cited in Conrad and Schneider 1980: 87). Nothing in the work of independent researchers (those whose livelihood did not depend upon defining alcoholism as a disease, and the hospital as the natural locus of treatment) contradicted the "industrial" comparison. I was particularly interested in changes in the "social relations of production" which the growth of this industry implied and required. Field work seemed to me the surest way of reaching an understanding of those changes. I arranged for a summer of participant observation at General.

My field work was shaped by a less-than-sympathetic view of the agency. I knew that the bulk of General's patient census was in treatment primarily as a matter of coercion, and that this reflected conditions which had been elsewhere observed (Weisner and Room 1984; Fillmore and Kelso 1986). I was also convinced that the phenomenal increase in the provision of private, for-profit treatment and of such treatment centers reflected the corporate hospitals' "expansion of alternative delivery systems" (Cooper 1986) rather than a bona fide and inexplicable explosion of chemical

dependency in America.

I believed the provision of chemical dependency treatment within a corporate context to be transforming the social role of the alcoholic into a directly exchange-valuable social entity through which surplus value (profit) is generated. Marx (1977) has argued that the mode of production determines the social relations of production. I had come to believe that the treatment industry's cooptation of AA's twelve step recovery program constituted an expansion on this Marxian theme. In short, I suspected that AA's program had been found to be amenable to a corporate restructuring which produced both exchange value and behaviors which were acceptable to General's consumers (see Chapter 3). This unsympathetic perspective presented me with an enduring ethical conflict which proved to be the most difficult aspect of my field experience. After a brief description of GTC's organizational structure, I shall return to this central methodological problem of my field work.

A BRIEF HISTORY OF GENERAL TREATMENT CENTER

I chose General as the preferred site for my field work partially because of acquaintances I already had there (Lofland and Lofland 1984: 7). The agency was the oldest and largest in the area, and I believed its organization mirrored general changes in both the health care and treatment

industries.

General is a private, hospital-based alcoholism treatment agency, founded in the early 1970s. Since then, the agency has steadily expanded the diseases it treats, the population it serves, and the services it provides. General now deals with an array of "chemical dependencies", including alcoholism, drug dependency, compulsive gambling, eating disorders (specifically bulemia), and "co-dependency" (roughly, "addiction to the addict").

In a brochure documenting the history of GTC, the agency describes its mission as follows:

> The entire philosophy of GTC is a positive, drug-free lifestyle. Chemical dependency is seen as a disease which involves all aspects of life -- health, social, psychological and emotional, and the whole person is treated.

Within five years of its founding, General grew from 28 to 73 adult inpatient beds. In the early 1980s, it added a 23 bed adolescent-inpatient treatment unit, bringing the total inpatient capacity to 96. The mean treatment stay for adult patients is 30 days; for adolescents, 45-60 days. Adolescents are characteristically slower to catch on to the nuances of the disease model of addiction. They are also more rebellious. Both factors account for their longer average stay in treatment (see Chapter 5).

The daily charge per patient is $170 a day (2), which

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2. As the financial director advised me (and other members of the staff confirmed), this is a flat room and board fee.

translates into $5,100 per month, per patient. From 1982 through 1986 the agency averaged 430 "successfully treated" adult, and 229 adolescent inpatient discharges, per year. The adult unit yielded $2,193,000, and the adolescent unit, $1,167,900, in average yearly gross revenue over that same period of time (3).

General is a relatively small, but integral component within an emergent health care conglomerate, Midwest Health Care Corporation (MHCC), also founded in the early 1970s. The Corporation has employed a variety of "bridging strategies" (Scott 1983a: 106), including shared services and both horizontal and vertical integration, to construct a network of formal and informal corporate linkages (see Figure 2.1, below) which, combined, constitute a virtual health care dynasty in the region.

MHCC owns Midwest Protestant Hospital (GTC's parent organization), and has established direct corporate links with Midwest Medical Warehouse (a medical supplies distributor), and Mid-American Health Alliance --which includes a nursing college, and an independently-managed Employee Assistance Program which has contractual arrangements with forty-two area companies. In the chemical dependency

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Cigarette and laundry money is extra, as are charges for psychological or physiological testing beyond normal evaluative procedures.

3. "Successful treatment" is a highly subjective category. I discuss the treatment procedure at length in Chapter 5. These figures do not include GTC's outpatient programs.

treatment business, GTC is only one of MHCC's agencies, which include another in-state agency, and two others in neighboring states. General is also a training facility which operates a year-long, state and federally recognized chemical dependency counselor certification program (4).

MHCC has informal corporate agreements with Midwestern Pediatric Hospital, Diagnostic Radiology Incorporated (a magnetic resonance imaging diagnostic center), and Saint David's Hospital. These providers pool their resources to reduce the costs of independently maintaining their various services (5).

In the mid-1970s, Midwest Protestant relocated to a more favorable suburban setting. General was, in part, formed to make favorable suburban setting. General was, in part, formed to make use of the facilities which Protestant vacated. These changes were part of the extensive restructuring of Midwest Protestant itself, and the creation of MHCC. The linkages illustrated in Figure 2.1 issued from these changes, all of which have transpired in the last fifteen to twenty years.

General itself is bureaucratically organized. The treatment services coordinator and the director of finance

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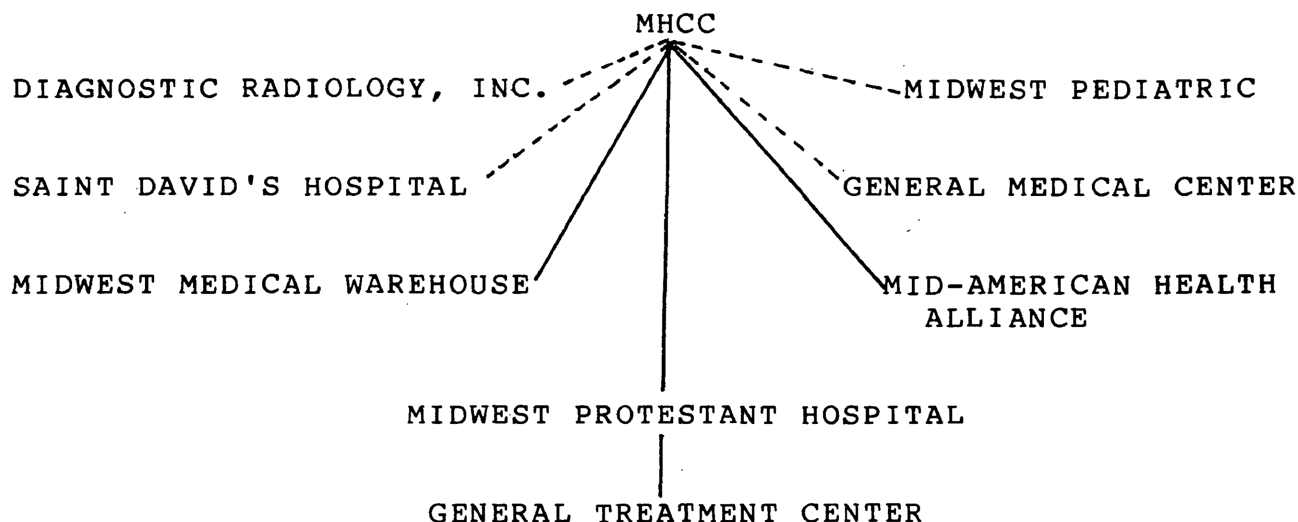
4. Training constitutes a substantial source of revenue for General. Trainees pay $1200 to undergo the year-long apprenticeship for chemical dependency counselor certification. They are not paid during this training period.
5. Costs in the region clearly demonstrate that such savings as these arrangements produce are not passed on to consumers. This has been attributed, in large measure, to oligopoly pricing practices -- see, for example, Littrell 1983b.

FIGURE 2.1

MHCC DIRECT AND INDIRECT CORPORATE LINKS



——— = direct corporate links
- - - - = indirect corporate links

directly answer only to the executive director, who, in turn, must answer to his liason at "corporate headquarters", as Protestant is called. Immediately beneath the treatment coordinator, the supervisors of the adult and adolescent inpatient and outpatient services coordinate the efforts of their counseling staffs (see Figure 2.2, below).

This thesis directly examines only the inpatient units (and primarily adolescent inpatient unit A) of GTC. For purposes of clarity, then, I will only comment upon inpatient

treatment, with special attention paid to the adolescent staff -- as this was where I spent the majority of my time at the agency (6). The adult and adolescent inpatient units are each divided into two sub-units. Whenever necessary, I will refer to these as Units A and B. Adolescent unit A treats only patients whose problems are believed to be limited to alcohol, drug abuse, or, occasionally, eating disorders. Unit B is devoted to "twin-diagnosis" patients, patients believed to be experiencing emotional or psychological disorders in conjunction with their chemical dependency. I was assigned to Unit A. Adult Units A and B treat only chemically dependent patients.

Figure 2.2 is an abbreviated diagram of the authority structure at General. I have given the principal actors psuedonyms, because their names will appear frequently. I have not included adult unit trainees, or members of the outpatient, family program, and public relations staff, in Figure 2.2, for purposes of simplicity.

Power in bureaucratic organizations flows downward. GTC is no exception. Finley, the executive director, receives his orders from Corporate headquarters (Midwest Protestant), and passes them down through the appropriate channels: primarily, through Dick Miller (the Treatment Services Coordinator), to

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6. Outpatient services are of equal importance to GTC's operations, and also have the advantage of being able to operate with fewer staff members, as that division's programs are organized on a schedule of weekly meetings.

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FIGURE 2.2

GTC'S AUTHORITY STRUCTURE

CORPORATE HQ

GTC EXECUTIVE DIRECTOR (Dan Finley)

TREATMENT SERVICES COORDINATOR
(Dick Miller)

DIRECTOR OF FINANCE
(Ned Peterson)

PUBLIC RELATIONS
MARKETING

ADULT INPATIENT SUPERVISOR
(Craig Johnson)

HEAD COUNSELOR/UNIT A
(Stan Wallace)

HEAD COUNSELOR/UNIT B
(Steve Duncan)

COUNSELORS/UNIT A
(Lucy Witecki)
(Greg Nisbet)
(Dick Simon)

COUNSELORS/UNIT B
(Floyd Nance)
(Maureen Killdeer)
(Kyle Poindexter)

ADOLESCENT INPATIENT SUPERVISOR
(Cliff Bonacci)

HEAD COUNSELOR/UNITS A AND B
(Nan Vincent)

COUNSELORS/UNIT A
(Nancy Drake)

COUNSELORS/UNIT B
(Lorrie Lyman)
(Betty Storz)

TECHNICIANS

ADOLESECENT UNIT TRAINEES, PRACTICUM STUDENTS, OBSERVERS
(Dana Fuller -- trainee)
(Emory Corman -- trainee)
(Ed Norman -- trainee)
(Butch Lindquist -- practicum student)
(John Rice -- observer)

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the inpatient supervisors, or, when financial matters are concerned, through Ned Peterson (Director of Finance). The head counselors on each unit are expected to see that administrative policies are followed by their counseling staffs. Observers and practicum students (myself and Butch Lindquist were the only two "in residence" during my stay at GTC) are out of the flow of authority.

I spent seven of my ten weeks on Adolescent unit A, one week with the "family week" counselor, and two weeks on Adult unit A. The staff members with whom I came into frequent contact were: Cliff Bonacci (Adolescent Inpatient Supervisor), Nan Vincent (the Head Counselor for both adolescent inpatient units), and Nancy Drake (certified counselor) on adolescent unit A (as well as Lorrie Lyman (certified counselor), during Stage 1 sessions for that unit -- see Chapter 5); Madeline Vickery (certified counselor), during family week. This thesis is based almost exclusively upon my field work on the adolescent unit. Thus, although I encountered a number of other administrative and staff personnel while in the field, I will introduce the others only as the need arises.

My schedule at the agency was arranged to provide me with the fullest sense of the mechanics of treatment within the all-too-familiar constraints of any, but especially graduate student, research: time and the need to earn survival money. The training supervisor recommended that I spend mornings,

rather than afternoons, at the agency. She assured me that the substance of treatment was the daily group therapy session, held each morning; an assurance which other staff members supported. The afternoon schedule is almost identical to the morning schedule, with "counselor time" (patient-to-counselor, one on one sessions, to which trainees and observers were not given access) serving as the functional alternative to group therapy. The daily morning schedule on the adolescent unit proceeds as follows:

Monday-Friday

6:30	A.M.	Wake-up Call
6:40-6:55	A.M.	Group Exercise
6:55-8:00	A.M.	Showers and Duties
8:05	A.M.	Grace
8:10-8:35	A.M.	Breakfast
8:40-8:50	A.M.	Preparation Meeting
8:50-10:20	A.M.	School
10:20-10:30	A.M.	Break
10:30-12:00	P.M.	Group (Stage 1)

(GTC pamphlet)(7)

Each morning, counselors attended the preparation meeting and group and/or stage 1 (8). The other activities were either supervised by supporting staff or expected of the patients without supervision. The technicians -- "techs" -- were responsible for overseeing wake-up, group exercise, and grace, as well as for accompanying the patients when they left

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7. Throughout the thesis, a "GTC" citation will signify an in-house publication.
8. See Chapter 5, for a discussion of stage 1 and group therapy.

the unit for breakfast or school (9). The techs, then, were staff assistants attending to the mechanical details of social life on the unit. They were often students, working towards social work or counseling degrees, and were usually either AA members themselves or came from an AA family.

THE CENSUS

Of the thirteen patients who constituted the cohort which went through adolescent inpatient treatment on unit A during my field work, two were 15 years old, three were 16, seven were 17, and one was 18. All had had trouble with their families, eight had had either academic or disciplinary (or frequently, both) problems at school, seven were in trouble with the court system. Eleven of the thirteen were boys; two were girls.

The size of the cohort was reasonably representative of past GTC cohorts. During a five year period in the early 1980s, GTC averaged 228 adolescent inpatients per year, or an average monthly census of 19. There were 5 patients on the other adolescent unit, unit B, during my stay, bringing the total to 18. The cohort was comprised, proportionately, of both more boys (85%, versus 5 year mean of 64%) and more court referrals (54%, versus 5 year mean of 37%) than GTC's five year averages. Importantly, the last two years of the agency's

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9. General maintains two state certified teachers on staff, to help adolescent patients maintain or catch up on their current status in school. This is required by state law.

records (see Appendix, Tables 2.1 through 2.4) indicate substantial census losses, largely due to increased competition in the area treatment market. The adolescent program's census for 1986 was down 24% (from 275 to 210) from its peak, two years' prior. These declines occurred throughout the agency: the adult inpatient program's census had declined 32% patients in five years (from 660 to 450); the outpatient program's census declined 20% from its peak, five years earlier (from 150 to 120); and the family treatment program was down by 42% (from a peak of 565, five years before, to the 1986 figure of 325). These figures represent substantial financial losses: the inpatient units alone lost $1,568,250 compared to the agency's best years (10). These losses affected treatment relations at General during my field work. For example, the counselors' frequent complaints about their heavy caseloads reflected the administrative decision to not replace personnel who left.

THE DIMENSIONS OF FIELD WORK

The interactional nature of field work has led Oleson and Whittaker (1970: 384) to speak of participant observation as an exercise in "role making" (1970: 384). They observe that

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10. Calculated by multiplying per-patient daily charges times average treatment stay, and multiplying that figure times the number of patients lost. Thus, the adult unit: 30 days x $170 = $5,100 x 210 (lost patients) = $1,071,000; Adolescent unit: 45 days x $170 = $7,650 x 65 (lost patients)= $497,250 (+ $1,071,000 = $1,568,250).

researchers, and those with whom they interact, pass through stages of increasing familiarity, in much the same manner that anyone gets to know another. But the field worker's position is more complicated.

Gold (1970: 370 ff.) notes that field work ranges along a continuum from the researcher's role as "complete participant" through the role of the "complete observer". The majority of field work falls between these two extremes: one is most often either the "participant as observer", or, the "observer as participant". The latter best captures my experience at General.

Because of my suspicion of the treatment industry, I repeatedly confronted the problem of how best to "balance role demands with self [demands]" (Gold 1970: 371). My lack of sympathy for agency goals cast this problem in fundamentally ethical terms, which arose at each of the stages of field work Denzin (1970) identified. The six problems through which the observer-as-participant must pass are: 1) gaining entry; 2) establishing and maintaining membership ("role making"); 3) avoid altering by one's presence the behavior of others; 4) maintaining objectivity in the face of new experiences; 5) recording and analyzing the data; and, 6) overcoming ethical aspects. Denzin's comments accurately reflected my own experiences, yet the ethical dimension constituted an overweening and ongoing concern, at GTC. As such, it was not a

matter of "overcoming" my ethical concern, as a discrete and separable problem, but of considering the ethical dilemmas of each new occasion.

GAINING ENTRY

The first three of Denzin's "problems of the observer-as-participant" did not prove especially difficult. General's status as a training facility for aspiring chemical dependency counselors made new faces part of the landscape. Gaining entry to the agency, then, involved one phone call and one office visit to the training supervisor. I informed her that I was a graduate student in sociology whose research and course work had frequently involved the social problem of alcoholism, and that I was interested in learning more about the actual mechanics of treatment. During the office visit, I reiterated that position. At this visit, we also clarified that I was not a counselor trainee. She assured me that would create no problems, as the agency routinely had probation officers and staff from other agencies coming to observe, but not participate in, the treatment procedures employed by General.

Ethically, my principal concerns were to not misrepresent myself as an enthusiast of treatment therapies and to protect staff members and patients, while I learned more about the machinations of chemical dependency treatment. Gold's distinction between self and role proved to be on the mark as to both establishing and maintaining my membership at the

agency.

BECOMING A MEMBER

Establishing and maintaining membership at General was an ongoing exercise in finding a reasonable balance between demands of the observer role and my unsympathetic stance. This proved to be a difficult balance to sustain, though the battle was largely internal. My research role was not visibly compromised; my self emerged from the field work in a more beleaguered condition. The majority of role-threatening possibilities were overcome by the availability of a ready-made role of "observer" at the agency. For the most part, I was expected only to step into that role, rather than make a new one.

For example, my first day on the adolescent unit, one of the trainees -- I will call her Dana -- took me aside and immediately began divulging "inside" information: the unit had been shorthanded for months, she said, and the one certified counselor that had been carrying most of the patient load was "on the edge" These conditions fluctuated with the size of the census, she told me (11). Since admissions had been down, the high attrition rate among counselors was allowed to run its course. The result was an overburdening of the remaining

11. Quotation marks intended to connote colloquial or special uses of a word are mine. All other quotation marks are either research related or taken from field notes, and will be so cited. Dana's remark was taken from field notes.

counselors (12).

While I was just another "observer", Dana undoubtedly saw me as a sympathetic outsider. We were both graduate students -- she, in counseling and education -- and she apparently sensed a kindred spirit. Moreover, she was to be the only staff member with a working familiarity with sociology: she'd "taken some courses in 'soc'" and thought they were "really interesting" (13). This early exchange provided me with an awareness of my built-in role; role-making throughout my tenure proved to be largely a matter of fine-tuning and clarifying the established observer role. I inquired and was informed (or, often, I was informed without inquiring). I became a <u>confidante</u> to most of the counselors and trainees with whom I worked. I was, as an outsider, someone to whom it was safe to voice complaints regarding administrative practices. I filled an essentially passive, "sounding-board" role, which had preceded me, in the general role of the

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12. General no longer enjoys their early monopoly on private treatment in the area. Within the past five to ten years, all of the area hospitals have diversified and expanded their alternative delivery systems. The subsequent crunch in census size at General was particularly acute on the adolescent unit, and in the "family programs".

13. Despite freely describing chemical dependency treatment as an outgrowth of psychological and sociological perspectives, it seemed that no one -- aside from Dana -- had even the most rudimentary grasp of the nature of sociological theory or research. I was routinely quizzed on this: "what, exactly, does a sociologist do?" Answer: "Examines the social structure, the repeated patterns of behavior, of some area of human social life". This invariably seemed to satisfy the curious.

observer.

Despite a fairly pat role position, there were those for whom my presence required further clarification. Supervisory personnel and patients especially wanted to know more about me. This desire for further information arose frequently enough that I developed a short description of my role which varied little and seemed sufficiently explanatory: "I am a graduate student in sociology and I'm here because I want to learn more about alcohol problems and their treatment".

NOT ALTERING THE SCENE OR OTHERS' BEHAVIOR

Because of the familiarity of my "made" role, I was confident that I did not change the scene or affect normal agency interactions. Patients and staff, through such questions as I have mentioned, did much of the work of establishing my role. My two primary interactions with staff and patients together, were "preparation meeting" and "group therapy". The latter was the more difficult of the two. Preparation meeting required little of me beyond silence. Staged much like an abbreviated AA meeting, one patient read aloud the "thought for the day" from one of a variety of AA's inspirational books (14), followed by any volunteered remarks by other patients as to the relevance of the passage to their

14. Alcoholics Anonymous publishes a vest pocket-sized book containing an inspirational message for Twenty-Four Hours a Day. A passage from this, or similar books, is read at the opening of both "prep" meetings and other, AA meetings I have attended.

own behaviors. For example,

> I can relate to this because, you know, my false pride is what got me in here. Instead of talking out my problems with my family or my friends, I'd just stuff bad feelings inside and tell myself, you know, 'hey, man, you can handle it -- you don't need to talk to anybody'" (15).

The training supervisor's guidance proved to be correct: group therapy constituted the core of the treatment process. The transformation of patients was clarified and refined here. It also proved to be the most consistent source of strain for me between demands of role and self. Patients' lives were routinely interpreted within the rigid, yet simultaneously all-inclusive, boundaries of the disease model. These interpretive efforts often seemed to me to be forcing the proverbial round pegs into square holes. Although interpretive practices contributed to my unsympathetic view, I never voiced my convictions, remaining outwardly neutral.

This neutrality was only once severely jeopardized. Nan, the head counselor of the adolescent units, believed that I should carry a small patient load. She felt that I would reach a fuller understanding of the treatment process by actually "treating" one or two patients. Word of this decision filtered down to me indirectly, and after a few days of rumor, I found my name listed as the "primary counselor" for a new patient, Mary.

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15. Field notes.

Mary was in for a fourteen day evaluation -- an "eval". Patients sent to General for evaluation were given the same battery of psychological tests as already-diagnosed patients. After agency staff scored the tests, they offered their conclusions as to whether the evals' behaviors were "consistent with a pattern of chemical dependency" (16). All of Mary's psychological testing and her responses on the various patient history forms indicated that, far from being a substance abuser, she was a decidedly normal adolescent.

The ethical dilemma Mary presented grew from the strain between self and role, and from the researcher's imperatives of "not altering the scene". I believed I should not act as a counselor considering my basic disagreements with agency practices. Moreover, I was not qualified, had not been consulted, and had not had an opportunity to discuss the matter formally. GTC, Mary or her mother, the insurance company, or I would have been compromised by my assumption of a fuller participant role as counselor. I arranged to meet with Nan.

The meeting was brief. I told Nan that I thought that I

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16. The evaluators' assessments, at the end of each of the patient's evaluative questionnaires, nearly invariably concluded that "this patient demonstrates a pattern of behavior consistent with chemical dependency", regardless of the pattern. Mary's chemical use was, rather, consistent with normal adolescent experimentation: at 16, she had been drunk once -- with friends -- and didn't like it, and had used no other drugs, although she had been around friends who had used other drugs.

was being railroaded into a situation for which I was neither practically nor ethically prepared. I explained that I believed that I was being asked to present myself as someone other than myself. I also pointed out that even if I were qualified, I was only at the agency half-days, and that this would surely compromise therapy. Nan replied, "it'll be okay, John, we don't do treatment, anyway. God does". I responded that that was a fine sentiment, but that it did nothing to allay my concerns. Our meeting ended unresolved. I went to keep my appointment with my "patient". I introduced myself to Mary, explaining that I was not her counselor, nor a counselor at all, but because her primary counselor was otherwise engaged, I thought we could get acquainted.

The information in Mary's chart suggested that her mother had engaged General as punishment, rather than out of genuine concern regarding Mary's substance abuse (of which there was almost none). Mary had had trouble getting along with her mother since her parents had divorced, about a year earlier. She was angry with her mother about the divorce. She said that her mother arbitrarily treated her like a little girl when their wishes conflicted, but otherwise expected her to shoulder adult responsibility around the home. Mary was expected to cook, clean, and, especially, to care for her younger brother and sister, while her mother "went out on dates or to parties on the weekend". On the night that Mary

had gotten drunk, she and her mother fought. The next day, her mother told her they were going to see a counselor to "straighten out our problems", and took Mary to General for her evaluation. I left this conference convinced that Mary was normal in every way, and that, more than ever, the assumption of a counselor role was ethically impossible.

Nan did nothing to reassign Mary to an appropriate counselor, so I undertook that effort on my own. I explained to Nancy, the sole, certified counselor on the adolescent unit, that someone had better take Mary as a patient because I could not and would not, repeating my reasons. I also pointed out to her that I did not think that Mary was a substance abuser. Nancy took Mary as a patient. Shortly thereafter, I learned that Nan still wanted me to carry a case load. I spoke with the training supervisor and arranged for my transfer to the adult unit. By this time, I had spent seven weeks on the adolescent unit. I explained having arranged for the transfer as a chance to get the fullest exposure to the agency. Without the transfer, I think the separation between role and self would have been impossible to maintain. I would have either been forced to withdraw from the field altogether or to compromise my ethical standards. I was reassigned to the adult inpatient unit for the last three weeks of my research.

Nan's attempts to press me into counseling service issued, I believe, from agency responses to two years of

declining censuses (see Appendix, Tables 2.1 through 2.4). As Dana had admonished on the first day, Nancy had been carrying the bulk of unit A's patient loads for quite some time, and she had begun to voice complaints about her burden immediately prior to my arrival on the unit.

In spite of "God doing treatment", my assumption of the counselor role would have violated my efforts to maintain a low profile. It would also have been a blatant deception. Nothing novice researchers might read about field work can completely prepare them for its actuality.

MAINTAINING OBJECTIVITY

Despite my critical predisposition towards General, the criticisms are sociological: they address structural issues. Although, as will become increasingly clear, the structure frequently worked against the patients and against the therapeutic efforts of the counseling staff, it appeared that some of the patients were improved by therapy. Many, however, were not.

The social structure of alcohol treatment issues from public policy (see Chapter 3) which places health care providers in the position of attempting to satisfy contradictory goals: successful patient treatment and profitable, efficient operations. In this setting, then, maintaining objectivity consisted primarily of acknowledging the apparent improvement of some patients, despite structural

constraints, and the recognition that these structural constraints issued from goal conflicts shaped at the policy level. Objectivity was difficult to sustain when considering the part health care providers played in shaping those policies (Starr 1982), or the evident enthusiasm for corporate practices at the agency.

RECORDING AND ANALYZING THE DATA

My unsympathetic predispositions towards the treatment industry, and the constraints of my observer-as-participant role, shaped the manner in which I recorded and analyzed the "data". Again, ethical concerns were primary.

From a practical perspective, recording my findings was unproblematic -- particularly during my seven weeks on adolescent unit A. Between prep meeting and group therapy, I was usually alone, and spent the time recording the proceedings of morning report and "prep". I also used this time to read the patient charts, as Nancy and Dana suggested I should. Each day, I left the agency immediately after group therapy, and was free to record group interactions at home, uninterrupted.

These conditions changed during my time on adult unit A. The adolescent unit was sorely understaffed. Nancy and the two trainees (Dana and, later, Emory) were too occupied with their own work to pay much attention to me. The observer role on the

adult unit was more closely monitored. I was in the company of a staff member at all times. Moreover, observers were not given access to patient charts on the adult units. As a result of these limitations, I logged the events from the adult unit only after I had left the agency for the day.

I never took notes in the presence of staff or patients. I believe that would have compromised the therapeutic environment. Taking notes would have inhibited self-disclosure. Moreover, patient turnover was so frequent that one explanation of my note-taking would not have sufficed; ongoing placation would have been required. Staff, I am certain, would have been equally discomfited by fervid note-taking.

In summary, I was more an observer than a participant. Although much of the therapeutic regimen involved rudimentary behavioral modification, such as an introductory psychology text might provide, I did not offer comments, when I was occasionally asked to, without deliberately drawing attention to my non-counselor status. My participation was required, to a limited extent, but I maintained my role as observer by offering a straightforward helpfulness, rather than offering therapeutic insight. This seemed to be an acceptable blend of deferral to professional expertise and patient curiousity, as well as a satisfactory demonstration of what I was doing at the agency. The need by patients and staff (as well as myself)

to establish and maintain my observer role on the unit underscores Denzin's (1970: 369) conclusion that "the act of observation must be seen interactionally".

ETHICS

Erikson (1970) has forcefully argued against disguised participant observation, which he defines by the researcher's deliberate misrepresentation of self. Deceptive research, according to Erikson, may (1) inadvertently bring harm upon the unwitting subjects of that research (whose participation has not been freely given); (2) may prevent one's colleagues from gaining future access to the field, and may discredit the discipline's scientific standing; (3) may expose students to unethical practices by unethical practitioners; and, 4) is highly unlikely to reduce the effect of a researcher's presence in the field (17). Partly because of issues stated in Erikson's analysis, I did not deliberately misrepresent myself or my research. Ultimately, however, there are important points on which Erikson and I disagree.

His argument, followed to its logical conclusions, precludes sociological analysis of vitally important

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17. Erikson argues that sociologists are not trained actors, and that a false identity cannot be indefinitely sustained. He contends that the researcher's assumption of a false identity will distort the field experience in ways which the researcher cannot know. For example, the regular members of a social group may adjust their behaviors to accomodate the disguised researcher. These accomodations alter the scene, outside of the researcher's awareness, and produce a form of bias which will be completely overlooked by the researcher.

dimensions of social life. The assumptions which underlie Erikson's position seem to be that those in power would willingly submit to critical scrutiny and, barring that consent, the ethical sociologist must forego such research. This position depends upon one's definition of ethics. Power in modern society is bureaucratically-administered. Bureaucracy's penchant for secrecy is legendary. Erikson's argument, then, effectively closes off substantively crucial areas to sociological inquiry, leaving us to conduct only approved research, in approved locations, taking approved perspectives. Ultimately, I would argue that Erikson's criticism issues from erroneous assumptions regarding bias. In his concern for the bias a disguised researcher may introduce into the field, Erikson overlooks or ignores the bias which might arise from unilaterally according the courtesies of objective inquiry to the most powerful members of society. Often, these members feel and offer no reciprocal courtesy, to say nothing of their inclinations to mislead. Erikson's position, however inadvertently, leads to taking sides.

Becker (1970) has argued that taking sides is inevitable, and that accusations of researcher bias are equally inevitable. If one views social structure from the point of view of the subordinates in that structure, cries of bias will arise from the superordinates. He contends that the wisest course of action is for researchers to frankly report

their point of view and dispense with pretensions of a non-existent objectivity.

Methodologically, I have attempted to strike a compromise between Becker and Erikson's positions. I have accorded to GTC, and to its personnel and patients, the protection of anonymity. I had and have also taken every effort to maintain at least a measure of social scientific objectivity, both during field work, and in the reporting of my findings. Ultimately, however, my position is more in line with Becker's: my sympathies admittedly lie with the patients. They are manipulated, far more often than they manipulate. One should observe that it is the social structure of alcoholism treatment which shapes the actions and interactions recorded in this thesis. GTC's practices are determined by this structural component, just as are the actions of the other participants. The principal difference is that General has deliberately shaped that structure; the patients have not. The disparity between "public" and "operational" goals (Perrow 1986) is General's; not the patients'. I shall, nonetheless, leave it to the journalists to name names, and will fully accept the credit, indifference, or censure of my colleagues for this thesis and the methods and ethics which have shaped it.

Having discussed the setting, and the ethical considerations which have helped to shape this thesis, I will

conclude with a brief discussion of the logic of inquiry upon which my conclusions have been predicated.

GROUNDED THEORY

My principal motivation for doing field research was to expose myself to the change in social relations which I believed had accompanied changes in the alcoholic role and its treatment. Through acquaintances in AA (with whom I had spoken at length and I attended numerous meetings), I had learned a great deal about the nature of that program of recovery from alcoholism. I had also begun to suspect that there were fundamental differences between AA's and GTC's understanding of alcoholism and recovery. I believed that a comparison with corporate treatment would be instructive.

In the field, the differences between AA and GTC took on a distinctive character. The lives of the patients were spoken of, handled, and manipulated as things mysteriously separate from the patients themselves. They were, as it is said, subject to "powers greater than themselves" -- their disease, and God, and GTC's purportedly "life-saving technology". During my tenure at GTC, it became clear to me that the social relations of corporate treatment strikingly corresponded with Marx's (1977: 165) observation that "it is nothing but the definite social relation between men themselves which assumes here, for them, the fantastic form of a relation between

things": that is, the characteristic social relations of commodity production. And it is to these social relations this thesis attends.

The relevance of Glaser and Strauss' "grounded theory" (1967) to the methods of research upon which the present argument is based issues, in part, from their claim that theoretical constructs may be derived from empirical circumstance. Yet, grounded theory aspires to more than aimless fact-gathering. Rather, through such practices as the "constant comparative method", grounded theory calls more for an abductive approach to research: a synthesis of deduction and induction in which the researcher freely moves between the empirical and the theoretical worlds. This abductive approach accurately describes the methods of my field work.

Deductively, I believed that GTC was primarily motivated by profit. I had derived this working hypothesis from conversations with my AA and treatment industry acquaintances. The specific theoretical construct of commodification, however, emerged in the field. Rather than verifying a clear-cut theoretical framework, then, the field work proved essential to developing that framework. As some earlier remarks in this chapter suggest, this reciprocity was true throughout the preparation of this thesis.

Ultimately, there are, of course, shortcomings to field

The circumstances at one agency in a relatively sparsely populated part of the country cannot be statistically generalized to the prevalence of such practices. Nor may participant observation be the most suitable research method for an analysis of historical currents, or the large-scale machinations of poltical- economic social structures. But such research does not occur in a vacuum. The literature on the transformation of the alcoholic role in society, and on the rise of the corporate hospital is burgeoning. Moreover, this research is part of a lengthy sociological tradition which has addressed itself to the "uses" of the feckless, powerless, and outcast members of society: consider, for example, Goffman (1961), Perucci (1974), Scull (1977), Foucault (1979), Ryan (1976). That tradition has guided this thesis, itself directed towards the human consequences of the economic rationalization of human health and life.

CHAPTER 3

CREATING THE TREATMENT MARKET: THE INSTITUTIONAL RELATIONS OF COMMODITY PRODUCTION

The growth of the treatment industry is a case study of the manner in which organizations are both shaped by and shape their institutional environments (Perrow 1986; Meyer and Rowan 1983). The rise of corporate medicine and the medicalization and hospitalization of alcoholism should be understood as environmental, contextual changes which have reshaped and reorganized the social role of alcoholism. This reshaping and reorganization created treatment, and the conditions by which the commodification of alcoholism has occurred. Providers of treatment have taken their cue from these official changes, and have set about shaping their institutional environments accordingly.

Perrow (1965: 912) has identified three interdependent dimensions of organizations which are of analytical importance: culture, structure, and technology. Scott (1983b: 15) has explicitly linked the cultural and structural dimensions, arguing that institutional environments are comprised of "shared belief systems and relational frameworks". Scott (1983b: 15) acknowledges these "shared beliefs" are not necessarily based in fact, and refers to them as "rational myths". Their importance stems both from the fact that they are shared, and by whom they are shared.

Two rational myths have shaped the commodification of

alcohol treatment: belief in the efficacy of corporate health care, and belief in the "accomplished" (Schneider 1978) definition of alcoholism. After identifying the specific environmental actors among whom these beliefs are defined and shared, I will discuss the beliefs themselves.

THE ENVIRONMENTAL ACTORS

Littrell (1983a) has observed that there are seven significant relationships among the actors in a bureaucratic system: 1) elites to elites; 2) elites to subordinates; 3) elites to consumers; 4) elites to an underclass; 5) subordinates to consumers; 6) subordinates to the underclass; 7) consumers to the underclass. The machinations by which a treatment market has been constructed have depended upon the shared beliefs and relational frameworks which have arisen among these actors.

GTC (see Chapter 2) is part of a larger corporate bureaucracy. As such, the social relations at General reflect the seven significant relationships which Littrell observed. Figure 3.1 (below) identifies the actors with which the present discussion will be concerned. However, at GTC there are important variations to this model of bureaucratic relations.

Littrell (1983a: 7-8) defines bureaucratic elites as those who hold positions of power: they "occupy the highest position [in the bureaucratic structure]", and "act as the rational

FIGURE 3.1
THE SOCIAL ORGANIZATION OF ALCOHOLISM TREATMENT

LEVEL 1: ELITES:

Employers	Midwest Protestant/GTC Administrators
Insurance Companies	Courts
Social Service Agencies	

LEVEL 2: SUBORDINATES
Employee Assistance Program Representatives
Insurance Company Claims Representatives
GTC Counselors

LEVEL 3: CONSUMERS

Employers and Employee Assistance Programs	Families
Insurance Companies	
Social Service Agencies	
Courts	

LEVEL 4: UNDERCLASS
Patients

managers [within] the confines of their organization". Level 1 of Figure 3.1 lists the treatment elites: employers, insurance companies, social service agencies, the courts, and GTC and Midwest Protestant's administrators.

All of the elites, except the hospital administrators, occupy a double position in the treatment hierarchy. For example, employers who demand that recalcitrant employees seek treatment or lose their jobs are clearly acting as elites within their own social structure but as consumers within the social structure of treatment.

Level 3 in Figure 3.1 illustrates this dual role of

both the financial and social power to sustain a burgeoning treatment market. Littrell (1983a: 8) defines consumers as those who "stand outside a particular organization but have a market relation with it". In the social organization of treatment, the bureaucratic consumers are the most important source of referrals to GTC. To employ an industrial analogy, then, they are both the suppliers of the raw materials and the consumers of the transformation process. Their role in the system makes the system possible. As such, they play an integral part in shaping the nature of treatment itself. Indeed, the goals of treatment reflect bureaucratic understandings of psychological health (see Chapter 5).

Families are also important consumers of treatment, but their relationship to GTC corresponds with a more traditional consumer role. Their consumption of treatment is underwritten by the bureaucratic consumers, particularly insurance companies employers, and EAPs. This qualitative difference in their status in the treatment system explains their separation from the bureaucratic consumers in Figure 3.1, Level 3. Their "market relation" with GTC coincides with the presence of the bureaucratic elites.

The final variation on Littrell's view of bureaucratic relations is the transformation of the patients into the bureaucratic underclass. Littrell (1983a: 8) observes that,

> [L]ike consumers, [the underclass] stands outside a particular organization with no

> [L]ike consumers, [the underclass] stands outside a particular organization with no market relationship to it, though the underclass may be affected as an incidental cost by the organization's policies.

In short, in Littrell's view, the underclass either does not enter the structure of bureaucratic relations, or does so only marginally. In the treatment system, the patients are supplanted from their traditional role as consumers of health care, and are relegated to the underclass. However, the role of the underclass in the treatment system differs from Littrell's original formulation. The patients enter, pass through, and exit the system. Their status as an underclass is constituted by their role as the raw materials upon whom the transformative techniques of treatment are performed. The relations among the elites, subordinates, consumers, and underclass, as they have been defined, constitute GTC's treatment market.

Two environmental changes paved the way for the development of the treatment market: 1) the successful redefinition of the alcoholic role and the subsequent inception of insurance coverage for the treatment of alcohol problems; and, 2) the "rise of corporate medicine" (Starr 1982). Each of these changes are officially expressed in the form of public policy. Prior to these changes treatment did not take the form of commodity production. Occasionally, individual problem drinkers did seek medical assistance, but received it willingly. It was not until the early 1970s that

treatment as a commodity market emerged.

The need for this market reflects the agency's corporate, profit-oriented identity. It is this identity which provides the context for the social relations of alcohol treatment. Those relations, at the institutional-environmental level, are the focus of this chapter.

In order to elaborate this view, I will discuss the rise of corporate medicine, then, turn to the cultural and ideological foundations underlying this growth. These new social relations must embody the requirements of commodity production. Three main ideas form the ideological foundations of corporate medicine's role in the treatment of alcohol: the invention of "hidden alcoholism"; the legitimation of coercion into treatment, called "intervention"; and, the creation of "chemical dependency".

THE ORIGINS OF CORPORATE ALCOHOLISM TREATMENT

General's role as a corporate entity reflects the "rise of the corporate hospital" (see Starr 1982, for an excellent discussion) in America. The corporate hospital issued from the belief that for-profit health care operations would successfully coexist with adequate human service, and that the necessities of competition on the free market would foster greater efficiency and lower costs from and for health care providers.

This belief became policy in the early 1970s.

"subjecting medical care to the discipline of ... markets" (Starr 1982: 380) would curb the continual upward spiral of hospital costs. This free market, competitive model, a platform endorsed by both the AMA and the AHA (American Hospital Association), was officially adopted with the passage of the 1973 Health Maintenance Organization Act (1).

One mechanism which has arisen from the hospitals' new corporate status is the "expansion of alternative delivery systems" (Cooper 1986), which are designed to offer health care consumers a variety of previously unavailable choices while simultaneously allowing hospitals to capture as large a piece as possible of the health care market. Alcoholism treatment, and thus General, is one example of an alternative delivery system (2).

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1. Isolating the HMO Act from the abundance of health care legislation and proposals at that time should not be taken as unproblematic. I have selected this bill because it uniquely underscores the market assumptions underlying health care policy during the Nixon administration, and since. As such, it may be taken as paradigmatic of the view that if health care providers are forced to compete, costs and waste will be reduced, and access to and quality of care will improve. The corporate hospital of the present has its origins in these assumptions. For more detailed discussions of these changes, see Starr, 1982; Brown, 1983; Sidel and Sidel, 1983; Rosenberg 1987 (see References).
2. Although experience has now demonstrated that the transformation of health care providers into free market competitors has produced nearly the opposite of the desired results, this rationale underlies the current methods of operation of many of these providers. Consider, for example, the following headlines as at least partial indicators of the lack of this model's success: "Health Care Outlays Rose 8.4 Pct. in '86" (Omaha World Herald: January 10, 1988); "Big Losses for Health Insurers -- A Record Loss in '87 for Health

The current interest in the treatment of alcoholics differs sharply from the historical pattern of hospital impatience with and indifference towards the problems of abusive drinkers. Only after the insurance industry agreed to underwrite the costs of alcoholism treatment did hospitals develop their present interest. Shortly after the passage of the 1970 Comprehensive Alcoholism and Alcohol Abuse Prevention

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Insurers" (New York Times, February 15, 1988; "Hospitals Linked to Discrepancies in Medicare Pay" (New York Times, February 11, 1988); "More U.S. Families Going Without Health Insurance" (Omaha World Herald, February 17, 1988). This pattern of continually increasing costs combined with decreasing public access to health care has, with the exception of a brief period of relative stability in 1984-5, continued unchecked. Each new attempt at regulation produces a lateral move on the part of health care providers. Health care in 1986 accounted for 10.9% of the Gross National Product (GNP), and the Health Care Financing Administration has estimated that national spending for health care will rise to 15% of the GNP -- $2.5 trillion -- by the turn of the century.

Moreover, Branden (1986: 57) has documented the empirical consequences of policy based upon rational myth. As of 1986: "1) 37 million Americans have no health insurance while millions more are underinsured; 2) Over half of the poor are not covered by Medicaid; 3) Nine million children are denied routine medical care while twice that number lack access to dental treatment; 4) Between four and six million widowed/divorced spouses have lost insurance coverage; 5) In 1984, 200,000 Americans were denied emergency hospital care, and another 800,000 were denied routine care because they didn't have enough money; 6) 59 percent of poor or near-poor blacks and 63 percent of Hispanics were uninsured for all or part of the year in 1984; 7) Senior citizens on average paid 18 to 22 percent of their health bills out of their own pockets -- as much as they paid before the establishment of Medicare". Branden (1986: 57) also found that, "A recent study in Ohio, for example, found that the typical family paid $2,650 for health coverage last year [1985], an increase of 17 percent over 1984 costs". These findings dramatically underscore the consequences of policy based upon myth -- recalling Thomas' social construction observation, above (see Chapter 1).

and Rehabilitation Act, which proposed to treat rather than to punish alcoholics (3), Midwest Protestant announced plans to expand its "chemical dependency" services (General),

> [f]rom its current 56 beds on an "as needed" basis to meet continually increasing demand for service. The addition of a youth-oriented unit is recommended. Also, studies call for complete cycle of care which through industrial counseling intercepts the alcoholic earlier and which coordinates the alcoholics' return to work and a fully productive life [sic]. As these services expand, there will be increasing demand placed on other ancillary services to provide increased support to the chemically dependent patient (Midwest Protestant News Release, 1975) (4).

Midwest Protestant's expansion was part of the nationwide increase in the number of treatment agencies supported in important part by the provision of third party reimbursement. Between 1979 and 1984, the number of private, for-profit treatment centers rose from 199 to 851, a 328% increase. The total number of private treatment agencies, including nonprofit ones, increased by 76% over that same period of time: from 2,935 to 5,176 (NIAAA 1984: 15) (see Appendix, Table 3.1). These figures clearly show a rapid increase in

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3. This Act called for the decriminalization of public intoxication, and mandated the treatment, rather than criminal prosecution of drunken offenders. It also established the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and enlisted the insurance industry's financial support in including alcohol treatment in health care policies.
4. I am indebted to my fellow graduate student, Burton MacHolmes, for providing me access to planning documents, certificates of need, and press releases he encountered in his own research.

treatment centers, but they do not explain how the increase has come to pass. Although insurance coverage created the financial potential for generating surplus value required in commodity production, a market still had to be created. Without insurance, the alcoholic role could not have acquired a surplus value.

With the inception of third party reimbursement, GTC could begin to organize a market for its "complete cycle of care". As Midwest's press release indicated, the corporate consumer of their services would be industry (employers and employee assistance programs), and the courts. Schools and social service agencies were soon added.

THE IDEOLOGICAL FOUNDATIONS UNDERLYING THE GROWTH OF GENERAL'S MARKET

The requirements of the new social relations needed to develop an alcoholism treatment market included a new set of beliefs by which to explain and justify market relations. Three crucial changes in the traditional thinking about alcoholism were required. Following Bendix (1956/1974: 2), I will refer to these new beliefs as "ideologies of management". That is, those

> ideas which are espoused by or for those who exercise authority in economic enterprises, and which seek to explain and justify that authority.

Ideologies of management underlie the transformation of key members of the elite into the corporate consumers of

General's services. When these members of the elite are added to the already-existing consumers (families, primarily) of treatment services, three vitally important events occur: 1) the consumers in the system increase dramatically in sheer numbers and, more importantly, in power; 2) they provide the funding which allows for the continued and continuing expansion of the market and, 3) they displace the patients from their position as consumers, creating of them an underclass.

Protestant's press release (above) illustrates General's ideological vocabulary. They refer to the "demand" for their services, and assert that "studies call for" their services. This vocabulary portrays the agency as responding to a community need, an ever-increasing demand. These claims by the agency

> [a]re not, of course, statements of fact. They are rhetorical remarks designed to persuade people to think or believe as their authors do (Littrell 1988: 5).

They are also designed to legitimate the social relations the agency requires in order to create and maintain a reserve army of "consumers", a group of people who will submit to control with relatively little struggle. The agency's "public goals" (Perrow 1986) are tailored to legitimate the utilization of treatment services to a newly powerless group of former consumers, for example, a family. Virtually the entire social world of alcoholism has been reconstructed. And

it is this reconstruction which has undergirded the transformation of those key elites into bureaucratic consumers.

The expansion of the treatment market, and the social relations which support it, has been accomplished by expanding the range of behaviors said to be either alcohol-related or alcoholism-like and by creating constricted understandings of what constitutes healthy behavior. Many beliefs, attitudes, and values have supported these changes, but the principal ideological constructs are as follows: 1) the creation of the "hidden alcoholic"; 2) the legitimation of coercion into treatment, under the more humanistic-sounding name of "intervention"; 3) the abstraction upon the original disease model of alcoholism, and its central precept of "loss of control" over behavior, into a more encompassing, generic "dysfunction" -- "chemical dependency". These ideologies of management have been marketed to key consumers, especially the courts, schools, employers and EAPs, and the insurance companies. The success of this marketing campaign is evident in the pattern of referrals to the agency (see below). Contrary to the agency's and the consumers' preferred self-image of "helping the patients to help themselves", the successful growth of GTC has depended primarily upon helping the consumers to help General, by underwriting

the development of the agency's market (5).

HIDDEN ALCOHOLISM AND INTERVENTION

It has long been held that alcoholics cannot be helped unless they want to be. This perspective is clearly not conducive to the development of a broad-based market for alcoholism treatment. It allows alcoholics the privacy of a personal (and cost-free) decision to undertake self-transformation -- AA's traditional function. Industry representatives have countered this point of view with the notion of the "hidden alcoholic" -- those drinkers whose problems have not yet come to official attention or been treated. Hidden alcoholism is frequently cited as an explanation for the disparity between AA's 1985 membership of 585,000 (Denzin 1987: 17) and the treatment profession's assertions that as many as one in ten Americans is alcoholic, and one in six is affected by an alcoholic. Two of the principal "symptoms" of alcoholism are said to be the alcoholic's denial of the problem and the progressive and fatal nature of the disease. Thus, the correct -- and implicitly moral -- course of action for the alcoholics' loved ones to take is "intervention", a technique which holds that

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5. As part of my research into the treatment industry, I interviewed the director of an employee assistance program. While describing her company's policy of referring troublesome employees to treatment centers, she said she hoped that that policy did not seem "too heavy-handed", and noted that the company liked to think of their policy as "helping the employees to help themselves".

> It is not wrong to create a crisis in the chemical dependent's life to get him/her to accept treatment. Family crisis intervention has been highly successful in getting chemical dependents to accept help and go into treatment (GTC in-house brochure).

"Creating a crisis" in the "chemical dependent's" life usually involves a confrontation, in which family members, employers, friends, and the family's minister and/or physician -- either individually or in consort with one another -- demand that the chemical dependent enter a treatment facility. Such a demand is not easily refused, as failure to comply may, and does, involve such weighty sanctions as divorce, job loss, or jail time (6).

Intervention underscores the dimension of social power which the new class of treatment service consumers exercise. Indeed, backed by the authority of the courts, intervention has proven to be an exceedingly effective mechanism for coercing potential patients into "accepting help". The phrase "accepting help", when contrasted with the alcoholic "seeking help", highlights the transformed social relations underlying commodified alcoholism: rather than "there is help available", the message becomes "we <u>are</u> going to help you". Similarly, the agency's references to "the chemical dependent", rather than "your loved one, friend, or employee", subtly illustrates the former consumers' new status in the changed social relations

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6. These remarks on confrontation are based upon earlier research, and upon conversations with acquaintances in AA and/or the treatment industry.

of treatment. When the agency speaks of the "demand" for their services, they are referring to their consumers' demand, but those consumers are not the patients.

PSEUDO-INTENTIONALITY AND THE LOSS OF SELF-CONTROL

The expansion of behaviors said to be alcohol related and alcoholism-like has, in important ways, depended upon its twin process -- the narrowing range of behaviors said to indicate emotional and mental well-being. The principal tenet underlying each, however, is essentially the same: the idea of "loss of control" over one's behavior. In turn, "loss of control" underlies the creation of the more inclusive category, "chemical dependency". Chemical dependency is a broad categorization, encompassing virtually any human behavior over which one may be said to lose control.

Borrowing from Rush's inductive conclusion, over two hundred years ago, that the loss of control decisively differentiates addicts from non-addicts, General has formulated a model of addiction based upon a simple calculus, which is presented to the patients in the form of a mathematical formula:

What did I intend to do?
- What did I do?

= X

Presumably, if X -- the difference between what patients intended to do and what they did -- is demonstrably large (the

"size" of which is left undefined), that patient has lost control. That they did not intend to drink, but did so anyway, the patients are informed, should be taken as a warning sign, if not a bona fide symptom, of their addiction: X, then, "equals" chemical dependency (see Chapter 5).

The invention of chemical dependency has opened the door for reimbursable treatment for a broad array of purportedly alcoholism-like behaviors. The corporate consumers' acceptance of the notion of chemical dependency is manifest in the extension of insurance coverage to treat an increasing number of presumably alcohol-related or alcoholism-like dysfunctions, as well as in the diversity of the agency's referral sources. Effectively, this has afforded a division of labor of sorts; a "specialization of addiction", in which one may lose control and presumably become addicted to other people (co-dependency), to food (compulsive overeating), to gambling (compulsive gambling), and to drugs other than alcohol (drug addiction). The usual criterion for receiving treatment is insurance coverage (although during my stay at the agency, one "compulsive spender" privately paid for and received treatment; an irony upon which several counselors remarked) (7).

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7. The specialization of addiction is also evident in the growth of chemical dependency related self-help books, almost without exception written by chemical dependency counselors. With the development of "family systems therapy", the assumption that family members of an addicted person also require treatment has received extensive support. The family

As Marx (1977) has observed, the division of labor is a crucial component of commodity production. The invention of psuedo-intentionality, and of chemical dependency, has created the potential for General to extract exchange and surplus value from a number of previously unavailable sources. The expansion of alcoholism-like behaviors, and the narrowed conceptions of wellness, have added to the potential pool of both consumers and the underclass. The elites, motivated by surplus value, and the subordinates, inspired by newly-spawned careers in the addiction field (also illustrative of the specialization of addiction), have fundamentally altered the institutional social relations surrounding alcoholism. The consumers have been convinced of the wisdom or effectiveness

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systems model draws upon an analogy of a mobile: when one of the pieces is removed, the balance of the mobile is disrupted. The chemical dependent is the missing piece. This imbalance is said to be evident in and to negatively affect all the members of a family system. These writers argue that the results of this close proximity to an addicted loved one include: difficulty identifying one's true emotions; an inability to communicate with, trust, or establish intimacy with others; and/or a general sense of ennui (see, for example, Subby 1986; Woititz 1986; Schaef 1986, 1987; Beattie 1987). Although it is unclear how far back in one's ancestry these problems may be said to reach, one author (Smith 1988) -- in a work entitled Grandchildren of Alcoholics -- has recently explored a three-generation model. The literature on addiction has also lately expanded to include "addictive organizations" (Schaef and Fassell 1988), and the "addicted society" (Schaef 1987). Because the bulk of these titles are penned by counselors or consultants employed in the helping professions, the arguments offered by the authors recall Becker's (1963) remarks regarding moral entrepeneurialism. General stocks these titles in their patient library, and gives them to family members as a regular practice. They also offer treatment for any and all family members, as well as the chemical dependents themselves.

of the transformative technology General has for sale, and the patients become that which is to be transformed. These changes are part of a larger pattern, which has been extensively documented.

REFERRALS AND CONSUMERS: "WIDENING THE AGENCY'S OUTREACH"

Borrowing from Scott's (1983b) terminology, shared belief systems beget relational frameworks. The ideologies of management which undergird the cultural transformation of the alcoholic role are manifested structurally. The evidence indicates that this cultural-structural reflexiveness is a nationwide phenomenon.

For example, Fillmore and Kelso (1986) have suggested that treatment agencies serve more to alleviate the burdens of the criminal justice system than to care for alcoholics. They observed increasing referrals to treatment from public assistance and social welfare agencies. They also found that treatment centers were frequently handling such general problems as antisocial behavior, criminal misdemeanors, and spouse abuse.

Weisner (1983: 126-127) comes to similar conclusions, and suggests some structural factors which account for this "rechanneling of clients": 1) overburdening of the criminal justice system; 2) the lower cost of treatment relative to incarceration; 3) the growth of the treatment system and an accompanying increase in the demand for patients; 4) the

employment of paraprofessionals and their helping zeal; and, 5) the treatment system's drive for equitable status in the overall social problems system. She also notes that an offender's diversion into treatment depends upon ability to pay, effectively making the treatment option a matter of socioeconomic status, rather than demonstrated need. The latter also underscores the importance of exchange value to the commodity production process.

Weisner and Room discuss the effects of "privatization", "the movement of entrepeneurial and investment groups into the human services 'industries'" (1984: 167). Privatization depends upon either governmental subsidy or alternative sources of financial support, such as third-party reimbursement. They also comment upon the remarkable growth of private, for-profit agencies since funding has been arranged (see Appendix, Table 3.1).

The rapid growth of treatment facilities has been accompanied by an expansion in the number of problems defined as alcohol-related, as manifested in nationwide referrals "for wife battery, child abuse, robbery, forgery, and assault" (Weisner and Room 1984: 176).

The pattern of referrals to both General's adult and adolescent inpatient treatment programs mirrors this research. For example, 18 percent of General's total 1986 census (N = 660) was court-referred (N = 121); 9 percent were referred by

employers and/or employee assistance programs (N = 57), and another 9 percent from (N = 57) social service agencies (see Appendix, Tables 2.1 through 2.4).

Perhaps the most striking aspect of GTC's primary referral sources is their diversity. Virtually every imaginable public and private dimension of social life now serves as a potential referral source. Although families remain the principal source for referrals to the adult inpatient treatment (22% of the total 1986 census -- 99 patients), and an important consumer of adolescent inpatient treatment (22%, again: or, 46 patients), the agency's aggressive efforts to expand its consumer base have paid well. Bureaucratic consumers contributed 40 percent (N = 180) of the total adult inpatient and 56 percent (N = 118) of the total adolescent inpatient censuses at General in 1986 (See Appendix, Tables 3.2 and 3.3)(8). Thus, the institutional market relations have proven an invaluable addition to General's gross revenues.

By contributing 118 patients to the 1986 adolescent

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8. Among the bureaucratic consumers I include: courts, intervention, employers and employee assistance programs, other agencies and "all other" for the adult census, and courts, school, employers and EAPs, other agencies and intervention for the adolescent census. All figures are taken from GTC's 1986 annual report, provided to me by the agency.

It is important to note, also, that there are discrepancies in the agency's report: their admissions and the total number of discharges, of all types, seldom agree, and cannot be accounted for by transfers. Officially, these "missing" patients are left an enigma.

inpatient census, bureaucratic consumers contributed 5,310 additional patient days (118 times 45 days) to GTC's coffers. The daily charge per patient is $170. Thus, in 1986, bureaucratic consumers generated $902,700 (5,310 x $170) in gross revenue.

The other referral sources merit comment, as well. For example, although AA or the other twelve step groups are not "consumers", per se, (they do not directly purchase the commodity) they do assist the agency's profit margin. In 1986, this assistance accounted for 13 percent (N = 88) of the agency's census (9).

"Self" referrals were recorded as such, even when the patients acknowledged that they had been given a choice of either checking themselves in, or being checked in (10).

CONTINGENCIES

General has successfully cast a wide net. Yet, as with most statistics on alcohol-cum-chemical dependency, there is reason to be at least partially skeptical (see Chapter 1) that census growth accurately reflects the growth of alcoholism and

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9. This relationship is directly contrary to the founding AA members' cautionary precepts regarding the professionalization of AA. AA, and the other "twelve step" groups, have been cultivated as lucrative referral pools. Essentially, the more treated, the greater the subsequent influence upon AA. AA's "production" has always remained steadfastly use-valuable. This is changing, as they increasingly become a satellite of GTC.

10. There were undoubtedly some bona fide self-referred patients, but I have good reason to doubt the numbers were as high as the agency reported.

other addictions. Indeed, the research just discussed suggests that census growth may reflect more inclusive definitions of the problem, rather than a growth in the problem, per se. Although my "sample" is clearly too small for generalization (as discussed in Chapter 2), nearly all of GTC's 1986 adolescent census (N = 210) can be accounted for by a power differential between the patients and those by whom they were referred: 32% courts, 22% family, 14% other agencies, 8% schools -- 76% of the total referrals were by traditional agents of social control. I will conclude this chapter with a brief introduction to each of the thirteen adolescent inpatients I met in the field (11), and the ways in which they found themselves at the agency. Their paths into treatment illustrate the institutional social relations upon which GTC's market has been constructed.

THE PATIENTS

Quentin (15 years old) was referred by Child Protective Services (CPS). His family life was demonstrably nightmarish, fraught with physical and sexual abuse, a drug and alcohol abusing mother, and a long procession of his mother's "men friends" -- all of whom shared a propensity for misusing and

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11. I met a number of other patients while at the agency. Some ran out on treatment (literally) or were on unit B; some were graduating when I first began my field work, others were just coming into treatment as I was leaving the field. The group in this thesis were those with whom I became familiar and, therefore, about whom I can speak with a degree of certainty.

abusing Quentin, as well as controlled substances. Quentin's interactions with every traditional figure of social authority -- school, police, social welfare agencies, family -- had been, at best, antagonistic. He had had his own bouts with drug and alcohol use. These factors, combined with the failure of any and all official attempts to provide Quentin with guidance, had resulted in his referral to General. As with most of the patients, Quentin's behavior seemed to spring from a reservoir of anger, of which his substance abuse was more a manifestation, than an independent or causal factor. This, at least, was the reasoned opinion of his case worker at CPS, and several GTC staff members. Treatment, judging from the comments in his chart, was a last-ditch effort to salvage Quentin's life.

Ernie (15 years old) was referred by his mother. His father's employer had shut down most of its area operations two years before, and given long time employees the option of transfer or severance pay. His father had stayed with the company, and had spent much of the past year and a half 700 miles away, visiting as often as possible. Ernie and his mother had fought frequently since the transfer. His grades plummeted; his behavior at school had become a recurrent source of phone calls from school officials. He increasingly ignored his mother's wishes, and had become "surly and belligerent" towards her. He was also spending less and less

time at home, and refused to discuss his behavior with his mother. Finally, after a fight in which he appeared to be "on something", and during which he shoved his mother against a wall, she and her husband brought Ernie to General.

Nathan (16 years old) was also a disciplinary problem at home and at school. He was given to sudden, angry outbursts -- many directed towards his younger brother -- which alternated with long stretches of withdrawal from and noninvolvement with his family. His school grades worsened, and he was simultaneously staying out late at night, and refusing to explain his behaviors or his absences. After repeated attempts to discuss his actions with him, his parents sent him to General.

Mary (16 years old) was discussed at length in Chapter 2 (see "Not Altering the Scene or Others' Behavior").

Travis (16 years old) was also referred by his family for disciplinary problems at home and school. He shared with Charles (see below) the distinction of being a member of an "AA family". In fact, in Travis' case, he was the tenth member of his family to receive treatment at GTC. In his chart, when asked why he thought he was in treatment, he had responded "because my family thinks anything they don't agree with is caused by alcoholism or drug addiction". Travis identified his family problems as issuing from "my inability to do anything right, as far as my dad's concerned" (taken from Travis'

chart).

Danny (17 years old) was referred by juvenile court for drunkenness and disturbing the peace. While drunk, he and some friends had vandalized their high school. Some years before, Danny had been assessed by a school counselor as learning disabled -- an evaluation his grades did not contradict. He was given to angry mood swings, frequent fighting with boys from rival schools, and -- increasingly -- the refusal to obey either his parents or school officials. He had been drunk when apprehended on the night of the school vandalism incident. He and his step-father had frequently engaged in shouting and pushing matches with one another. These had gotten worse immediately prior to his referral to treatment.

Kyle (17 years old) was court-referred for possession of a controlled substance on the West coast, where he had been staying with his grandmother during Christmas break from the military academy he attended. His behavior had become more erratic since his parents' divorce five years earlier. Since the divorce, he had spoken with his mother once on the telephone. When his father had remarried, Kyle had been advised that he did not seem to fit in with his new step-family, and his father had made arrangements for boarding school. Kyle had been asked to leave boarding school for disciplinary reasons, and was subsequently sent to the military academy. He had been referred to GTC, as his father's

-- who lived in the agency's geographic region -- insurance was paying for the treatment.

Eddie (17 years old) was referred by his family. His step-mother and he had fought from the moment she had joined the family. He had also fought frequently with his father, who -- according to the chart -- had physically abused Eddie as a child. Eddie's family and school problems were markedly similar to the other patients' -- rebelliousness, hostility, fighting. Following a particularly violent argument with his step-mother, his family had sent him to treatment. In his chart, Eddie had commented that he lived with his father "because my mother doesn't want me" (quote taken from Eddie's chart).

Kevin (17 years old) was referred to GTC by the courts, after a series of minor offenses -- primarily vandalism. His relationship with his family closely followed the typical problems -- failure to help around the house, surly attitude, late nights. His behavior and grades at school also reflected characteristic patient patterns -- low marks and disciplinary problems.

Charles' (17 years old) family had sent him to GTC for a chemical dependency evaluation, after he had failed to call to let them know he would miss dinner one night. This was uncharacteristic of Charles. Moreover, his parents had smelled alcohol on his breath when he did get home, and had acted

quickly. Charles, like Travis, came from an AA family. Unlike Mary, Charles voluntarily stayed for the entire treatment, rather than being released after the evaluation period.

Timothy (17 years old) was a family referral. His behaviors were consistent with the other patients, both in terms of flagging interest and performance in school, and either withdrawal from or antagonism towards his family.

Fiona (17 years old) was the only girl in the treatment cohort who stayed for the entire process. She was a court-referral. She had left home after a fight with her step-father, and had stolen some money from a public assistance relief fund at her church. Although Fiona swore that she had taken the money "just as a loan", until she could find a job and an apartment, the officials did not believe her. Treatment was offered as an alternative to criminal justice processing. Her family and school life also fit the usual pattern. She fought with her step-father and mother, particularly about her boyfriend (of whom they did not approve), resented the work she was expected to do around the house, and had gotten poor marks in school.

Nick (18 years old) was indirectly a court referral. He had robbed an ice cream vendor in his neighborhood. Performance in treatment was more pressing for him than for the other patients: at eighteen, he was no longer under the

jurisdiction of juvenile court. Nick had had no serious problems with school or his family. His grades were average, and he got along "pretty well" with both his mother and father. Things had started to change about a year earlier, when his parents had embarked on a business venture together that required them to be away from home about twenty days out of every month. Nick had started "getting a little wild" at that time -- giving parties at his parent's house, drinking and doing drugs. Eventually, the wildness had gotten out of hand. Nick claimed he robbed the vendor because he was out of money and food, and his parents were gone. His lawyer had advised Nick to go through treatment prior to his sentencing date, in the hopes of reducing or eliminating jail time.

Clearly, there are some common themes in the patients' backgrounds: problems with authority figures, family difficulties, and the patients' failures to behave in accordance with the wishes of parents, educators, and the police. The most common problem, and the issue most-mentioned and discussed in patient charts and in group therapy (see Chapter 5), was the troubled nature of the patients' family lives. A certain antagonism towards authority figures is a familiar characteristic of adolescence. The fact that this antagonism is so frequently (and, often, quickly) interpreted as a symptom of a disease by GTC's referral sources is an indication of the changed understandings of alcohol and drug

abuse. Many of these changes may, at least in part, issue from the treatment industry's successful promulgation of the ideologies of management -- hidden alcoholism, intervention, and the need for treatment.

This chapter has examined the institutional relationships which have shaped the social reality of alcoholism treatment. The social relations between and among the elites and (especially) the bureaucratic consumers are based upon the principles of market exchange. These relations bear directly upon all the interactions within the treatment system. Elite-to-elite and elite-to-consumer relations issue from the assumptions that deviation from normative behaviors is symptomatic of a disease, and that the recovery from that disease is purchasable: the aforementioned "relation between things" which is characteristic of commodity production (see Chapter 1). The brief discussions of each patient's path into treatment indirectly illustrate the nature of the patients' relations with the elites and consumers under these assumptions. The patients are the "carriers" of a disease, and must be treated. The treatment process itself -- the subject of Chapter 5 -- is designed to remold the patients' identities to fit the institutionally-defined reality. This identity-reconstruction is the work of the subordinates. Thus, the elites' and consumers' agreed-upon definition of the problem requires specific attitudes and behaviors from the

subordinates and the underclass. All relations become shaped by the assumptions regarding disease and recovery.

CHAPTER 4

CAUGHT IN THE MIDDLE: COUNSELING ON "COMMODITY TIME"

Chapter 3 illustrated the creation of the treatment market, and the development of the necessary social relations (elites to elites, elites to consumers, elites to the underclass, and consumers to the underclass) to sustain that market. In this chapter, I will illustrate the impact which the market has had upon the social relations of elites to subordinates and subordinates to the bureaucratic consumers.

All relations in the social organization of treatment are oriented towards the sale (or purchase) of treatment. The administrators at GTC set standards of action and attitude which will maximize surplus value and ensure the continuity of production.

THE REALITY OF TREATMENT

Treatment, despite the medically connotative ring of the word, is a psychological procedure designed primarily to modify the patients' behaviors and attitudes. Behavior is what brought the patients into treatment; behavior, then, becomes the barometer of the success of that treatment. Behavioral modification, as an arm of clinical psychology, is a mechanism of re-socialization (Berger 1966; Berger and Luckmann 1966; Mannheim 1936). "Psychology", as Berger and Luckmann (1966: 175) have observed, "presupposes cosmology". Treatment is based upon a particular view of social reality, and it is deviations from this reality which are being treated; the

deviations are the "disease". Berger and Luckmann (1966: 175) go on to observe that one must inquire "into which reality?" [original emphasis] are patients being re-socialized.

The elites within any social structure shape the nature, the reality, of that structure. The bureaucratic consumers of treatment are, themselves, modified elites, with the power to define reality, albeit within different spheres of social life. For example, businesses reflect their administrators' views of reality. The social reality of chemical dependency (CD) (1) treatment, as practiced at GTC, is the reality preferred by the elites whose shared beliefs created the present social structure of treatment. These elites include administrators of MHCC, Midwest Protestant, and GTC (who provide the service) on the one hand, and the administrators of the businesses, schools, courts, insurance companies and social service agencies (who consume the service), on the other. These are, in many ways, complementary realities, centered around the exchange which is the essence of treatment social relations. The hospital administrators get a new and lucrative market, and the consumers purchase the service which promises a more compliant and responsible employee, a more law-abiding citizen, a healthier insured, a better student, father, husband, mother, wife, son, or

1. Hereafter, I will use the abbreviation CD, to denote chemical dependency.

daughter. The wishes of the elites of various structural microcosms are simultaneously satisfied. The subordinates of this social structure are charged with the responsibility of bringing patients into line with the realities of the elites and the bureaucratic consumers. I will discuss each of these interactions.

ELITE-TO-SUBORDINATE RELATIONS

The overarching concern of MHCC and GTC's elites is the generation of revenue. This concern is regularly conveyed to the counseling staff, most often through administrative attention to the limits of insurance coverage. Elite to subordinate relations occurred primarily in three structured settings: morning report on the separate units, weekly unit staffings, and weekly agency-wide staff meetings. The administration seldom attended these functions as a group. When they did attend, they frequently exercised their power to shape the reality, including the priority, of the agency's treatment goals.

COMMODITY TIME

Time is redefined by the elites to meet the requirements of commodity production. This "commodity time" affects treatment by imposing limits upon the counselors' therapeutic efforts. The counseling staff is caught between the demands of their administrative superiors and the bureaucratic consumers.

The elites must structure organizational action in a

manner that will maximize surplus value; the bureaucratic consumers seek to maximize return on their investment. Each has an interest in keeping the treatment process as short as possible. At $170 a day, the bureaucratic consumers put a lid on their expenses by refusing to pay for more than a limited amount of time. GTC's administrators ensure that patients are not retained beyond insurance limits, or stretch more liberal coverages to their limits. Time, for both the elites and the bureaucratic consumers, is money; as such, it serves both therapeutic and anti-therapeutic purposes.

Therapeutically, the daily scheduling of treatment effectively trains the patients in the importance of being on time, and of accomplishing daily requirements in a responsible and timely manner. This training is well-suited to the discipline required by the bureaucratic consumers: one shows up on time for work or school, accomplishes assigned tasks by the time they are due, and keeps appointments with bureaucratic entities such as the courts or public assistance agencies (see Chapter 5).

Anti-therapeutically, the production of recovery in the context of exchange must occur within a specific period of time. Insurers will only pay for, generally, thirty days of adult treatment, and forty-five days of adolescent treatment. Bureaucratic consumers, then, impose temporal limits on the treatment process. This accounts for GTC administrators'

remarkable fluency in the vagaries of various insurer policies, as well as their studious attention to the number of days patients have been in treatment. Ultimately, it matters less how well served the patients have been by their stay in treatment, than how much of their treatment is third-party reimbursable. The experiences of Quentin and Nathan demonstrate the importance of time to General's bottom line.

Nathan was released from the adolescent unit after thirty days, despite his repeated failure to adhere to the agency's treatment regimen. His progress as a patient was minimal: he had accomplished few of the assignments required of the patients, seldom spoke in group therapy, and only intermittently performed the housekeeping duties (cleaning rooms and showers, vacuuming the halls) which the agency considered important to the treatment process. Nathan's "graduation" incensed a number of the patients who had been in treatment longer and thought that they behaved far more in accordance with treatment norms than he had (2). For several days following, Nathan's graduation became the focus of group and individual counseling sessions. The normal daily course of treatment was continually interrupted by patients'

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2. Graduation is a socially structured ritual which is intended to signify a patient's successful completion of treatment. It affirms the patients' reconstructed identities, and acknowledges their efforts in bringing this transformation to pass. The entire unit, as well as the patients' friends and family participate in the event, and the patients take the ritual very seriously.

indignant outbursts. Travis, for example, announced during group therapy that

> I think it sucks, Nancy. The guy [Nathan] was as screwed up the day he left as he was when he got here. I mean, if Nathan was recovering, then I'm not chemically dependent at all (3).

Behind closed doors (in sessions at which I was in attendance), the counselors assured one another that there had been no alternative to Nathan's release. Once insurance coverage had expired, there was nothing to do but "cut him loose".

Quentin's case exemplifies the use of commodity time when insurance coverage is open-ended. Quentin's mother had been twice divorced. Both his father and his step-father had routinely beaten him; the step-father had also sexually abused him. This pattern had continued unabated through a succession of his mother's subsequent boyfriends, as well. She herself had had a long history of alcohol and drug abuse, and did not intercede on her son's behalf because she had been "too fucked up most of the time to know or care" (4). Responsibility for Quentin had passed from Child Protective Services, to juvenile court, and finally to General. He had spent the larger part of his life in and out of social welfare, penal, and medical institutions.

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3. Field Notes.
4. Field notes. A comment made to me by Quentin's primary counselor, during a unit staff meeting.

In private, several of the counselors expressed the opinion that cases such as Quentin's are, at best, marginally served by therapies designed to address drug or alcohol dependency. Treating the substance abuse reversed the implicit causal relationships between the way Quentin's life had gone and his use of drugs and alcohol. Quentin's life was miserable long before his drug and alcohol use began. This was true for a number of the patients. The counselors routinely referred to the substance abuse of patients like Quentin as "killing the [emotional] pain". Despite the misgivings of the counseling staff, Quentin was retained for a protracted stay as a patient; an administrative decision, based upon his open-ended nature insurance coverage (see "Unit Staff Meeting", below).

At each of the socially structured points of interaction between elites and subordinates -- morning report, unit staff meetings, and the agency-wide staff meeting -- GTC's administrators routinely stressed non-therapeutic aspects of the agency's priorities and the subordinate's responsibilities. Time was only one dimension of this reality-defining. The administrators frequently made off-the-cuff evaluations of the patients' problems, pressured staff physicians to diagnose in accordance with known reimbursable categories, expected counselors to carry extremely heavy caseloads, and, despite the counselors' frequent complaints about understaffing, demanded that the counselors maintain

impeccable charts on each patient. Each of these administrative demands was conveyed during staff gatherings; each had no bearing upon patient well-being.

UNIT STAFF MEETINGS: ELITES TO SUBORDINATES

Unit staff meetings were a weekly event for both the adult and adolescent inpatient personnel. At these meetings, the entire "treatment team" (GTC in-house brochure) convened to discuss the disposition of the patients on a case-by-case basis. The unvarying cast of characters representing the adolescent unit included: the treatment coordinator for the unit, the head and individual counselor(s), the school teachers, the recreational therapist, the chaplain, and any counselor trainees, practicum students, and/or observers that had been assigned to that unit. Often, but not always, Dick Miller, the treatment services director, would sit in on these meetings, and his comments often served to affirm the agency's economic imperatives, as manifested in his concern for the time remaining in patients' insurance coverages.

During the unit staff meeting in which Quentin's progress in treatment was discussed, Cliff Bonacci, the director of the adolescent program, inquired "how much longer do we have him?". Nan, the head counselor, replied, "we have about three more weeks until his insurance runs out". This exchange was followed by discussion as to "what to do" with Quentin in the remaining time, and in which halfway house he might best be

placed.

The conversation then turned to Quentin's lengthy stay at the agency. Bonacci and Dick Miller entered into a discussion regarding the merits of different insurance companies. They agreed that, "Traveler's [Quentin's insurer] is good -- very open, very flexible"; praise which reflected the fact that that company had not yet imposed the time limits upon the treatment process which were characteristic of many of the other major insurers. Miller remarked, "these other guys [insurers] just don't understand what we're up against". When Quentin's counselor observed there were only three weeks remaining in his coverage, the director remarked that, "we'd better move on placing him [arrange, as soon as possible, to find a halfway house for him], then, Nancy" (5), and, at just over one hundred days in treatment (roughly $17,000 in gross revenue), Quentin was released.

Miller also helped to shape the staff's propensity to engage in off-the-cuff diagnoses. His assessment of Eddie's problems is illustrative. During another unit meeting, the counselors were expressing their doubts that Eddie belonged in treatment. Nancy, his counselor, remarked that Eddie did not seem capable of understanding rules, and that when she talked to Eddie, he often just stared at her without responding. She went on to explain that Eddie's lack of comprehension of the rules was starting to cause resentments on the unit, because

5. Field notes.

she was treating him differently from the other patients.

Nancy pressed her case, arguing that she believed Eddie's problems went beyond substance abuse. Emory (one of the trainees) agreed with Nancy, and said that in two instances he'd had to tell Eddie to shower, "because he smelled so bad, and doesn't seem to notice, or care". Nancy added that a couple of days before, Travis had "just out and out told Eddie to either take a shower or stay away from him". Eddie had gotten furious with Travis, and threatened to "get" him. Miller had been taking in the counselors' conversation, and interjected, "Jeez, Nancy -- sounds like just another drunk to me". Several staff members chuckled at Miller's comment, and the question of whether Eddie might have been better served by other forms of therapy (in another setting) was dropped (6). It later became evident that Nancy had been correct about Eddie (see below).

AGENCY-WIDE STAFFING: ELITES TO SUBORDINATES

Administrators also focused staff attention upon the agency's corporate identity. This most often occurred at the weekly agency staff meeting, which involved all the inpatient and outpatient personnel at the agency. The content of the meetings was often business-oriented, rather than therapeutic, and appeared to primarily serve the function of professional

6. All of the comments regarding Eddie were taken from field notes.

socialization and the transmission of administrative goals. I was in attendance during what might best be described as a quarterly report. Ned Peterson, the director of finance (the official in charge of the files, payrolls, and record keeping) was invited to address agency personnel as to GTC's economic well-being. His remarks are illustrative: "Business is good. Right now, we're running at 95% of our 1987 projections, and I just received a memo from corporate HQ [Midwest Protestant's common nickname among GTC personnel] commending us on the good year we've been having so far. So, keep up the good work, people -- way to go". The staff applauded these remarks (7).

Another administrative priority was also addressed at these meetings, albeit oftentimes obliquely. For example, Denise, a long-time senior counselor at General, was given a going away party, upon her out-of-state relocation. Dan Finley, the executive director of GTC "emceed" the event, and his farewell speech emphasized another non-therapeutic administrative demand: Denise, we're really going to miss you around here. You've been a good, loyal employee, and you're gonna be hard to replace. And I just wanna tell you all, if we ever have to go to court, I'd want it to be about one of Denise's patients, 'cause her charting is absolutely impeccable (8).

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7. Field notes.
8. Finley's concerns about "going to court" were not unwarranted. Right before these comments, the agency was informed that the father of a patient who had been treated at

Finley then led the group in applauding Denise and her charting. The problem of patient records (charts) was a recurrent source of conflict between elites and subordinates: the counselors wanted to work with the patients, and felt too much time and attention to paperwork was expected of them.

Charting, as the name suggests, involved recording (entering onto the computer) each patient's passage through GTC, from admission through graduation. Charting was a serious administrative matter, as GTC's uninterrupted operation depended upon a "clean bill of health" by JCAH (Joint Commission of Accredited Hospitals) inspectors, which, in turn, depended upon up-to-date and complete patient charts. Although the procedure was primarily a matter of pointing a "light-pen" at the appropriate phrase displayed on the monitor -- such as "pt. fringing the unit" [patient not participating in unit social life] -- there was an expectation that the counseling staff maintain complete records on each patient. This often translated into 2-3 hours a day at the computer

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GTC had filed suit against the agency, basing his claim upon the charge that his son had not been "cured". The patient's chart (which was missing) was to be used by the plaintiff as evidence. Litigation such as this reflects the changed nature of General's consumers As with any market exchange, there are directly contractual obligations which the agency may be reasonably expected to meet in the fee-for-service bargain. Unfortunately, at the time of this writing, there has been no resolution of the suit. It is reasonable to expect that the agency will spare no expense towards a favorable decision, as an award for the plantiff could establish a decidedly unfavorable precedent: for all practical purposes, consumers would be in the position of demanding a warranty to protect their investment.

terminal.

The counselors found themselves dividing their time between patient treatment and administrative demands. This conflict of interests was exacerbated by the administration's unarticulated policy of not hiring immediate replacements for counselors lost to termination, transfer, or "burn-out" (an all-too-common phenomenon). This policy was a direct result of declining revenue, itself an outcome of increased competition in the market (9).

The conflict over charting issued from the counselors' assumptions that the treatment of patients was the agency's primary goal. Their caseloads, they argued, were already too heavy (often 1:10, while the counselors argued that 1:4 would be ideal for providing effective therapy). They complained that they were faced with an either-or decision: either keep "impeccable" charts, or devote their attentions to the patients. Dick Miller and Dan Finley repeatedly stressed that the counselors must do both, but that they had to find a way to keep the charts "up-to-date and accurate". As Finley told

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9. Within a two-year period, area hospitals opened three new chemical dependency treatment centers in GTC's market. 1986 figures showed a marked decline, after several years of sharp increases. In 1987, they had recouped their losses through aggressive marketing and the expansion of existing programs, -- and were "running at 95%" of their 1987 projections (see Appendix, Tables 2.1 through 2.4). It is important to note that General's response to increased competition did not involve price but, rather, resource competition (Littrell 1983b). This suggests some answers as to why the "market solution" to health care has proven ineffective, at best.

one recalcitrant counselor, "if it isn't charted, you didn't do the work, as far as we're concerned". When she had responded that that meant her work with the patients was going to suffer, he had told her "you do what you have to do" (10). Ultimately, what the counselors "had to do" was either cut back on the time they spent with their patients, or stay overtime (as salaried employees) to do their charting; and sometimes, both. Thus, as I briefly discussed in Chapter 2, when I arrived at the agency, Nancy was said to be "on the edge". Although the adolescent unit's census was typically smaller than the adult unit, Nancy had effectively been the only full-time certified counselor on the unit for several weeks prior to my arrival. This, Dana told me, was one of the primary reasons Nan had thought it would be "good experience" for me to carry a couple of patients (see Chapter 2); to lighten Nancy's caseload.

Understaffing was a recurrent complaint on all inpatient units. Nancy, for example, was the primary counselor for at least eight of the adolescent patients (Dana and Emory each took two patients) during my field work. There appeared to be no sound structural reason for the high patient-to-counselor ratio; General was continually training new counselors, and thereby had an in-house supply from which to

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10. Another counselor confidence; the number of confidences increased during times of elite to subordinate tension at the agency.

draw. Yet, Nancy was left largely on her own for another three weeks before they hired another counselor for the adolescent unit.

Reducing payroll is one way to increase surplus, or keep it reasonably commensurate with previous years. Although 1987 had proven to be a good year, 1986 had showed a marked dropoff in agency-wide admissions. Every department had been down from the year(s) before (see Appendix, Tables 2.1 through 2.4). Increasing the ratio of patients to counselors, while not improving the drop-off in admissions, effectively minimized the economic loss. The combination of understaffing and the administrative demand for current and well-kept charts, resulted in low counselor morale.

MORNING REPORT: ELITES TO SUBORDINATES

Morning report was simply an abbreviated version of the weekly unit staffing. It was attended only by the counselors and their immediate supervisors, and a representative of the nursing staff, who simply updated the counselors as to the patients' actions during the previous night. The reports were often mundane. For example,

> Dave seems to be in a bad spot. Keeps talking about how he doesn't belong here, and he wishes he could see his wife. He isn't mixing with other patients -- kind of keeps to himself (11).

At the conclusion of one morning report on the adult

11. Field notes.

unit, the nurse said,

> Oh, by the way. Dr. Inman wanted me to tell everybody that he will no longer be changing his diagnoses to guarantee patients' insurance coverages.

What she had effectively announced to all in attendance (including non-insiders such as myself), was that Dr. Inman had in the past been providing fraudulent diagnoses to ensure third-party reimbursement, and now wanted to stop this practice. There was an extended silence following this announcement; most of the people in attendance looked down at the table, one or two doodled on yellow legal pads. Finally, the treatment director for the adult unit cleared his throat, and asked, "Okay. That everything?", and all rose from the table, much more quietly than was normal (12).

Shortly after the staff nurse's morning report announcement, I saw a memo addressed to Dr. Inman. The memo was from Dan Finley (the director of the agency). It read as follows:

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12. I attribute the evident discomfort of the staff, in part, to my presence. Moreover, the nurse had drawn attention to an aspect of treatment which suggested its orientation towards profit, rather than patient care. Even administrator comments as a rule attempted to convey the coexistence of, rather than choice between, patients and profits. The nurse, then, violated an important norm supporting the social construction of treatment. It is also quite likely that her failure to observe this norm put her fellow staff members in the position of confronting, however briefly, the disparities between their self-explanations as to GTC's mission, and the inescapable importance of profit at the agency. This was my understanding of the uncomfortable silence following the nurse's announcement.

> Dr. Inman,
> Maureen [a counselor on adult unit B] stopped by last night and said that the diagnosis "atypical eating disorder" is not good enough to garner third party payment -- if possible we need a diagnostic impression of bulemia [sic] to get our money! Maureen states that our diagnostic symptoms fit the DSM III [the third edition of the American Psychological Association's Diagnostic and Statistical Manual] ... if you have any questions, please see Maureen ... I'm just the messenger on this one.
> Dan (GTC memo, original emphases. The memo had also been initialled by Dr. Inman, and two other staff physicians to indicate "read and understood") (13).

The memo, when taken in conjunction with the staff nurse's announcement, points to a struggle for superordinacy between the staff physicians and the administrators; a struggle in which the administration had prevailed. Dr. Inman's attempted assertion of autonomy -- saying, through the nurse, that he will no longer defraud insurers to assist the agency's bottom line -- was contradicted by his initials at the bottom of Finley's memo (which indicate that the reimbursable diagnoses would continue).

These events underscore the full range of administrative control over subordinates, as well as the directions in which that control is exercised. The elites steadfastly fashioned a social reality in which profit (and other administrative interests) took priority over patient care. When considered in

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13. A member of the staff drew this memo to my attention. I later copied it word for word (within the limits of anonymity), without this staff member's knowledge.

conjunction with the reconstruction of identity for which the bureaucratic consumers were paying, the social reality of CD treatment strictly limited the therapeutic role of the subordinates, and effectively transformed the patients into the raw materials of the production process.

SUBORDINATES TO SUBORDINATES

The subordinates were most directly linked to the other actors in the system. They were responsible for the satisfactory fulfillment of administrative directives, for the dimension of accountability required by the consumers, for the transformation of frequently recalcitrant patients into more compliant role-performers, and for the relatively smooth functioning of the agency through their own interactions with their colleagues. Not surprisingly, the attrition rate among chemical dependency counselors is said to be quite high (14).

As a result of their shared burdens, the subordinates' relations with one another most frequently entailed commiseration and mutual support. Their daily reality consisted of unending crisis management: fielding calls from disgruntled parents, responding to a steady stream of

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14. This is a widely-circulated belief within the profession, and makes intuitive sense, considering the demands and frustrations of the work. I did not, however, witness this personally, although I did see the after-effects of the administrative practice of letting the attrition rate take its toll, without taking on new, replacement personnel. Nora's frustration is one example of these after-effects (see elite to subordinate relations, this chapter, above).

adolescent complaints, and continually struggling to satisfy conflicting administrative demands. Most of the conflict inherent in their position in the system was, then, between-level, rather than within-level, conflict. Not all, however, was uniformly smooth between subordinates.

During my field work, there was a recurrent communication problem between the counselor in charge of the "family week" program (see Chapter 5), and Nancy, the adolescent unit counselor (15). Ideally, the inpatient staffs were to coordinate their activities with Madeline in order to guarantee that the patients' counselor attended at least the first few minutes of the family week rituals, to introduce themselves to parents, or to visit with the family and provide the latter with some indications as to their child's progress. Also, the family week counselor needed an approximation as to the numbers of family members expected to attend. This line of communication was repeatedly broken, resulting in an accelerating war of words between Nancy and Madeline.

Nancy's attempts to satisfy the conflicting demands which were made upon her -- charting, case overload, virtually no peer support -- resulted in her failure to notify Madeline which patients were scheduled for family week and how many

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15. As I have mentioned, General eventually did hire another adolescent counselor to assist Nancy. During most of my time with Nancy, however, she was the only fully-certified counselor on our unit. Nan or Cliff filled in when Nancy had a day off.

family members were expected. Madeline, then, found herself facing a roomful of family members, sometimes half of whom she had not expected. Because she did not know they were coming, she was unfamiliar with their patients, and with the families' histories. After four weeks in a row of these missed communications, Madeline strode into Nancy's office, and announced that because of Nancy's failure to communicate, Madeline, the agency, and Nancy looked "like fools" -- and the families vented their frustrations on Madeline. She told Nancy she was "sick of this shit", and stalked away (16). These missed communications occasionally had negative consequences for the patients (see Chapter 5).

SUBORDINATES TO BUREAUCRATIC CONSUMERS

The subordinates were effectively caught between the realities of the elites and the bureaucratic consumers. The introduction of the bureaucratic consumers into the social relations of treatment exacerbated the strains of the counselors' role. The external demands of time-limited behavioral reconstruction often found the counselors on the phone, seeking additional reimbursable time in treatment from an insurance company "gatekeeper", or discussing suitable halfway house placements with a patient's probation officer.

Conversely, although the counselors were indirectly

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16. Field notes. Confrontation in Nancy's office.

accountable for the success or failure of patient treatment, they often expressed appreciation for the additional "leverage" which an impending court case could bring to bear upon the attitudes and behaviors of recalcitrant patients (17). Employer or EAP-referred patients also often proved easier to motivate. The threat of job loss or jail time, by most counselors' assessments, offset the additional accountability (see Chapter 5).

COMMODITY TREATMENT

The institutional relations of the treatment market constitute the social reality which proscribes the actions of the members of the treatment system. The subordinate members of any social structure shoulder the burdens imposed by the elites. GTC's counselors are no exception to this general rule, although they are, perhaps, a special case. They are caught between the wishes of two sets of elites, and must meet the administrative demands of both. This chapter has broadly outlined those demands. Ultimately, it is the production process itself which demonstrates the full impact of the commodification of alcohol treatment. The commodity relations between the counselors and the underclass of the treatment

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17. Ultimately, the agency must bear the brunt of disgruntled consumer ire. Nonetheless, GTC keeps careful records of counselor productivity, and too many dissatisfied customers issuing from one counselor darkens the promise of a bright future in CD counseling.

system are shaped by the requirements of the exchange between the elites and the bureaucratic consumers. If bureaucratic power flows downward, the consequences of that power will be seen most clearly and felt most keenly at the bottom of the structure. Chapter 5 discusses the social relations at the bottom of the treatment system.

CHAPTER 5

MANUFACTURING RECOVERY: COMMODITY RELATIONS IN THE PRODUCTION PROCESS

Chapters 3 and 4 have illustrated the social relations among the elites, subordinates, and bureaucratic consumers of the treatment system (Levels 1 through 3 of the system, see Figure 3.1). The beliefs shared among the elites established GTC's treatment market. The market, in turn, shaped the social relations of treatment to match the requirements of commodity production. Chapter 4 highlighted the effects of market relations upon the role of the subordinates of the system, who were forced to juggle elite and bureaucratic consumer expectations. This chapter will document the commodity production process itself; the relations between the subordinates and the underclass and (less importantly) the relations among the patients. These relations at the bottom of the treatment hierarchy most clearly illustrate the role of the treatment underclass, and their transformation into the raw materials of commodity production.

SUBORDINATES TO THE UNDERCLASS: THE PRODUCTION PROCESS

Treatment, as suggested above, constituted a time-limited process of identity-reconstruction, in which the patients were instructed in the nature of the consumers' reality and the behaviors necessary for them to fit into that reality. The process itself was based upon AA's recovery regimen,

streamlined to meet the time limits of insurance coverage. Patients were more or less expected to "work through" the first four or five of AA's steps during their treatment. For the adolescent patients, the process was somewhat slower -- a step every ten days to two weeks, generally; the adults were often quicker at working the steps. After a brief description of the normative structure of the unit, I will discuss the treatment process "step-by-step".

THE "REACTION-CONSEQUENCE" ECONOMY

Aside from adhering to the step-a-week production schedule, the social life of the inpatients was based upon a normative pattern of daily responsibilities and behavioral rules. Patients took turns cleaning the unit, dividing the responsibilities among themselves: for example, Travis would be required to vacuum the halls one week, while Kyle was designated to straighten up the break room. Each patient was given one such daily task. All patients were required to make their beds, straighten their rooms, and take their scheduled showers on a daily basis. Deviations from these expectations were tallied each morning during the prep meeting. Patients were expected to bring unnoticed violations to the staff's attention, and to take or assign blame for those violations which were noticed.

Before the meeting officially began, one patient (who had been assigned) always reported on the unit's condition:

> There's a bar of soap left in the shower, and Room 8 has cigarette packs stacked up on their dresser (1).

The "offenders" then confessed, which drew a "reaction": Nick, for example, would say "I guess that's my soap". The tech on duty that day would record the violation in the reaction log. Three reactions elicited a "consequence", the most frequent of which was "pj's", in which the patient receiving the consequence had to wear hospital pajamas, rather than their own clothes, for a specified period of time.

The severity of the consequence depended upon the severity of the violation. When I first arrived on unit A, staff had discovered that several of the male patients had been gambling and "having sexual contact" with one of the female patients on unit B. The consequences imposed upon the offenders included pj's for an indefinite period of time, total restriction from telephone privileges for two weeks, and no visitors for two Sundays.

If a patient was already serving consequences, and took a reaction, the consequences were extended. Patients that had taken a consequence had to go without a reaction for three days to a week (again, dependent upon the severity of the violation), after which they were required to "request out" of their consequence at the beginning of group therapy. The other patients either granted or denied the request; permission from

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1. Field notes.

the group had to be unanimous.

Kyle, after a long stretch in pj's, announced, " I'd like to request out of pj's today. I haven't taken a reaction in the last four days". Timothy asked, "what's your job?". Kyle told him he was assigned to empty ash trays in the break room. Timothy nodded, and said, "I don't have any problem with it, then". All the other patients agreed, except Quentin, who observed, " I dunno, Kyle. I had to put a cigarette out in the group room last night, 'cause the break room ashtrays were so full". Kyle, glaring, responded, "C'mon Quentin. I dumped 'em right after that". Quentin replied, "Yeah, but I had to ask you first. And when I did, you gave me a real dirty look -- just like you're doing now. I just don't think you've done that great a job". When Kyle attempted to respond, Nancy interrupted him -- "Okay, okay. Sorry, Kyle. Another day in pj's. You can request out tomorrow" (2).

The veteran patients often set behavioral and attitudinal examples for the newcomers. As Kevin neared graduation, he became a model of the patient in recovery. During one prep meeting, for example, Kevin announced,

> I need to take a reaction. I didn't vacuum the group room yesterday. It didn't look like it needed it, at all, so I skipped it. Then, I got to thinking, you know, that that's my job whether it needed it or not, and by not doing it I was letting myself and everybody else down (3).

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2. Field notes.
3. Field notes.

The tech logged the reaction. Kevin's confession exemplifies a treatment ideal, in which patients learned to monitor their own behaviors. Many long term patients took up this practice of self-management, and reported their own violations, in genuine (or contrived) demonstrations of their newly-emerging, responsible identities.

Often, patients nearing graduation took it upon themselves to monitor other patients' behaviors, as well. Again, Kevin was a good example. The patients were not allowed to carry matches or lighters, and had to ask the nurse for a light when they wanted to smoke a cigarette. One of the patients' friends had smuggled in a lighter on the previous visiting day. During the pre-prep meeting reaction tallying, Kevin told the group (and the staff),

> I'm gonna give somebody here a chance to get honest about what they've been doing. They know who they are. It's his lie, but, I know about it, so he's making me lie for him, and that's no good for my own recovery. So, I'm gonna give him the chance to get honest, and if he doesn't I'll do it for him.

The patients then sat, staring at their laps, until Kevin shrugged, and said, "Okay, Tim. Give 'em the lighter". Timothy went to his room, and returned with the lighter, took a reaction and the ensuing consequence (4).

Time was also an important component of the reaction-consequence economy. Each week, a different patient was

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4. Field notes.

assigned the role of unit timekeeper. The job required keeping track of the time between scheduled events, and calling out on the unit, "three minutes to group (or school, or breakfast)", followed by two and one minute warnings. Patients routinely tried to blame the timekeeper if they arrived late for a designated activity: "Ernie didn't warn us what time it was". Occasionally, the timekeeper forgot; more often, the others tried to use that as an excuse.

The emphasis upon the timely fulfillment of daily responsibilities, and the reaction-consequence economy, were ongoing considerations in the evaluation of patient progress. As Kevin's confession illustrated, the patients either internalized, or became adept at pretending that they had internalized, the importance of these norms as indicators of their progress in treatment. There was a strong correspondence between the values upon which these treatment norms were based and the consumers' influence upon the nature of the treatment process. Patients were introduced to, and expected to internalize, a modified version of AA's recovery program, within the time limits imposed by insurer coverages. The remainder of this chapter will discuss the week-to-week (step-by-step) mechanics of GTC's version of that recovery program.

STEP ONE: DAYS 1-15

> "We admitted we were powerless over alcohol, that our lives had become unmanageable" (5).

The patients' first week at General was spent in introduction and orientation to the agency. It was also the most important week and step of the entire treatment process, containing the essential lessons the patients were expected to learn and incorporate into their new identities. Each step was essentially a continuation of the first. The lessons of treatment followed a sequential logic: that the patients' presence in treatment was the direct result of loss of control over their behavior; that they had lost control because they were powerless in the face of their disease; and that their lives were unmanageable as a result of that powerlessness. During the course of learning the first step, these messages were repeatedly stressed. The lessons were each both overt and subliminal. In the first instance, every dimension of their lives became interpretable within the context of the disease model. This intepretive scheme -- grounded in, and designed to affirm, the consumers' reality -- remained a constant throughout the patients' treatment.

Subliminally, the lessons of treatment contained an unmistakable double _entendre_. Because they had proven to be unmanageable to the consumers, the patients were, indeed,

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5. The first step of Alcoholics Anonymous (see References).

powerless. Because the patients had not controlled themselves, the consumers had assumed the responsibility for their control. For the next two to three months, the patients found themselves powerless to decide any aspect of their lives for themselves. As pre-patients, the adolescents I met had shared their refusal to voluntarily comply with the normative requirements of the consumers' reality; as inpatients, their compliance with that reality became compulsory. This compliance was identified by the AA term, "acceptance". Each of these lessons was taught the first week of treatment.

Upon arrival, the patients surrendered their personal belongings, which were held for them for two days. They were issued hospital pajamas to wear during this period. Clothing which was deemed "inappropriate", for example, torn clothes, or T-shirts emblazoned with the logos of drug-celebrating rock bands, was held for the patients until their eventual release, as were personal belongings with which the patients may have hurt themselves or others (lighters, for example).

During these first days, the patients took a battery of psychological and physiological tests, and were interviewed by all the members of the treatment "team" (GTC brochure; see "Unit Meeting", Chapter 4). The results of these interviews and tests were gathered and placed in a three-ring binder. These became the patients' charts. The charts accompanied the

patients when they officially took up residence on the inpatient unit to which they were assigned, and were added to throughout treatment. After the first two days, the patients began to live the daily schedule of treatment. For five working days after their introduction to the agency, new patients attended Stage 1 (called, simply, "stage" by agency staff) (6).

Stage took place at the same time as group therapy. It served as preparation for group, as well an introduction to the mechanics and realities of treatment life, and to the disease for which they were to be treated. Lorrie Lyman was the stage counselor for the adolescent units. Each day of stage, the patients spent an hour and a half learning the disease model and its applicability to their own lives. On their first day, they were given a pencil, paper, and an assignment packet containing one assignment for each of the five days. These assignments effectively established the reality which the patients were subsequently expected to assume as their own. As such, they were the core of the production process. I will first discuss the assignments, followed by a discussion of my week in stage.

1) The patients were instructed to compose a biographical sketch, which included family and school background, their

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6. Stage 2 follows the patients' graduation from inpatient treatment. Graduates generally take up residence in a halfway house, often the GTC-owned Miller Hall.

history of substance abuse, a list of "any other addictive or co-dependent persons in family" (GTC stage assignment packet), and a description of how they got into treatment. Lyman then called upon each patient to read his/her completed assignment aloud, and subsequently supplied intepretive analyses (see below).

2) The second assignment called for patients to read and fill out a "diagnosis of symptoms" sheet. They were to identify symptoms which they had personally experienced. The list included such traditional alcoholism-evaluation items as --

> Blackouts -- memory loss; the inability to remember all or parts of what occurred or what one does when drinking.

And,

> Indefinable fears (being afraid but not knowing exactly why; afraid of things not related to reality. Fear of being in room full of people, phone ringing, doorbell ringing, etc. [sic]).

And,

> Recognition of spiritual need (Feeling helpless enough about the use of chemicals that we begin to feel we could use some spiritual help with our problems with chemicals. Seeing the need for help from a power greater than ourselves).

Lyman interpreted patient responses to these questions, as well. Ernie, for example, (see below) did not find any of the items to be applicable to him. Lorrie then suggested that,

"Obviously, one of Ernie's symptoms is denial, or the avoidance of reference to personal chemical use" (see Chapter 3, "Hidden Alcoholism and Intervention") (7).

3) For the third assignment, patients were asked to draw a diagram which reflected their relationships with people and things close to them, and to illustrate how close they were to those things or people in the diagram. They were instructed to include their "favorite chemicals" and "things like partying". Lorrie then drew attention to, for example, Charles' apparent sense of being closer to his parties than to his family (see below).

4) The patients were required to read a "powerlessness and unmanageability" worksheet, and answer accompanying questions. The worksheet bears close scrutiny, as it identified the central components of CD, and of treatment.

> Powerlessness over alcohol is a key concept in recovery from alcoholism. That one is powerless over alcohol is the admission absolutely necessary in order to build up sobriety.

The sheet also had an explanation for the reciprocal concept of unmanageability, the meaning of which "[H]as been broadened in treatment":

> [W]hen speaking of unmanageability in the treatment situation, it is important to remember these three things:
> 1. The alcoholic who is drinking will sooner or later fail in his responsibilities to himself, his social system, and his job.

7. Field notes.

> 2. Noone [sic], alcoholic or not, can prevent feelings, no matter how unwanted they are, from sometimes coming to him. He is not, however, compelled to act out these feelings.
> 3. Noone [sic], alcoholic or not, can control the thoughts, feelings, or behavior of another person; nor can anyone control events or situations.
> 4. The state of unmanageability is not a negative state of being. <u>Rather, it is a reality of life and in fact can be a positive state of being when accepted. Thus the goal is acceptance of life's unmanageability as a reality [sic]. Acceptance of unmanageability means freedom from God's responsibility and other people's responsibilities</u> (GTC stage assignment) [my emphasis] (8).

Although the last observation is the fourth of the "three things" which it is important to remember when considering unmanageability, the heavy emphasis upon patient acceptance of powerlessness as an intrinsic component of reality was one of the most important lesson of the treatment process.

There was also a page detailing the God-concept, or "higher power", upon which AA's non-denominational spirituality is based. Among the listed merits of developing one's spirituality, were two comments which underscored the reality of the patients' situation in treatment:

> [The patient] loses some of self-centeredness [sic] as he sees his subordinate position in the universe [and] He gains a sense of direction and some positive values as he looks outside himself for meaning in life (GTC stage assignment).

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8. I have been unable to effectively translate the meaning of this last sentence. It appears to be espousing the freedom which comes from the surrender of one's life and will to a higher power.

The patients, upon recognition of a "power greater than themselves", would come to recognize their subordinacy -- if not in the universe, then in the treatment system. These remarks draw attention to the core of the treatment process: the patients' "acceptance" of the reality which was imposed upon them.

5) The last assignment required the patients to compose a poem from a list of feelings, senses, and colors. "Love stinks black" was one I encountered a couple of times. This project was designed to assess the patients' frame of mind in treatment. Their mood, judging from their poems, was not good.

I attended stage with Ernie and Charles. Their stories were illustrative of two common paths into treatment; Lorrie's interpretations of their stage assignments exemplified the essence of treatment reality and goals. Although I briefly summarized their pre-patient stages at the end of Chapter 3, I will repeat them here.

Ernie's mother had found her son unmanageable, indeed. When Ernie told his story (assignment 1), the troubled nature of his family life was a recurrent theme. Several times he remarked that he "really missed" his father since the company transferred him to another city. Ernie's chart indicated that that move had been the beginning of his troubles. Since his father's transfer, he and his mother had been engaged in a continuous fight. Ernie commented that his dad "wasn't around

to keep me in line", and that "he really knocked me around".

It became increasingly evident that GTC was not the place for Ernie. This became especially clear through Lorrie's inability to interpret his behavior in a way which fit the psuedo-intentionality model of loss of control. When discussing a fight with his mother, in which Ernie had shoved her against a wall, Lorrie commented that that was a perfect example of loss of control. Ernie laughed, and said,

> Loss of control, hell. That was exactly what I wanted to do. Well, no -- I guess I screwed up a little bit, there. What I really wanted to do was shove her through the wall (9).

Ernie eventually did not complete treatment at General. Unlike other patients who also may have gotten more directly relevant counseling in another setting (10), Ernie was too clearly psychologically troubled to justify retaining him at the agency. When the subject of his mother came up, he invariably said, "I'm gonna kill that bitch when I get outa here". Nothing in his demeanor suggested that he was speaking metaphorically. Nancy, however, failed to observe the physical

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9. Field notes. Although Ernie's remarks are clearly an extreme case, this was a recurrent problem with the psuedo-intentionality model. Patients often responded that they had, in fact, done exactly what they had intended to do; for example, gotten drunk because they wanted to get drunk.
10. I base this remark upon staff counselor judgments. Quentin is a perfect example of a patient that a number of staff members believed should not have been kept at General. Again, the direction of causality in Quentin's case was reversed, according to these counselors: his life was not in shambles because he used drugs and alcohol; he used drugs and alcohol because his life had been a nightmare.

changes Ernie underwent when discussing his mother. Consequently, she briefly lobbied for his retention, arguing -- in Dick Miller's language -- that "he's [Ernie] just another drunk". Emory and Dana observed that if Nancy was wrong, Ernie's mother's life was on her conscience, not theirs. Nancy finally relented and, eventually Ernie was transferred to a General Medical Center, a predominantly psychiatric facility (which was also part of the MHCC network).

Charles was a quiet young man, a trait reflected in his story. He was a good student, and fulfilled most of his family responsibilities diligently and without complaint. His step-father was an AA member and a regular guest at GTC's weekly "speaker meetings" (in which an AA member comes to the agency to address the patients on a variety of addiction-related topics). His mother had divorced a practicing alcoholic a few years before. When Charles missed family dinner one night, then came home with alcohol on his breath, his parents had immediately placed him in General, for a two-week evaluation.

Lorrie interpreted Charles' missed dinner within the context of psuedo-intentionality. He had been at a friend's, and they had "smoked some pot and had a couple of beers". Time, he said, had gotten away. When Charles noticed he was late for dinner, he had gone straight home. Listening to Charles' story, Lorrie had listened, arms folded, interjecting

occasional "uh-huhs". When he had finished, she asked, "You see what this means, don't you, Charles?". He thought a minute, then said, "Well, no. Unless you mean I missed dinner one night, and my parents got mad about it, and stuck me in here". Lorrie replied, "Well, it obviously means your 'using' is more important to you than your family".

Charles found this interpretation upsetting. "No, it doesn't. I love my family. I don't want to hurt them". Lorrie then remarked that, although Charles said he did not want to hurt his family, "wasn't that exactly what you did?". Charles, visibly upset by this time -- face flushed and angry -- argued, "I made a mistake. One mistake. And now you're trying to tell me that means I don't love my parents? I'm sorry, but I just don't agree with that, at all". Lorrie then recounted the discussion, step by step, turned to the blackboard, and -- next to where she had earlier written "powerlessness" -- wrote "LOSS OF CONTROL" (in capital letters), and, above that, the psuedo-intentionality formula:

What did I intend to do?
-What did I do?
LOSS OF CONTROL

Then, pointing at the top line, Lorrie said, "you didn't intend to hurt your parents, right?". Charles said, "right". She pointed to the second line, and said, "you did, though, didn't you?". Charles shrugged, and said, "I guess so". Finally, she pointed at LOSS OF CONTROL, and said, "see,

that's how crazy this disease makes us". Charles said nothing (11).

Although he was in for a fourteen-day evaluation, Lorrie's remarks evidently had an impact on Charles. After about ten days, he announced in group that he thought he should stay for the entire treatment process.

The importance of the patients' internalization of the lessons imparted during the first week was underscored by the staff practice of occasionally sending patients back through stage. During my week in adolescent stage, a young man about whom I knew nothing attended the sessions. Lorrie clearly recognized him: "So, Burt, somebody decided you needed a refresher course, huh?". He grinned, and replied, "yep, guess so". After his first appearance, I asked Lorrie about him. She told me that sometimes the patients tried to "run their own treatment". When this happened, she said, they were returned to stage, as they needed "reminding". Running their own treatment proved to be a recurrent theme in the treatment process.

Stage, following on the heels of having their belongings taken from them (albeit temporarily), being forced to wear identical pajamas, and having their freedom utterly revoked, strikingly demonstrated to the patients the reality of their new circumstances. They had entered a realm in which

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11. Field notes.

their own identities and realities were unequivocally characterized as sick, and in which their every behavior was scheduled and closely monitored. Moreover, for many of them, it was a reality which they could not leave. The lessons of the first step of treatment -- powerlessness, unmanageability, loss of control, and acceptance -- presented themselves to the patients with all the force which the new consumers had introduced into the social reality of CD treatment. The failure to accept the reality before them promised more and harsher punishments than treatment.

STEP TWO: DAYS 16-25

> "Came to believe that a power greater than ourselves could restore us to sanity" (12).

The patients were generally slow to believe that a power "greater than themselves" could restore them to sanity. They were, first of all, reluctant to view themselves or their behaviors as _in_sane. They were also often unwilling to surrender their efforts to define their own newly-forming identities and realities. This intransigence was at the heart of a distinction, important to GTC staff and administrators, between "admitting" and "accepting" CD. Thus, in the production process, steps one and two were reciprocal. Step one was considered equivalent to the patients' admitting

12. The second of AA's twelve steps.

their CD; step two, with accepting it. Industry argot described this distinction as the difference between "talking the talk" (admitting), and "walking the walk" (accepting).

Breaking down patient resistance to accepting the reality of their circumstances was a primary lynchpin of treatment. Group was one of the mechanisms designed to break through this resistance ("denial" -- see Chapter 3, "Hidden Alcoholism") and to demonstrate to the patients that their new reality was non-negotiable. If the stage agenda was to initially define the reality and its non-negotiable nature, the remaining weeks in treatment followed through on this agenda. Ultimately, the early weeks, and the first two steps, paved the way for the third step, which explicitly called for the patients to surrender the definitional rights to their own reality, and to make a "conscious decision" to turn their "lives and wills" over to their "higher power". This decision required patient acceptance of others' power over them and, reciprocally, the acceptance of their own powerlessness in the face of the consumers' and elites' reality-defining capabilities. These requirements undergirded the nature of group therapy, as well as other resistance-breaking techniques such as "peer reviews" and "case reviews". These techniques will be the focus of the next section(s).

GROUP THERAPY

The logic of their powerlessness and unmanageability met

with more than a little resistance by some of the patients. Travis, for example, pointed out to Nancy during group one day that he was not convinced his pre-patient life had been unmanageable. He pointed out that he had gotten fair marks in school and, aside from his father, had gotten along "pretty well" with his family. He concluded that, "I thought I was doing okay, you know?". Nancy responded by asking him if he had been doing so well on the outside, how did he account for his presence at General. She observed that, "your parents didn't think you were doing so great, and your teachers didn't think so", and said she was tired of telling the patients that, "if you weren't sick you wouldn't be in here, now, would you?"

Travis started to answer her, "I don't know, Nancy, I just thought ...". Nancy cut in, and told him that that was the problem -- he thought too much. She advised him,

> Don't think! Your brain's broke, you can't think. That's why you're in here (13).

This exchange between Nancy and Travis highlights group therapy's goal of effecting the patients' acceptance of treatment realities. Comments from a GTC pamphlet designed to explain the role and the mechanics of group therapy illustrate the logic which underlies the process:

> Experts in the treatment of alcoholism and other harmful chemical dependencies agree that

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13. Field notes.

> one of the most difficult aspects of the disease is self-delusion. Chemically addicted persons are unable to see themselves or their life-circumstances realistically. Their obsession with the use of chemicals impels them to live in a "world of their own" built upon unreality. Lies, alibis, deception, pretensions to mask, cover up, and protect their addiction becomes [sic] their way of life -- yet they stubbornly insist on prescribing their own treatment, deceiving themselves that they know what is best for them (GTC pamphlet on "Group Therapy").

Patients were advised that group was a process of "self-discovery", the necessary pre-condition for effecting positive change in oneself. Underscoring the theme of unnegotiable reality, the pamphlet stressed that "Acceptance of <u>what is</u> precedes change". Thus, Travis (and, indeed, every patient) was advised not to think, because <u>what is</u>, in his case, was his chemical dependency -- which included a "broke brain".

Thinking, in general, was held in low regard among GTC counselors. Feeling, which occupied a central role in group, was held to be more important than thought: "To know each other as feeling persons is the goal [of group therapy]" (GTC pamphlet). There were two techniques vital to "breaking through self-delusion to self-discovery [as a feeling person]": "leveling" -- revealing one's "secret" feelings --, and "confronting" -- telling someone how they appear to us (or "hearing" how we appear to them). Leveling and confronting were the techniques by which patients learned to be "genuine".

Genuine-ness, in turn, involved presenting feelings openly. One was also being genuine, "when I present you with my picture of you". Leveling and confronting were to be performed on a "feeling level", because --

> Most of us are badly out of touch with our feelings [and] have ignored our feelings for years in an effort to see the facts. In group therapy <u>feelings are facts</u>, "how does that make you feel?" is a question asked frequently to help us focus on these facts (GTC pamphlet).

On one wall in the group therapy room, a poster listed the feelings which held most currency within the treatment process. "Since most of our feelings are new to us, let's look at the ones we use everyday -- mad, sad, glad, afraid, ashamed, hurt" (GTC pamphlet). The patients were instructed to express themselves in terms of these feelings, which would "help patients to acquire a more accurate self-image" (GTC pamphlet).

Often, the requirement to speak in the vocabulary of feelings resulted in patient confusion. During one group, for example, Danny was "sharing" (14) some of the difficulties he had had getting along with his father. He recounted an episode in which he had cut the grass, "without being asked or nothin'". Then, his father had come home, "and he bitches me out for leaving the gas can on the grass. He said,

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14. "Sharing" was a stock treatment term for patient discussion of their stories, their views of others, and their feelings.

'it'll kill the lawn, you dumb ass', and he never said nothin' about me cuttin' the grass".

Nancy asked him, "how did that make you feel?". Danny replied, "it pissed me off". Nancy pressed on, "and what is that feeling?". Danny, as if cheating on a test, snuck a glance at the feelings poster, and said, "I dunno, afraid?". Nancy asked him how it had made him afraid. Danny said he didn't know, and tried another furtive look at the poster. Nancy laughed, and said, "You can look, Danny. That's okay to do." She coaxed, "did what your dad said make you feel...". "Ashamed?", Danny tried. "How about angry, Danny? Or, maybe, hurt?". "Yeah, he made me angry and hurt". "No", Nancy corrected, "he didn't make you feel anything. You felt angry and hurt". "Okay. I felt angry and hurt" (15).

Kyle also had difficulty learning to communicate on a feeling level. In Nancy's estimation, he shared with Travis the propensity to think too much. This tendency manifested itself in Kyle's dogged refusal to accept treatment interpretations of his biography. A number of group sessions were devoted to breaking through Kyle's "desire to control everyone and everything" -- which was Nancy's evaluation of Kyle's intransigence. Kyle proved especially resistant during one session in which he was sharing the way his life had gone the past few years. His parents had divorced five years

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15. Field notes.

earlier. Since that time, he had spoken with his mother once on the telephone. His father had remarried, and Kyle did not get along with his new family. As a result, his father had placed him in a boarding school -- from which Kyle had gotten expelled. His father then placed him in a military academy. Kyle had concluded, from the events of the past five years, that "my family doesn't want me around".

"Sounds like you've got a little self-pity going on there, Kyle", Nancy commented. Kyle said,

> Does it? Well, I don't feel sorry for myself or anything. It's just the way it is, you know? My family doesn't want me around, and they've made that pretty clear.

Nancy theatrically put the back of her hand to her forehead, tilted her head back and shook it, saying,

> "My family doesn't want me, and they've made that clear" -- God, Kyle. Gimme a break. If that isn't self-pity, what is?

Kyle said, "Hey, it's not self-pity. It's reality". Nancy responded,

> No, Kyle, that's not reality. Here's reality. Your family probably doesn't want you. I don't doubt that. But they probably don't want you because your using makes you too much of a pain to live with.

Kyle said, "This stuff started when I was twelve, Nancy. I wasn't using then". Nancy told Kyle that this incident exemplified his failure to make progress as a patient, because his "head wasn't in treatment". Instead, she told him,

> You're always trying to figure the whole thing

> out -- always scheming, always trying to make sure Kyle stays in control. Give it up, Kyle. You can't run your treatment. You couldn't even run your life. Just give it up.

Kyle said, "I'll tell you what I'm trying to figure out, Nancy. I'm trying to figure out just what the hell it is you want". She responded, "and until you quit doing that, you're spinning your wheels in treatment" (16).

Fiona was also slow to believe in her "insanity" or in a power greater than herself. Midway through her second step, Nancy, Emory, and Dana concluded that Fiona was doing a good job of "talking the talk", but had showed few signs that she was "walking the walk". Although she spoke often in group (generally taken as a positive sign), her comments primarily focused on the other patients. Nancy concluded that Fiona was "working other people's programs, instead of her own" -- industry argot for someone telling other people how to work the steps, while not working on them themselves. Counselor discussions such as these invariably became an "issue" for group.

During group that same morning, Nancy casually asked Fiona how she thought her recovery was coming along. Fiona said she thought she was doing pretty well. Nancy commented that she had noticed that Fiona was "quick to talk about the other patients' problems", and observed that -- in her experience -- patients often used advice-giving as a technique

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16. Field notes.

to draw attention away from themselves. This, Nancy said, was a way of "controlling treatment". She went on,

> And I was just thinking about you this morning -- thinking that you were maybe doing some of that. Running your own treatment, by running everybody else's -- you know?

She then asked the group for "a little input, here", saying, "I don't know. Maybe I'm crazy. Do you guys think she's doing any of that?". Quentin, who often seemed to enjoy moments such as this (his reaction to Kyle's request out of pj's -- above -- was characteristic), said he had noticed that Fiona's focus was usually on somebody else's treatment. The other patients demurred.

Group focus often shifted this way, from one patient to another, one issue to the next. The practice effectively kept the patients off-balance. Their efforts to do what was expected of them, which often seemed to be in the hope of speeding their graduation, frequently resulted in "thinking too much", and "trying to figure things out". The counselors frowned upon both of these. Patient "schemes", as staff referred to these efforts, led to "running their own treatment" which, as Nancy's remarks illustrate, was not the way things worked. Thus, patients who seemed to think they were doing well often became a counselor target. Patients were told that whether they were doing well or not was for the counselors to decide, not the patients.

Fiona's turn in the spotlight culminated with Nancy's decision (after consultation with Dana and Emory) that Fiona had to stop wearing make-up until further notice. This decision was based upon the belief that cosmetics helped Fiona create the outward appearance that she "had it all together", while she was inwardly "as sick as ever". Nancy, when conveying the staff decision, said that she herself used to use make-up "to hide", and pretend that everything was "okay with me". Fiona, very upset, asked Nancy, "so, what do you use it for, now?". Nancy had responded that Fiona's question was another attempt to draw attention from herself: "What _I_ wear make-up for isn't the point, Fiona. I've _been_ through treatment. They took my make-up away, too, for the same reasons. And they were right" (17).

The shifting group focus landed upon each of the patients at some point. The catalyst was invariably an "issue" which the patients "hadn't dealt with", such as Fiona's make-up "masking her feelings". Issues were derived from the treatment belief that "you're only as sick as the secrets you keep". Subjects about which patients demonstrated defensiveness or sensitivity, then, inevitably became an issue. Timothy, for example, was overweight. He steadfastly avoided any references to his heaviness. He was also one of the more silent patients. This silence gradually came to the attention of the

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17. Field notes.

counselors, and was interpreted as a signal that Timothy was "nowhere in his treatment". Nancy and the trainees (Dana and Emory) began to focus upon Timothy and, much like they had with Fiona, concluded that he was deliberately drawing attention away from himself by being quiet. They decided that Timothy's "secret" was dual dependencies -- compulsive overeating, combined with CD. Ultimately, the approach mirrored the focus on Fiona. Nancy drew Timothy into group discussion, asked him how he thought he was doing, and so on. This was the recurrent pattern for each of the patients. In Timothy's case, he indeed proved to be sensitive about his weight. When the focus shifted to discussions about that, he became defensive and combative (this was subsequently interpreted as an "anger issue", and appropriate assignments were given to address that issue). During his period as the group focus, Nancy asked Timothy how talking about his issue made him feel. "Shitty", he responded. He was directed to use the list on the feelings poster, and subsequently concluded that what he had meant was "hurt, angry, and ashamed". Nancy arranged a session with one of the agency's eating disorder counselors, and Timothy was put on a "nutritional program". The focus moved on to another patient, another issue.

Keeping secrets and attempting to run their own treatment were the problems which occupied the bulk of the patients' group time throughout my stay at the agency. The issues which

the shifting focus of counselor attention unearthed were interpreted as secret-keeping which, in turn, was interpreted as running one's own treatment. Each, then, became barometers of the patients' progress in recovery. Each was taken as indicative of their failure to accept their powerlessness, and they were advised to "take step one with it" (admit and accept that they had no control).

The patients occasionally demonstrated their frustration with what they perceived as the elusive goals of treatment. As Kyle had asked Nancy (above), "what do you want?". Kyle was persistent about this question, and it became a running conflict between them. Nancy invariably answered Kyle cryptically: "I want you to quit trying to figure out what _I_ want, Kyle", and "I want you to work treatment, get onto a feeling level, and stop thinking so much", and so on. During one of these exchanges, Nancy had asked Kyle, "I've got a better question, Kyle. What do _you_ want?". Kyle asked, "honestly?". Nancy answered, "yes, honestly". Kyle said, "I want to get the hell out of here, and I want to know what I have to do to do that". Nancy's answer highlights the reality of treatment at GTC:

> You want to know when you're gonna be ready to leave here, Kyle? Okay, I'll tell you. You're ready to leave here when you don't want to leave here, anymore. That's when (18).

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18. Field notes.

STEP THREE: 26-39 DAYS

> "Made a decision to turn our will and our lives over to the care of God as we understood Him" (19).

The decision to surrender one's life and will to a higher power came no easier to some of the patients than did the first two steps. Most, however, arrived at some level of acceptance, however superficial, of their powerlessness by the end of their second step. Group therapy, combined with the daily schedule and the reaction-consequence economy, usually accomplished their acceptance. Those patients who still had not come around by the third step faced one of the two primary techniques the agency employed to "get their attention": "peer reviews" and/or "case reviews". The former occurred in group on a semi-impromptu basis. Nancy simply announced that the staff all agreed that a particular patient was just going through the motions, and directed that patients' peers to "confront" him. Case reviews were reserved for only the most intransigent patients. The process was the same, but the patients' treatment team, rather than their peers did the confronting. While I was in the field, I attended several peer reviews, but only one case review: I will discuss Danny's peer review, and Nick's case review.

Peer reviews were a middle-level sanction; more severe than simply becoming group focus for awhile, but less severe

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19. AA's third step.

than a case review. Both forms of review were designed to "shake the patient up", as staff described it, but peer reviews allowed the patients to shake each other up in the relative comfort of one another's company and in the familiar setting of the group room.

Danny had been an uncooperative patient from his first day. He had fallen asleep during group more than once, never shared his story with the other patients, and attempted to make staff and fellow patients alike keep their distance from him by raising his voice and getting angry. Several times he had threatened to hit other patients. Nancy announced during group one day that she had had it with Danny coasting through treatment, and said that she had the distinct impression that his peers felt the same. She then asked for their feelings about Danny. The patients tended to follow the lead of the first speaker, who, in turn, tended towards mild criticism. They seemed to know they were expected to be "genuine" (see above), as their comments would indirectly reflect their own progress in treatment. As such, they knew that they should say something honest about (in this case) Danny's shortcomings. However, their remarks usually also reflected empathy: next time, it could be them in the hot seat. Each peer review I witnessed exhibited a strikingly similar tentativeness; the comments were much like those directed towards Danny:

I don't know, Danny. I wish you'd learn to

> open up with the group a little more. You've been here for awhile now, and I don't feel like I know you, at all. Seems like every time somebody tries to reach out to you a little bit, you shut 'em off. You seem so angry and so alone that when I look at you, it makes me sad and scared for you. You don't really seem to want to be here, or to hear what Nancy or anybody else says. It does seem like you're just killing time, or something. I've thought about trying to get to know you, but -- you're kind of a big guy, and with that anger and everything, I'm kinda scared of you, to tell you the truth (20).

Nancy always summarized the proceedings. In Danny's review, she noted that most of the other patients had said they were a little scared of him, and asked him how that made him feel ("kinda sad").

The bureaucratic consumers often played a part in Nancy's summary comments. She pointed out to Danny that she would soon be talking with his probation officer. She said that she wanted to be able to give a good report on Danny, but,

> To tell you the truth, Danny, the way things've been going, I'm not going to be able to tell him anything good.

She concluded that unless she "saw a big improvement in the next few days", she'd have to tell the probation officer that Danny was doing poorly in treatment (21).

A case review was the next logical step, if patients did not respond to their peer review. This was a more formal and formidable sanction. The patient was notified in advance, and

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20. Field notes. These remarks are a compilation of patient comments during peer reviews.
21. Field notes.

told that the failure to respond to treatment made a case review, to be held in Nancy's office on a given day at a specific time, necessary. Literally, the patient's case was to be reviewed by all relevant staff members, and a decision as to whether the patient would be allowed to finish treatment would be made after the review. Logically, case reviews were most effective with court-referred patients, for whom treatment was all that stood between them and criminal sanction. Nick had not responded to treatment. He did not do in-house school or treatment assignments, never spoke in group, and maintained -- much like Fiona -- an easy-going demeanor which the staff saw as a <u>facade</u>. He had also attempted to escape from treatment, a couple of weeks before, and was caught because he had hurt his back in the attempt.

Nancy's office was hot and crowded, the day of Nick's case review. The format of the proceedings was the same as the peer reviews. Each person on Nick's treatment team spoke to him for a few minutes, evaluating his status as a patient. Nick sat in one corner, sweating and red-faced, his hands trembling slightly. The staff members comments bore little resemblance to patient comments in a peer review. Nancy began the proceedings, asking Nick if he understood what the review was all about. "To tell me what I'm doing wrong in treatment, right?". Nancy explained that that was only partially correct; that, dependent upon the staff's decision after the review,

Nick might have to leave treatment, and "let the courts decide what to do" with him. She told him that he was wasting everybody's time, and that several members of the staff "didn't want to even mess with a review -- just send you back to court". The staff members then took their turns talking to Nick. The nurse on unit A that day said, "I don't know, Mick, you seem to think you're at some kind of garden party, here". "Nick", he said, when she paused. "What?". "My name's Nick, not Mick". She responded, "sorry, Nick. Anyway, I just haven't seen any indication that you understand or care what your situation is, here, or how serious it is". She went on to tell him that she didn't see much point in keeping him here if he was just trying to get out of going to jail.

This was the general thrust of most of the comments. Each of the staff members observed that Nick's performance in their experience was, at best, indifferent: the chaplain, for example, noted that Nick's "lack of a relationship with your higher power" didn't seem to bother him much; the recreational therapist said Nick was always disrupting the games and outings for the other patients. Champ, the school teacher, made the most vitriolic comments. He told Nick he thought some time in jail might be "just the thing" to straighten him out. Champ also remarked that, unlike some of the other staff members, he did not believe there was a "nice kid" under Nick's "cool guy shell". "In fact", he said,

> I think that the Nick that stuck up the ice cream vendor is a little prick, and since you've been in here, I haven't seen you do one thing to indicate that you're not just a little prick, or that you give a shit about trying to change any of that (22).

Champ finished by telling Nick that there was no good reason to let him "keep hanging around, jerking everybody off"; that the courts could have him.

Nancy concluded the proceedings by telling Nick that "we'll just have to see", and that if she had to decide that day, Nick would be in court tomorrow morning. After that, Nick left Nancy's office, clearly shaken. The staff members briefly discussed the review, and agreed that if Nick didn't start to rapidly improve his treatment performance, they would be surprised. He did, and much like Kevin (above), soon became a leader in group and on the unit.

Each of the steps, and the treatment procedures based upon them, were designed to break through the patients' resistance to having their identities defined and their realities shaped for them. The emphases against patients running their own treatment and against keeping secrets, group therapy's continually shifting focus in search of issues, peer and case reviews, and Nancy's illuminating comment to Kyle about being ready to leave treatment when he no longer wanted to leave, were all practices which effectively undermined the patients' confidence in themselves and exemplified for them

22. Field notes.

the reality into which they were being trained to fit. Nancy's (and other staff members) references to the new consumers helped to enforce the patients' acceptance of this reality: Nick, Danny, Kevin, Kyle, Fiona, Quentin, and Fiona all faced criminal sanctions as an alternative to compliance with treatment. For the other patients, the fear (real or not) of permanent estrangement from their families proved sufficient to break down their resistance.

FAMILY WEEK

Generally, adolescent patients had their "family week" roughly concurrent with the third step of treatment. Family week was, in actuality, a three day event in which the patients' parents and other family members came to General to learn about their patients' disease and the family's role in their recovery process. The first day, Madeline, the family week counselor, lectured and showed the families films demonstrating that CD was a family disease. She introduced the families to the psuedo-intentionality model (see Chapter 3 and above) and to the family systems model of addiction -- which drew an analogy between the family system and a mobile: the addicted family member was said to be equivalent to a piece of the mobile which, because it is missing, threw the whole family out of balance. Towards the end of the first day, the family members were instructed to write out a list of their patients' behaviors and the way those behaviors affected the

family, and to bring this list with them the next day. They were, moreover, given a formula to follow when writing their list: "When you [the patient] did this [a troublesome act], I felt this way". Madeline stressed that they must discuss the effects of the patients' behaviors upon the family in terms of feelings. Otherwise, she explained, the confronting and leveling of the next day could easily degenerate into bickering. "People can't argue with feelings", she told them. "They can argue with you about details all day, but they can't tell you how you feel". The patients were simultaneously preparing their own lists, documenting their alcohol and drug use histories.

The next day, patients and their families met. Neither were allowed to speak directly with one another. First, the patients read their abuse histories, then listened to their family members' lists. A number of both patients and family members cried during the proceedings. When the families had finished, the patients were taken back to the unit, and a staff member explained that the patients had gone back to the units, where they had the support of the other patients and the counseling staff. She thanked the families, and told them that, "family week is when most of the patients really start to make progress". She said that the patients usually had a hard night after seeing their family members, but that they should quickly start to improve. She thanked them again, and

asked them to return to the "family room", where Madeline was waiting for them (23).

Patients had a difficult time with family week, both in anxious anticipation and in their reactions after it was done. Eddie, due to the aforementioned communication problems between Nancy and Madeline (see Chapter 4, "Subordinates to Subordinates"), had a harder time than most. Nancy had failed to notify Madeline that Eddie's step-mother would only attend the second day. She had told the step-mother that she should prepare a list of Eddie's behaviors to read for that day, but had not included the cautions and admonitions, which Madeline normally supplied, regarding the form the family members' comments should take. Eddie's step-mother had taken carte blanche with the confrontation. As a result, Eddie had been, in Madeline's assessment, "like one of those ducks in a shooting gallery". Eddie's step-mother had virulently insulted Eddie in front of everyone. Madeline subsequently "leveled" with Madeline about the incident, saying that Eddie had been called a "scumbag", and told that, as far as his step-mother was concerned, Eddie could "rot" in treatment, because he was not coming home as long as she was alive. Madeline pointed out to Nancy that things had gone that way --

> All because you can't remember to tell me who's coming to family week and who's not, and

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23. Field notes.

> when. Good work, Nanc'. And good luck straightening that poor kid out (24).

Emory, who had been at the confrontation, later told me that Madeline's description of the event was accurate. Eddie, Emory said, had been "beaten up pretty bad". When his step-mother had finished, she had just walked out of the room.

Earlier in that same day, Eddie had voluntarily spoken in group for the first time. His comments, with the benefit of hindsight, darkened the already-dark events that took place at the confrontation. He had begun by saying that he was scared about meeting his family later that day. His comments began to wander, leading the group through a free associational description of the nightmare that had been his life. With absolutely no inflection in his voice, he told the group that his father always made him ride in the back of his pick-up truck, "like a dog". He said that his father and step-brother would point at him through the truck window, and laugh. He "tried to make my dad laugh", like his step-brother could, but that his dad would --

> Just look at me, and say "that s'posed to be funny? Who told you you was funny, Eddie? Well, you ain't" (25).

Eddie then finished his leveling by telling the group about some friends of his father who raped him on their living room couch, while his father watched, and his mother slept

24. Field notes.
25. Field notes.

upstairs. After saying that he did not expect much from family week, Eddie resumed his customary silence. Travis had said, "God, Eddie. I had no idea".

After family confrontation, Eddie had cried much of the day. He stopped later that day, and spoke to no one for several days afterwards. Nancy finally had a conference with him in her office, and said Eddie had requested a transfer to unit B (the double diagnosis unit).

The final day of family week constituted an in-house outreach to the family members, combining educational lectures about co-dependency with a free "co-dependency evaluation" by the family and outpatient program's head counselor. Family members were given a sheet entitled "Are You a Co-Dependent?", followed by a list of some symptoms of co-dependency. They were then asked to fill out the evaluation and, if they had checked enough "yes" answers ("one or two is enough to cause concern"), were invited to speak with a staff member about the agency's treatment programs for dysfunctional families and co-dependents. Throughout the last day, family members were reminded that the patients could not get well in a sick family system.

As indicated above, each step built on its predecessors. With the acceptance of elite and consumer definitions of reality, the patients were adequately prepared

to undertake the final step of their inpatient treatment (26).

STEP FOUR: DAYS 40 TO GRADUATION

> "Made a searching and fearless moral inventory of ourselves" (27).

Subordinates to Subordinates: A Rejoinder

By the time the patients were prepared to do their fourth step, their grasp on their new reality was quite firm. As Kevin's self-monitoring behavior (above) illustrated, the patients often took on the role of "junior techs". Whether sincerely or not, they had become somewhat adept at "talking the talk", and "walking the walk". The quality of their role performances was, however, decidedly uneven: most still found it difficult to sustain the new identity. Nonetheless, they were usually "within treatment norms", and freely confessed to reaction-getting behaviors. Their explanations for their past behaviors were rooted in, and seen from the vantage point of the consumers' reality. They spoke of themselves as sick, and in terms of the "craziness" of their disease. From this perspective, enumerating the components of their moral failings (the "searching and fearless moral inventory of the

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26. Adolescent patients normally completed AA's first four steps as inpatients; some completed the fifth step, as well -- which involved sharing their "inventories" (see the 4th step) with God, themselves, and another human being. The majority of adolescent patients completed their 5th step in Stage 2, or in outpatient "aftercare".
27. AA's fourth step.

fourth step) (28) was no longer a matter of not knowing what their offenses were, but of being certain not to overlook any of those offenses. By this step, the patients had internalized, however temporarily, as much of treatment reality as they ever would (29). As such, their self-evaluations were in line with the counseling staff's assessment of their progress. These assessments were done during the weekly unit staffings.

I have discussed (see Chapter 4) the elites' reality-defining contributions during unit staffings (Miller's assessment of Eddie as "just another drunk", for example). These meetings were designed for the subordinates' evaluation of the patients' performance in treatment. Counselors, reading from standardized evaluation forms, briefly discussed each of their own patients, and offered therapeutic suggestions to one another. The discussions were frequently perfunctory, and followed the format of the "eval'" forms to the letter. For example, Nancy summarized Kevin's status as a patient, immediately prior to his graduation, in the following manner:

> Kevin. 43 days in treatment. He's within treatment norms. Admitting and accepting CD. Unresolved issues since last time -- none, really. He finished reading a pamphlet on the fourth step, and he's working on it, now.

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28. This step recalls the blend of moral and medical components which is characteristic of the disease model (see Chapter 1, "Changes in the Perception of Alcohol Problems").
29. See Chapter 6. Six month follow-up on GTC graduates yielded results which were disappointing to the agency.

> We're going to go over it together during counselor time today, but he's ready to go. New issues since last time -- mostly just which halfway house he's going to. I think Miller Hall. He fought that a little, then said, he'd just have to take first step with it, and go where we thought he should go. Kevin's come a long way. I told his probation officer that when we talked a couple of days ago (30).

Step Four: Subordinates to the Underclass

Kevin proved to have the strongest grasp on the nuances of counselor-to-patient relations. Nancy's earlier remarks to Kyle highlighted the core of these relations -- that patients were ready to leave when they no longer wanted to leave. The underlying theme of those remarks was patient surrender of the rights to identity-formation and reality-definition; in a word, "acceptance". As a result of Kevin's grasp of this central principle, although he had started inpatient treatment after Kyle, he graduated before him. Nancy's observation that Kevin had decided to "take first step" with his halfway house placement illustrates these dynamics clearly. Rather than argue about where or whether he should be placed in Stage 2 (a halfway house), Kevin accepted Nancy's (and GTC's) ruling on the matter. Kyle, conversely, fought tooth and nail throughout treatment. He was always trying to "run his own treatment". As his ongoing struggles with Nancy demonstrated, until the

30. Field notes. Compilation of a number of unit staffing evaluations of patients progress. The comments in these evaluations, much like the patient comments in peer reviews (above) varied little, patient by patient, or week to week.

patients accepted others' dominion over their lives, they were not considered to be progressing in treatment satisfactorily (31).

Kevin's comments and behavior on the unit (see above) as he neared graduation, exemplified the centrality of acceptance to the treatment process, and to evaluations of the patients. Taking step one became Kevin's stock-in-trade. Whether sincerely or cynically (Goffman 1959), Kevin had mastered the fine dramaturgical details which comprised the role of the recovering chemical dependent. The principal detail of this role was the willing surrender of the power to run one's own life. Kyle, conversely, had to ride out the length of his insurance coverage before he graduated.

UNDERCLASS RELATIONS

An in-depth discussion of the relations among the inpatients during their stay at General would constitute another thesis. The structure of these relations was largely a matter of inference from my vantage point; clearer and more accurate insights would have required insider status which was unavailable to me in my observer-as-participant role. I never saw the patients outside the context of their interactions

31. Kyle's efforts to figure out what he needed to do to get out of GTC underscore the patients' unawareness that the length of their stays in treatment were largely predetermined by the length of their insurance coverages. Had they known this, one can imagine an entirely different set of reactions to treatment by the patients.

with GTC staff. Nonetheless, there are some remarks to be made, albeit based upon the limits of my role in the field. I observed two basic, recurrent patterns of patient interaction. Each involved efforts to complete their time in treatment as quickly as possible.

1) Patients often learned their roles from one another's examples. Whether Kevin was sincere or not was impossible to gauge. Regardless, he clearly set an example for the other patients, who began to present themselves as "accepting" of their circumstances, however trivial these presentations were. They began to take the first step about everything. Even to my untrained eye, Kevin's influence upon the others' eagerness to be powerless was evident. Patients began to fall over one another in a rush to confess their latest transgression: "I left soap in the shower, so I'd better take a reaction. Well, I'll just have to take first step with that". Ultimately, the niceties of the recovering role were beyond the ken of many of the patients. Whereas Kevin's was opaque, the other patients' performances were generally transparent. Nonetheless, the impact of Kevin's "successful" grasp of the bureaucratic consumers' expectations was not lost on his fellow inpatients. Genuine or not, Kevin had showed the others the door out of treatment, and developed a faithful following of understudies during his pre-release days. As with all performance, Kevin's success may well have reflected a greater native talent than

possessed by the other patients.

2) The second dimension of patient relations which was most evident was exemplified by Quentin's fondness for conflict. A group of headstrong and defiant adolescents, thrown together by fate, and forced to get along, inevitably produced cliques and divided camps. Quentin never passed on the opportunity to stir up dissension, while steadfastly maintaining his own outward guise of innocence. His methods of leveling and confronting often involved "getting honest" with one of the other patients. The honesty, in turn, usually entailed drawing another patient's reaction-getting behavior to the attention of the staff: "You know, Eddie, you haven't cleaned the break room once since that became your job. That kind of hurts me and makes me scared for you". Ultimately, those characteristics which had landed the patients in treatment in the first place appeared to preclude the formation of a unified front among them. Attempts to get one another into or out of trouble with the staff diverted their attention from the lessons which patients such as Kevin learned and applied.

There was undoubtedly more to patient interaction than discussed herein. My attentions were admittedly focused elsewhere, for example, on the methods by which patients were taught to accept the definitions of social reality espoused by agency staff.

CONCLUSIONS

The reality of treatment, based upon the patients' acceptance of staff authority over them, reflected the realities which shaped the overall social structure of treatment. The counseling staff was charged with implementing the procedures which were designed to bring patient behaviors into line with treatment reality. In turn, treatment reality issued from, and was shaped by, the power of the elites and consumers whose money subsidized and whose power controlled and molded the treatment process. The consumers purchased, and GTC provided, the service by which the patients learned to conform with the elites' and bureaucratic consumers' wishes. That service was the transformation of patient identity, and their subsequent internalization of a model of human behavior which narrowly defined normality.

This chapter examined the interaction between the subordinates and the underclass. Treatment was structured in ways that guaranteed the accomplishment of the dominant members' goals: the bureaucratic consumers got patients who had learned to equate submission to authority with psychological well-being; GTC's administration got the $100,000 or so dollars in gross revenue which these twelve adolescents generated for them. In the process of meeting these goals, the dominant members of the treatment social structure clearly and repeatedly demonstrated that whether the

patients, their families, or the counseling staff were well-served by the production process was less important than whether they had served the production process well.

In the next chapter, I will illustrate that General's public claims to success are contradicted by their own research. Despite their findings, the agency continues to press these exaggerated claims -- a fact which casts still more light upon the priorities which guide General's administration. Moreover, the transformation of health care and human service into bureaucratic-corporate enterprise is a variation on important theoretical issues in sociological thought. These issues include, but are not necessarily limited to: the subjection of every realm of human life to rational controls, the growth of purely instrumental rationality as the sole basis for social action, and the restless expansion of commodity production and relations as the basis of social life. Current practices at General demonstrate the correctness of these theoretical assumptions, as well as the practical consequences with which those assumptions have long been concerned. I will turn, now, to these considerations.

CHAPTER 6

A PRACTICAL AND THEORETICAL VIEW OF ONE-DIMENSIONAL TREATMENT

There are a variety of ways in which the present social reality of addiction treatment might be analyzed. This chapter will take two of those directions. In the first section, I will discuss whether treatment does what it claims to do or, more directly, whether GTC's claims of 75-80 percent success rates are, in fact, accurate. This section is best thought of as practical criticism. I will temporarily set aside the problematic nature of the social reality of treatment and simply assess whether, indeed, 75-80 percent of the agency's graduates successfully maintain their reconstructed identities. To make this evaluation, I will draw upon the results of a study GTC conducted to assess its own work. My analysis of their information shows that they exaggerate their success rates.

The second section of this chapter takes a critical, sociological point of view. Treatment directly corresponds with sociological criticisms of advanced industrial society (e.g., Baran and Sweezy 1966; Braverman 1974; Mandel 1975; Marcuse 1964). The commodification of CD not only leaves fundamental problems unaddressed, but the treatment process itself equates human psychological well-being with uniformity, punctuality, and submission to authority. Although I will situate GTC's treatment process within Marcuse's (1964) view of modern societies, Lukacs (1971/1986: 84) aptly summarizes

an important theme shared by many critics of modernity:

> What is at issue *here*, however, is the question: how far is commodity exchange together with its structural consequences able to influence the *total* outer and inner life of society? (Lukacs 1971/1986: 84) [original emphases].

Marcuse also addressed this question, explicitly attempting to place the social psychology of modernity within a framework which synthesized the theoretical perspectives of Marx and Freud. Marcuse argued (1964) that advanced industrial societies are "one-dimensional": that is, the dialectic between self and society has attenuated because society has overpowered self. The commodification of addiction is a case study in one-dimensional social control. Despite recurrent attempts to convey an image of treatment as AA-related and/or directly in keeping with the traditional (however mythical) healing mission of medicine, treatment is more an administrative, than medical, technique. It is designed to simultaneously generate profit and satisfy the consumers' demands for social control. Within the present structure of the treatment system,

> [E]xchange value, not truth value counts. On it centers the rationality of the status quo, and all alien rationality is bent to it (Marcuse 1964: 57).

A PRACTICAL EVALUATION OF SUCCESSFUL TREATMENT CLAIMS

General has attempted to gauge the success of their

treatment techniques, by conducting a survey of 380 recent graduates. In the last fifteen years, the agency has claimed, and continues to claim, 75-80 percent success rates. Success, from the treatment industry's practical perspective, is measured by patient abstinence at six month follow-up. In GTC's survey, the six most common types of dismissal from treatment were crosstabulated with five measures of abstinence. Results based upon patient self-reports appear in the Appendix, Table 6.1 (1). Of those patients who had successfully completed treatment and been sent home, 55 percent had remained totally abstinent. Treated patients released to Miller Hall (a GTC-owned halfway house) fared better: 82 percent were totally abstinent after six months. 29 percent of the patients who had walked out of treatment, without completing the program, reported themselves totally abstinent. 50 percent of the patients dismissed from treatment "at staff request" were, nonetheless, abstinent at six months.

The only success rate which approaches the 75-80 percent General offers for public consumption is for patients living in Miller Hall, a staff-supervised and agency-owned halfway house. Patients sent to their own homes, a far more

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1. As was characteristic of GTC's official statistics, these data leave a great deal to be desired. The agency does not specify the proportions of the total sample (N = 380) which applied to each dismissal category. Thus, we know that 55 percent of those sent home remained abstinent, but we do not know the equivalent of that percentage in absolute numbers. The data, nonetheless, give us a point of departure by which to evaluate the practical success of GTC treatment.

effective barometer of success (assuming patients are not to take up permanent residence in the shadow of the agency), have a roughly 50-50 chance of remaining abstinent; a $5,100 (or $7,650 for adolescent patients) flip of the coin, in short. Significantly, patients who were asked to leave treatment (dismissed "at staff request") were only 5 percent less succesful than were patients who completed the process. The patients who walked out, 29 percent of whom achieved abstinence on their own, recall the findings of Vaillant (1983) and Cahalan (1970), that problem drinking is often a transitory problem, subject to "spontaneous remission".

Two of the categories by which the agency evaluated patient abstinence may be designated as "qualified failures" (QF) and "outright failures" (OF) . QFs were described as patients who had had two or more "slips" (used drugs or alcohol), but who drank less than before treatment. OFs were those patients who used drugs or alcohol as much or more than before treatment. Of the patients sent home, 20 percent were QFs, and 13 percent were OFs. Of the patients who had walked out of treatment, 14 percent were QFs, 43 percent OFs. 50 percent of the patients dismissed "at staff request" were OFs. Although it is not clear why, 6 percent of the patients in Miller Hall "used" as much or more than they had prior to treatment, and 6 percent had had two or more "slips" (see

Appendix, Table 6.1).

Clearly, there is a marked disparity between General's claims to success and their actual level of success. This disparity mirrors that between their public and operational goals (Perrow 1986); a reflection which takes on greater clarity when one considers that the agency lies about its success rates. The results of the GTC study were not released to the public, and the agency continues its exaggerated claims. In this context, General exemplifies criticisms which have been aimed at for-profit health care, overall: the system is inefficient, exorbitantly expensive, and wasteful. The three categories of patients who completed treatment at GTC (and were subsequently dismissed to their homes, to Miller Hall, or to another, non-GTC halfway house -- see Appendix, Table 6.1) had an average failed (both OF and QF) treatment rate of 28 percent. The inpatient units grossed at least $3,901,500 during 1986. The findings in General's survey suggest that $1,092,420 of that was, effectively, wasted money (2).

From a purely practical interpretation of success, the agency's claims are highly exaggerated. It is likely that the failure rate is, in part, a reflection of the wide ranging reasons for referral to treatment. Many of the behaviors which

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2. Calculated by multiplying average patient stays per unit times $170, then multiplying that figure times the 1986 censuses for inpatient treatment at the agency, and figuring 28 percent of that total.

landed the patients at General are only dubiously CD-based. The adolescent cohort discussed in Chapter 5 was comprised of rule-breakers, who were often from troubled families and who frequently were in trouble with the law. Conventional wisdom on addiction (especially to alcohol) holds that bona fide dependency builds up over a protracted period of time. It is doubtful that adolescents have been using long enough to be genuinely addicted to anything (3). The characteristics of the adolescent census I encountered suggest that failures result from the difficulty of maintaining a "recovering CD" identity, when one is not addicted to anything in the first place. Alternatively, there is the difficulty of not being troubled when living in a troubled milieu. Many of the patients' family lives would not nurture a stable identity.

The practical failures of the agency may be traced to the excessively narrow interpretations of well-being and the nearly all-encompassing definitions of "sick" behavior upon which referrals are based. That these definitions derive from marketing techniques (see Chapter 3) suggests the problematic nature of commodified treatment as a whole.

TOTAL TREATMENT

Throughout this thesis, I have emphasized the context in

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3. During my stay at General, I knew of only one (adult) inpatient who required the traditional fruit juice and valium regimen by which the withdrawals from physical addiction are treated. This procedure was discussed daily at morning report, so I am confident I would have heard if there were others.

which changes in the alcoholic role must be understood: its redefinition as a disease, the subsequent provision of insurance coverage for treatment, and, especially, the rise of corporate medicine. These contextual changes have converged to fundamentally alter the social relations surrounding problem drinking and the efforts to address that problem. Corporate hospitals inspired by their new identities and the possibility of profits which insurance coverage offered, created the social relations necessary to make that possibility a reality (4). As Chapters 3 and 4 illustrated, the referrals these new relations garnered made for patients who were only dubiously addicted. However, these patients did share the misfortune and/or bad judgment of running afoul of the normative standards of one or more of GTC's powerful, bureaucratic consumers.

The exchange relations which shaped General's market are based upon the assumptions that recovery is purchasable, and that deviation from normative standards is a symptom of disease. These assumptions reflect the interests of the dominant members of the treatment system: profit and social

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4. Technically, GTC is part of a non-profit organization. This is a superficial distinction, comforting in its altruistic connotations, perhaps, but not borne out in application. Non-profits operate under constraints shared by all organizations: payroll, utility bills, and so on. Non-profits can not and do not operate in the red indefinitely, as a rule. In the specific case of GTC, Chapters 4 and 5 demonstrated the overarching importance of surplus value to the agency. The primary significance of the non-profit distinction is its supporting role in the agency's altruistic claims.

control.

General claims to operate in the spirit and tradition of AA. Superficially, there are similarities. Both organizations transform identity, primarily through the "encapsulation" of their charges within social, physical, and ideological "cocoons" (Greil and Rudy 1984). GTC has clearly coopted AA terminology, the first four or five of its twelve steps, and the disease concept of alcoholism. Here, the similarities between the two organizations end. AA's membership is largely voluntary, its recovery program has no artificial time-limits, and only coffee donations involve money changing hands. In AA, recovery has traditionally been undertaken by the individual members for themselves, their families, or concerned friends. Undoubtedly, a fair proportion of AA's members initially joined the organization in response to the threat of divorce, or trouble with employers or the courts. These threats quite probably issued from the drinker's actual drinking behavior, rather than, say, vague assumptions regarding disparities between the drinker's intended and actual behavior. Regardless of these observations, AA's membership is comprised of people who chose their own path, for their own reasons, and for no one's gain but their own and those close to them. A common remark at meetings I attended was that AA is a "program of attraction, not promotion", an observation which underscores the voluntarism underlying the

organization's relative success: AA does not court or coerce new members. Indeed,

> We are not an organization in the conventional sense of the word. There are no fees or dues whatsoever. The only requirement for membership is an honest desire to stop drinking. We are not allied with any particular faith, sect or denomination, nor do we oppose anyone. We simply wish to be helpful to those who are afflicted (Alcoholics Anonymous 1976: xiii-xiv).

Principles such as these hearken back to "a world in which men and nature were not yet organized as things and instrumentalities" (Marcuse 1964: 59). At GTC, the "wish to be helpful" becomes a command that the patients "accept help".

The attachment of a price tag to recovery transforms AA's twelve step program into a form of commodity production. Moreover, the treatment market draws together a variety of bureaucratic organizations, each invested in the production process: the school system, social service agencies, the courts and police, insurance companies, and employers. General itself is part of a large, corporate bureaucracy. Treatment, as effected by these powerful organizations, becomes an administrative procedure. Rather than an effort undertaken <u>by</u> problem drinkers <u>for</u> themselves and those close to them, treatment is administered <u>by</u> the corporate, bureaucratic hospital <u>for</u> the corporate, bureaucratic consumers. Treatment, I would argue, has little to do with recovery, and everything to do with providing a source of profit to GTC and MHCC, with

securing more tractable citizens, employees, or social work cases. These circumstances echo the "total administration" of Marcuse's "one-dimensional" society.

The one-dimensional society is marked by the demise of the dialectic between self and society, the collapse of critical thought, and the "total subjection of man to the productive apparatus" (Marcuse 1964: 1Ø1). Society, Marcuse maintained, has developed mechanisms of social control that make no distinction between irrationality and disagreement with established reality. The status quo constitutes a "totality", in which thoughts or behaviors that negate, contradict, or transcend the given reality are pressed into the service of that reality, and are subsumed within it. This totality is characterized by

> [A] pattern of <u>one-dimensional thought and behavior</u> in which ideas, aspirations, and objectives that, by their content transcend the established universe of discourse and action are either repelled or reduced to the terms of this universe. They are redefined by the rationality of the given system (Marcuse 1964: 12) [original italics].

The "rationality of the system" determines the operationalization of concepts and the utilization of technology in one-dimensional society. I will address each of these key elements to Marcuse's argument, in turn.

THE OPERATIONAL CONCEPT

Conceptual thought, Marcuse argued, is a dialectical and

lose their dialectical, critical foundation and serve instead to explain and predict social and natural phenomena only in their relation to the established reality. Rather than acting to "comprehend ... and thereby transcend the facts", one-dimensional conceptual thought "tends to express and promote the immediate identification of reason and fact, truth and established truth" (Marcuse 1964: 85). Such thought is not evaluative, but operational.

The operational concept "identifies the thing with its function" (Marcuse 1964: 94). The truth or falsity of the patients' "chemical dependency" is irrelevant. Once the patients _become_ patients, they are identified in terms of their function within the treatment system. They are expected to learn and "accept" General's interpretations of their lives: that they have a disease, and that by accepting others' authority over them, being on time, and fulfilling others' expectations from them, they will recover from that disease. In so doing, they learn to adhere to the bureaucratic consumers' normative requirements while simultaneously generating revenue for GTC. These are their functions within the system, and they are identified by these functions. Thus, their presence at the agency was "proof" of their disease. The patients' assertions to the contrary invoked the operationally-conceived principle of "denial", and thereby served as further "proof".

As suggested above, in one-dimensional reality one begins with the assumption that the established reality is rational and unflawed. Deviance, then, is irrational. Moreover, because humans are known to be rational, deviance "logically" leads to imputations of illness. Such is the language and logic of "total administration" (Marcuse 1964: 85 ff.).

Perhaps the most striking example of the fundamentally uncritical character of one-dimensional thought is the psuedo-intentionality model. Psuedo-intentionality serves an important supporting role to GTC's operationalization of the disease concept, purportedly providing "proof" of the patients' CD. Patients who failed to act in accordance with their intentions had "lost control", a vital symptom of CD. The logic of psuedo-intentionality suggests that humans behave like miniature bureaucracies, single-mindedly setting out to achieve a given end, and never straying from the most efficient means _to_ that end. Few people would be found "well" by this criterion. For one who accepts the reasoning of the psuedo-intentionality model, spontaneity, a singularly human affectation, becomes a sign of psychological dysfunction.

Psuedo-intentionality's vision of "wellness" is no less unsettling. If a perfect correspondence between intention and action is the equivalent of smooth psychological functioning, one could argue that Charles Manson was psychologically sound: he intended to kill people, and he did. Clearly, one's

acceptance of the tenets of psuedo-intentionality requires either the willing suspension of disbelief or an act of faith. As Marcuse has observed, operational concepts should not be interpreted in terms of their truth or falsity:

> One does not "believe" the statement of an operational concept but it justifies itself in action -- in getting the job done, in selling and buying, in refusal to listen to others, etc." (Marcuse 1964: 1Ø3).

All treatment logic exhibits these traits of one-dimensional thought. The disease concept is operationalized to explain the patients' required functions in the treatment system:

> [T]hese requirements, _as interpreted by the leadership which controls the apparatus, define what is right and wrong, true and false_ (Marcuse 1964: 1Ø1)[my emphasis].

These functions have been defined by the exchange relations between GTC's elites and (primarily) the bureaucratic consumers. As such, they are complementary: the attitudinal and behavioral requirements of "raw materials" are identical with those of the function of compliant, manageable citizen, student, and so on. The functions reflect pre-determined, corporate-bureaucratic requirements for behavior and attitudes: punctuality, predictability, and unquestioning submission to authority. In short,

> [T]he operational concepts terminate in methods of improved social control: they become part of the science of management (Marcuse 1964: 1Ø8).

TREATMENT TECHNOLOGY

General refers to itself as offering "the latest in treatment technology" (GTC in-house brochure). It is an instructive description. Marcuse held that technology is an important mechanism of social control in one-dimensional society. Technology, the practical application of concepts which have been operationalized in accordance with assumptions of "perfected" social reality, becomes an instrument which brings about the total identification of individuals with the established order:

> [T]echnological definitions are specific usages of concepts for specific purposes (Marcuse 1964: 108).

As I have illustrated, General routinely portrays itself as an altruistic health care provider, responding to the "crisis" of addiction in America. The "health care provider" image connotes the objectivity and scientific expertise which we have come to associate with the medical profession, in general. Contrary to this carefully-fostered image of altruism and scientific objectivity, treatment (as has also been said of science) is informed by a

> [T]echnological *a priori* which projects nature [or, in the case of treatment, patients] as potential instrumentality, stuff of control and organization (Marcuse 1964: 153).

The use of technology, then, as with the operationalization of concepts, depends upon the interests of those in whose service it is applied. As Chapters 3 through 5

demonstrated, treatment is applied in the service of GTC and its consumers. The techniques are those of fundamental behavioral modification: a series of socially mediated rewards and punishments, administered within a controlled setting. Yet, the techniques are determined by the elite-to-consumer exchange. As such, they issue from and are shaped by

> [A] specific mode of "seeing the world" -- and this "seeing", in spite of its "pure", disinterested character is seeing within a purposeful, practical context [of] anticipation and projection [in a manner] which experiences, comprehends, and shapes the world in terms of calculable, predictable relationships among exactly identifiable units (Marcuse 1964: 164).

This context, a "world of calculable, predictable relationships among exactly identifiable units", is the reality in which, and for which, the patients are to be transformed. The pre-patients' <u>un</u>predictability led to their referrals to treatment, just as predictability becomes a gauge of their progress in treatment and the success of their "recovery". Predictability and calculability are the watchwords of bureaucratic rationality. The emphasis placed upon them in the treatment process underscores the administrative interests which guide production.

CONCLUSION

I have documented a pattern of social relations surrounding the transformation of the alcoholic role, and argued that this pattern reflects the commodification of

alcoholism (and chemical dependency). I have also argued that commodification serves the interests of the superordinate actors in the treatment system: MHCC and GTC's elites (profit) and the consumers (social control). These relations constitute the exercise of power over those who deviate from the traditional demands of bureacratic administration, and bear direct correspondence with Marcuse's (1964) vision of advanced industrial societies and their impulse towards total administration: one-dimensionality. I have argued that GTC positions itself in the altruistic tradition of AA, but that their practices contradict any such comparison, and clearly demonstrate that the treatment process issues from "a pre-established universe of ends, in which and _for_ which it develops" (Marcuse 1964: 168). These ends bear little resemblance to AA's version of recovery.

A more sympathetic observer might point out that bureaucratic organizations have a well-noted propensity for goal displacement, in which "an instrumental value becomes a terminal value" (Merton 1968: 253). This same observer would argue that GTC's emphasis upon the efficient processing of patients unintentionally undermines the agency's primary goal of helping addicted people.

I would direct that observer's attention to the pattern of relations and interactions at General: the coercion of dubiously addicted people into treatment; the time-limited

adaptation of AA's twelve-step recovery program; the release of patients upon the expiration of their insurance coverage, regardless of their "progress in treatment"; the pressure upon staff physicians to fraudulently diagnose patients in accordance with known criteria for reimbursement; the efforts to recruit new patients during family week; the recurrent problem of understaffing, and the related effort to press an untrained observer, such as myself, into a counseling role. It is only through close attention to these and other details of the production process that Ned Peterson (GTC's financial director) was able to announce that "Business is good", and that the agency was "running at 95%" of their "1987 projections". Each of these practices are matters of administrative decision; each, rather than pointing to goal displacement, suggests that

> [W]e cannot freely assume good will on the part of [organizational] leaders. What some sociologists like to see as "goal displacement" may refer only to goals never entertained by the leaders. The outputs of the organization may be just what they planned (Perrow 1986: 170).

These comments directly correspond with the effects which bureaucracy has had upon the humanitarian impulses underlying alcoholism's social redefinition. In AA, recovery constitutes a state of being, a way of life, an end in itself. At GTC, recovery becomes "treatment", the operational and technological means to the ends of higher profit and more

efficient administration. This difference between AA member and GTC patient echoes Marcuse's (1964: 17) recognition that

> Life as an end is qualitatively different from life as a means.

Treatment, as a technique in the service of total administration, reduces real human problems into instrumentalities by which the interests of the more powerful members of society can be satisified. That the problem and its solution should be organized in its present form

> [S]eems to express the degree to which domination and administration have ceased to be a separate and independent function in the technological society (Marcuse 1964: 103).

Dan Finley (GTC's executive director) once assessed sociological criticisms of American health care with the observation that "sociologists are bright enough, I guess, but they just aren't in reality" (5). Marcuse argued that, in one-dimensional "reality", it is not only the powerless whose lives become objects of administration. In important ways, all participants in the treatment system become subject to the productive apparatus. The patients are simply relegated to the lowest status. In order for the commodity production process to be sustained, administrators must lie, consumers must subsidize the lie, and the counselors must shape patient identities to the satisfaction of the superordinates. Rather than relations among people, production and administration

5. Field notes -- counselor confidence.

begin to take on the thing-like appearance characteristic of commodification. This, Marcuse has observed, is reification:

> Only in the medium of technology, man and nature become fungible objects of organization. The universal effectiveness and productivity of the apparatus under which they are subsumed veil the particular interests that organize the apparatus. In other words, technology has become the great vehicle of *reification* -- reification in its most mature and effective form. The social position of the individual and his relation to others appear not only to be determined by objective qualities and laws, but these qualities and laws seem to lose their mysterious and uncontrollable character; they appear as calculable manifestations of (scientific) rationality. The world tends to become the stuff of total administration, which absorbs even the administrators. The web of domination has become the web of Reason itself, and this society is fatally entangled in it (Marcuse 1964: 168-169) [original italics].

Finley's comment suggests the fundamental accuracy of Marcuse's observations, as well as, perhaps, the administrative role in the genesis of one-dimensional society: the identification of "things" with their "functions" begins with those by whom the structure is built.

APPENDIX

TABLE 1.1 Intoxicated drivers (BAC 0.10% or higher) killed in motor vehicle crashes, United States, 1980-1984

	Total number of fatally injured drivers	Numbers of fatally injured drivers who were intoxicated	Percentage of fatally injured drivers who were intoxicated
1980	28,816	14,408	50
1981	28,200	13,818	49
1982	24,690	11,851	48
1983	24,138	11,103	46
1984	25,582	11,000	43
% change 1980-1984	-11%	-24%	

Source: Fell 1985 (Health and Human Services 1987: 8)

TABLE 1.2 Alcohol use among convicted offenders just before committing current offense, by crime type, United States, 1983

Current Offense	Number Convicted Persons	Percentage of Convicted Persons Who Used Alcohol
Total	132,620	48%
Violent	32,112	54
Murder/Attempted Murder	3,345	49
Manslaughter	1,188	68
Rape/Sexual Assault	4,017	52
Robbery	11,945	48
Assault	9,609	62
Other Violence (a)	2,008	49
Property	51,660	40
Burglary	17,335	44
Auto Theft	2,960	51
Fraud/Forgery/Embezzlement	5,976	22
Larceny	18,001	37
Stolen Property	3,676	45
Other Property (b)	3,712	51
Drugs	13,181	29
Traffic	5,469	26
Possession	6,830	30
Other Drugs	882	49
Public Order	34,036	64
Weapons	2,769	32
Obstructing Justice	6,856	43
Traffic	3,734	36
Driving While Intoxicated (c)	13,406	93
Drunkenness/Morals Offenses (d)	4,894	70
Other Public Order (e)	2,377	28
Other (f)	1,008	40
Information Unavailable	623	-

Source: U.S. Dep't of Justice 1985

a: includes kidnapping, purse-snatching, hit and run driving and child abuse

b: includes arson, destruction of property, property damage from hit and run driving, and trespass

c: includes driving while intoxicated and driving under the influence of drugs

d: includes vagrancy and commercialized vice

e: includes rioting, habitual offender, family-related offenses such as non-support or abandonment, invasion of privacy, and contributing to the delinquency of a minor

f: includes juvenile offenses and unspecified offenses

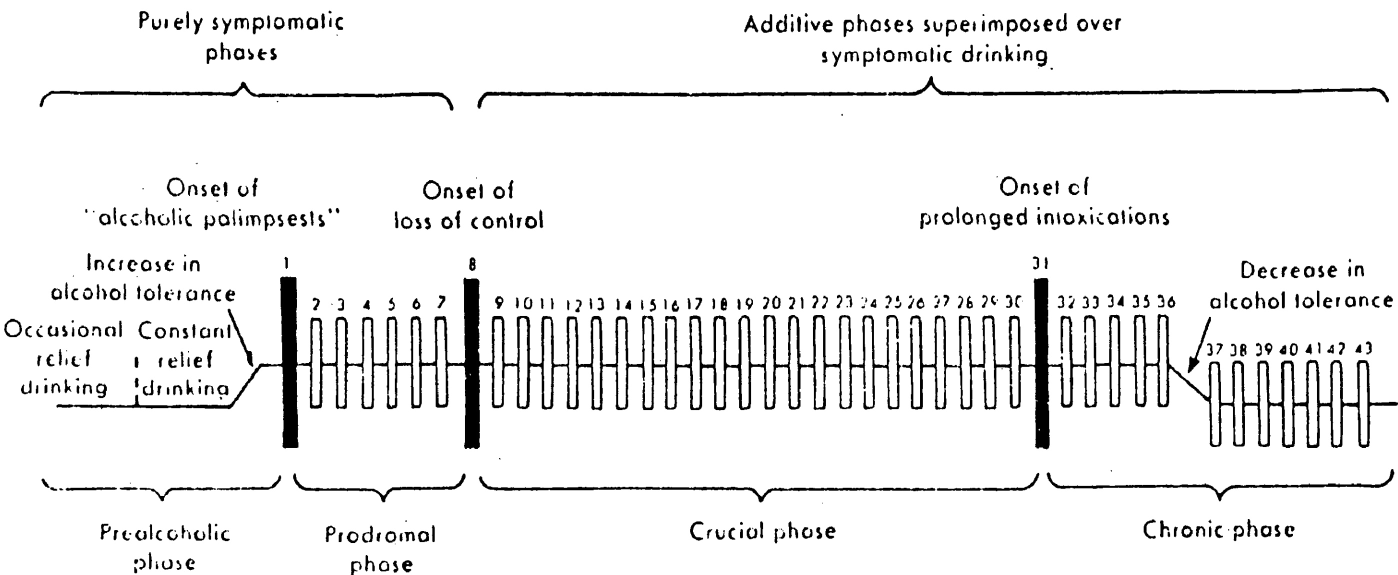
(Health and Human Services 1987: 13).

TABLE 1.3 Economic costs to society of alcohol abuse and alcoholism, United States, 1983

Types of costs	Costs ($ millions)
Direct	
Treatment (a)	$13,457
Health Support Services	1,549
Indirect	
Mortality (b)	18,151
Reduced Productivity	65,582
Lost Employment	5,323
Motor Vehicle Crashes	2,697
Crime	2,631
Social Welfare Administration	49
Other	3,673
Indirect	
Victims of Crime	194
Incarceration	2,979
Motor Vehicle Crashes	590
Total	116,875

Source: Harwood et al. 1984
a: for alcohol abuse and alcoholism, liver cirrhosis, other illnesses, motor vehicle crashes, and other injuries
b: at 6 percent discount rate
(Health and Human Services 1987: 23)

FIGURE 1.1 The Phase Model of Alcoholism (*)



(Jellinek 1952)

(*) "Large bars denote the onset of major symptoms which initiate phases. Short bars denote the onset of symptoms within a phase. Numbers above bars refer to the identities of specific symptoms which may be found in the original Jellinek article" (Conrad and Schneider: 91).

TABLE 2.1 Admissions and Dismissals (by type of dismissal) for GTC's Adolescent Inpatient Program, 1982-1986. (1)

	1986	1985	1984	1983	1982
Admissions:	210	255	275	220	180
Dismissals (*)					
WSA	40	60	50	45	15
Transfer	20	45	25	15	5
1/2way house	15	10	35	50	35
Miller Hall	70	40	45	15	25
Subtotal (a)	145	155	155	125	80
A (**)	35	45	35	30	30
ASR (+)	15	35	55	40	45
Subtotal (b) (++)	50	80	90	70	75
Total Dismissals (*+)	195	235	245	195	155

(Source: GTC Document 1987)
1. The notes provided below will apply to Tables 2.1 through 2.4.

(*) The categories require some clarification: WSA are staff-approved dismissals; Transfers are patients moved to another facility; 1/2 way house dismissals are released to a 1/2 way house not owned by GTC or MHCC; Miller Hall is a GTC-owned halfway house.
(a) These dismissal categories are considered "successfully treated" patients, and are tallied separately.
(**) ASA means the patient left against staff advice.
(+) ASR means the patient left at staff request.
(++) This subtotal is for unsuccessfully treated patients.
(*+) The disparity between total admissions and total dismissals reflects the characteristically less-than-rigorous methods of record keeping at GTC.

TABLE 2.2 Admissions and Dismissals (by type of dismissal) for GTC's Adult Inpatient Program, 1982-1986

	1986	1985	1984	1983	1982
Admissions:	450	565	600	635	660
Dismissals					
WSA	250	270	290	270	265
Transfers	30	65	45	50	50
1/2 way House	10	45	40	40	45
Miller Hall	70	75	95	90	80
Subtotal	360	455	470	450	440
ASA	50	60	80	110	140
ASR	5	15	15	30	30
Subtotal	55	75	95	140	170
Total Dismissals	415	530	565	590	610

(Source: GTC Document 1987)

TABLE 2.3 Admissions and Dismissals (by type of dismissal) for GTC's Outpatient Program, 1982-1986

	1986	1985	1984	1983	1982
Admissions:	120	130	115	125	150
Dismissals					
WSA	65	75	65	75	90
Transfers	6	8	2	10	5
1/2 way House	5	2	3	5	0
Miller Hall	4	15	5	5	5
Subtotal	80	100	75	95	100
ASA	25	15	10	15	30
ASR	10	10	20	10	10
Subtotal	35	25	30	25	40
Total Dismissals	115	125	105	120	140

(Source: GTC Document 1987)

TABLE 2.4 Admissions and Dismissals (by type of dismissal) for GTC's Family Program, 1982-1986

	1986	1985	1984	1983	1982
Admissions:	325	550	395	485	565
Dismissals					
WSA	280	475	315	385	455
Transfers	20	25	15	30	30
1/2 way House	0	0	5	0	0
Miller Hall	0	0	5	0	0
Subtotal	300	500	340	415	485
ASA	15	20	40	45	50
ASR	5	10	10	5	15
Subtotal	20	30	50	50	65
Total Dismissals	320	530	390	465	550

(Source: GTC Document 1987)

TABLE 3.1 Number of Alcoholism (*) Treatment Units By Ownership and Year

Ownership	1979	1980	1982	1984	% Change 1979-1984
Private					
For Profit	199	248	295	851	328
Nonprofit	2,736	2,959	2,769	4,325	58
Subtotal	2,935	3,207	3,064	5,176	76
Public					
State/Local Government	1,070	1,062	964	1,459	36
Federal Government	214	196	205	277	29
Other	-	-	-	51	-
Subtotal	4,219	4,465	4,233	6,963	65

* = includes both alcoholism only and combined [drug and alcohol] units

Source: National Drug and Alcoholism Treatment Utilization Survey, 1979, 1980, 1982
National Alcoholism and Drug Abuse Program Inventory, 1984

(NIAAA 1984: 15)

TABLE 3.2 Referrals to Inpatient Adult Treatment at General, as a Percentage of the Total Census, By Year and Referral Source

Referral Source	1986	1985	1984	1983	1982
GGA, AA, Ala-non (*)	16%	15%	17%	22%	25%
Other Agencies	6	9	8	13	15
Self	12	22	16	6	6
Family	22	15	20	20	16
Courts	12	4	10	8	10
Doctor	8	10	10	11	12
Employer	6	9	7	9	7
Clergy	2	2	2	2	2
EAP (MPH)(+)	6	6	6	4	4
Intervention (++)	8	6	3	-	-
All Other	2	2	1	5	3
	100%	100%	100%	100%	100%
	N=450	565	600	635	660

(Source: GTC Document 1987)

* GGA is the acronym for the "General Graduates Association", an informal, volunteer association comprised of former patients at General. The association coordinates GTC activities and events with those of AA, and has proven to be an ongoing and important source of referrals to General

\+ EAP (MPH) is the employee assistance program housed under the Midwest Protestant umbrella. As of 1986 the program had contractual arrangements with forty-two area companies to manage personnel difficulties, whether at home or on the job, which were believed to be the source of flagging productivity.

++ Intervention refers to General's "intervention services", a recently-formed (mid-1980s) program consisting of a small team of helping professionals trained in the tactics and niceties of confrontation -- "creating a crisis in the chemical dependent's life" to get him/her to "accept help" (especially General's help).

TABLE 3.3 Referrals to Adolescent Inpatient Treatment at General, as a Percentage of the Total Census, By Year and Referral Source

Referral Source	1986	1985	1984	1983	1982
GGA, AA, Alumni (*)	8%	4%	2%	3%	3%
Other Agencies	14	13	15	18	12
Self	6	4	3	1	3
Family	22	33	31	29	34
Courts	32	33	36	40	41
Doctor	5	3	3	2	4
Employer	1	0	0	0	0
Intervention	1	0	0	0	0
School	8	8	10	6	2
All Other (+)	4	2	0	2	3
	101%	100%	100%	101%	102% (++)
	N=210	255	275	220	180

(Source: GTC Document 1987)

* "Alumni" refers to former General patients not associated with the Graduates' Association

\+ "All Other" includes referrals from a combination of EAPs, attorneys, in-house transfers, and clergy

++ Percentages exceed 100% due to rounding

TABLE 6.1 Abstinence Rates (A1-A5) by Discharge Type at 6 month Follow-up

	Discharge Type					
	WSA(1) Home	GTC(2) 1/2 way	Other(3) 1/2 way	ASR(4)	Walk(5)	Transfer(6)
A1	55%	82%	50%	50%	29%	40%
A2	7	6	0	0	0	0
A3	5	0	13	0	14	20
A4	20	6	25	0	14	40
A5	13	6	12	50	43	0
	100%	100%	100%	100%	100%	100%

N = 380 (*)

1. WSA/Home: patient (pt.) was dismissed "with staff approval", sent home.
2. GTC/1/2 way: pt. was dismissed to GTC-owned Miller Hall.
3. Other/1/2 way: pt. was dismissed to halfway house not owned by GTC.
4. Walk: pt. left treatment before completion.
5. Transfer: pt. was moved to another facility.

A1: complete abstinence from alcohol and drugs.
A2: pt. takes prescription drugs only.
A3: pt. has had one or two "slips" (used drugs or alcohol).
A4: pt. has had >2 slips but "uses" less than before treatment.
A5: pt. uses drugs or alcohol as much or more than before treatment.

(Source: GTC survey)

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