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ABSTRACT

More deviant behaviors in our society are coming to be defined as medical rather than criminal, so that more control of such behavior is coming under medical and helping professions. Some conditions, e.g., alcoholism, seem to be caught "in between," with serious consequences. This paper looks at social worker perception of the alcoholic as "sick," in terms of a sociological conception of sickness as a social role. A bi-modal distribution is found for acceptance and nonacceptance. Also, a significant number are ambivalent. The implications of this lack of consensus are discussed.

Increasingly in our society more types of deviant behavior are being redefined as medical problems, and medicine as an institution is becoming a principal agent in social control. Kittrie (1971) calls attention to the "divestment of the criminal justice system" and the increase of the "therapeutic state," and Friedson (1970b) refers to the fact that what were once recognized as economic, religious, and personal problems have been redefined as illness, a tendency that Szasz (1961) notes with more than a little dismay. Lennard et al. (1971), concerned with drug abuse, have characterized contemporary society as one that views all problems as if they were medical ones that need treatment. This tendency, known as "the medicalization of deviance" (see Pitts, 1968; Twaddle, 1973), implies the shift in social control from legal auspices to medical ones. This transformation has been studied in a number of conditions, such as alcoholism (Chalfant and Kurtz, 1971, 1972a), drug abuse (Nelkian, 1973), kinesthesia (Conrad, 1975), and child abuse (Gelles, 1975).

While some of these studies seem to assume that medicalization is a fait accompli, it is clear that perhaps only in the case of

mental illness can it be said that the transformation is relatively complete. In other cases, such as alcoholism, the transformation may have proceeded far along the way toward the medicalized view, but the process is by no means complete. This seems to be particularly true in the case of alcoholism where despite the American Medical Association's classification of alcoholism as a disease, the indications are that there is still much inconsistency and indecision about the appropriate label to be given those with this condition (see Chalfant and Kurtz, 1971, 1972a, 1972b, 1978; Chalfant, 1975). This research, which is a partial replication of previous work (Chalfant and Kurtz, 1972b), seeks to explore this inconsistency in the definition of alcoholism so far as a particular group of "labelers" is concerned. In this study, we look at social workers, a key group of labelers, who make many decisions about the character of the condition which "besets" the alcoholic. Bailey (1960) noted, in her study of social workers and their attitudes toward alcoholics, that this group tended to treat alcoholism more as a behavior defect than as an illness. Several research reports have also noted this attitudinal ambiguity in dealing with the alcoholic (e.g., Pittman and Sterne, 1964; Straus, 1958; Finlay, 1974).

Decisions regarding alcohlism must be made on all levels of expertise and in all areas of social work specialization, for it is a condition that affects every facet of society. Such decisions made about the nature of alcoholism, in turn, deeply affect decisions regarding the quality and quantity of social services made available to those affected by problem drinking, as well as largely determining the atmosphere in which those services are offered. Robinson (1976) and Chalfant and Kurtz (1972) have pointed out that labeling a dysfunction as "accidental" (involuntary illness) will lead to more of a treatment perspective, while a "deliberate" label may lead to less than enthusiastic treatment, and perhaps even rejection. An additional ramification of the labeling decision made by the helping person is how that decision may affect the label which the problem drinker has already given himself. The social worker who views alcoholism as a largely accidental dysfunction may have to educate the alcoholic to that viewpoint; the alcohlic likely may feel much guilt and self-reproach over a problem which he/she sees as "avoidable" and which he/she considers to be deviant behavior. Such self-reproach and deviant labeling often inhibits the problem drinker from seeking help (or being coerced into it) until his/her problem is quite advanced.

Because many social workers are employed by and directly responsible to the public, they are generally viewed as representing the interests of the public. Social workers may be called upon to validate the classification of deviance made by others, whether other

professionals or the public in general. For these reasons, and because social workers function in both medical and nonmedical settings, they are an especially interesting group to study in relation to their responses to alcoholism.

Data for the study were collected by means of a questionnaire which was submitted to a sampling universe of persons holding the title of "social worker" in a medium-sized southwestern city. Responses were obtained from 118 (71.5 percent) of the 165 individuals employed in a wide cross-section of social work positions in that area. All respondents had at least a bachelor's degree, with about one-fourth holding a master's degree in social work. No significant differences were found between respondents with and without formal social work education.

The guiding hypothesis for the study was that although the alcohlic is not fully accepted as a sick person, this is a general observation which does not hold equally for all aspects of what we tend to define as sickness. Thus, it is hypothesized that while the respondents will not define the alcohlic as a truly sick person, they will indicate that the alcoholic is sick in some respects. The major concerns of this paper are to test this proposition, to identify those aspects of "sickness" in which the alcoholic is accepted and those in which he is not, and to discuss the implications of the patterns of judgements of the alcohlic made by the social workers.

Following a sociological approach, the specific attributes of sickness used in the analysis are those which were originally discussed by Parsons (1951), who presented the sick role as a cluster of four dimensions which defines the behavioral expectations of persons who are recognized as legitimately sick: a) persons in the sick role are to be excused from usual social responsibility, with the extent of excuse dependent on the nature and degree of their sickness; b) legitimate incumbents of the role are also to be seen as not "at fault" or not blamed for being sick; c) they are, however, expected to define their condition as undesirable; and d) also to seek (and cooperate with) technically competent help in overcoming the condition. While the validity of the sick role construct has been questioned by many sociologists (e.g., Gordon, 1966; Twaddle, 1969; Segall, 1976), and while such a model may not entirely fit the social worker's conceptualization of mental illness conditions (Bailey, 1960; Finlay, 1972; and Weinberg, 1973), it has been used successfully as an analytical tool by others (e.g., Kassebaum and Baumann, 1965; Sobel and Ingalls, 1964).

In the data collection process, each respondent was asked to rank the alcoholic on a five-point scale of acceptance for each of the four dimensions by selecting one of five options: "strongly agree;" "agree;" "undecided;" "disagree;" and "strongly disagree." The sum-

mated rating technique (Likert, 1932), in which each of the dimensions was accepted as equal and, therefore, addable to the three others, was used to construct an index of willingness to accept the alcoholic as a legitimate incumbent of the sick role. The resulting scores comprise a general index of acceptance of the alcoholic as a legitimate incumbent of the sick role.

FINDINGS

General acceptance. In constructing a general index for acceptance of the alcohlic as a legitimate incumbent of the sick role, points were assigned to all five options presented for each separate dimension, with four points assigned to the "strongly accepting" response, three points to the "accepting option, and so on down the line to no points for the "strongly nonaccepting" response. Although a 17-point scale was derived in this fashion, theoretically ranging from zero to 16, empirically it was found that scores were bunched in the 4-10 point area, with few respondents at either extreme. Further statistical manipulation led to some obvious combinations and five categories emerged: strongly accepting--accepting--ambivalent--nonaccepting--strongly nonaccepting. It should be noted that "ambivalent" is the term used to describe the middle category between acceptance and nonacceptance. This term was chosen because it denotes a situation in which the social worker's general score reflects simultaneous acceptance and nonacceptance. Only one such score was used to designate ambivalence, a score of 8, which also designates the exact midpoint of the scale. Such a score would also result if a respondent selected the "uncertain" option for each dimension, but no social worker exhibited such a pattern of responses. Rather, respondents who are classified as ambivalent exhibited mixed feelings toward the alcoholic.

As anticipated, the data reveal that few of the respondents could be classified as strongly accepting the alcohlic as a legitimate incumbent of the sick role (see Table 1); however, somewhat contrary to our prediction, a sizeable number were accepting (39.0 percent). On the other hand, nearly the same amount were nonaccepting of the alcohlic in that role, with 36.4 percent scoring as nonaccepting and another 5.1 percent falling into the strongly nonaccepting category. In addition, a significant percentage of the respondents fell into that category designated "ambivalent," a position which implies the acceptance of the alcohlic as a "sick" person in some respects, while simultaneously indicating denial in others. It is in the simultaneous acceptance-rejection pattern that much of our initial interest lies since this pattern seems to confirm our contention that the social worker perceives the alcoholic as sick in some

respects and not sick in others. It is of note that a much greater proportion of this sample are accepting than that of the previous study by Chalfant and Kurtz (1971) ten years ago.

Specific dimensions. An examination of acceptance-nonacceptance response for specific dimensions reveals that a varied pattern is present. On the first dimensions of the series, "release from social responsibility," only 1.7 percent of the respondents were found to be accepting, while 59.3 percent were strongly nonaccepting, and 34.7 percent were found to be simply nonaccepting (see Table 2). An additional 3.4 percent of the respondents indicated that they were "undecided" and were, therefore, classified as ambivalent, i.e., for this particular dimension they could not make an accepting or non-accepting decision.

Looking at the second dimension, "excuse from fault," the data distribution of Table 2 reveals that 4.2 percent of the respondents took a strongly accepting position relative to the alcohlic's legitimate incumbency in the sick role, while 24.6 percent took a position which indicates acceptance, although they did not take the extreme position which is suggested by the modifying term "strongly." A low 5.9 percent of the respondents indicated strong nonacceptance and an additional 43.2 percent took a nonacceptance position without the salient modifier, while 21.2 percent took an ambivalent position.

Data on the third dimension, "defining the condition as undesirable," show that 49.2 percent of the respondents took a nonaccepting position, with 8.5 percent taking the extreme position, and an additional 40.7 percent choosing the less salient negative option (see Table 2). At the positive end of the scale, 4.2 percent of the social workers were strongly accepting and 28.8 percent were accepting without taking the more positive stance.

On the final dimension of the series, "seeking help," a total of 9.3 percent of the social wroker respondents gave positive responses, with only one respondent strongly accepting, and the remaining ones merely accepting (see Table 2). At the other end of the scale, 11.9 percent of the respondents were strongly nonaccepting, and 61.0 percent were nonaccepting without the salient modifier. An additional 16.9 percent of the respondents were classified as "ambivalent."

Overall, three related conclusions stand out. Each of these conclusions is significant to the image of the alcoholic as held by social workers. Each will be discussed separately.

1. Social workers in the sample exhibit a lack of consensus relative to the question of whether the alcohlic should be considered sick.

If the acceptance-nonacceptance scale patterns are reduced to a threefold classification reflecting accept-ambivalent-reject positions, the data reveal that there is a bimodal response. Nearly equal per-

centage of the social workers were accepting and rejecting of the alcoholic, while a significant percent were quite simply ambivalent on the matter. Such a lack of consensus among a significant professional labeling group is extremely important to the community image of the alcoholic. More directly to the point, we have found that a group of professionals charged with the responsibility of screening certain conditions for the community and with providing a professional definition are themselves in disagreement about what is a proper definition. To the degree that agreement does exist, alcoholics are mostly denied legitimate incumbency in the sick role by social workers.

This finding suggests a series of new questions which are highly significant to the fate of the alcoholic as a social being. For example, if the alcohlic is not sick, how should his condition be described? Is the alcoholic a criminal, an immoral individual, a deviant who challenges the rules and regulations of society, or what? These are not idle or "theoretical" questions, for the responses to them can imply differential community reaction patterns in many vital areas of life, including what treatment is best for the alcohlic. Thus, if the alcohlic is defined as sick, the treatment would be medical in nature, possibly resulting in hospitalization. If, instead, the alcohlic is defined as non-sick, the "treatment" is liable to be commitment to a penal institution or a drying-out tank.

From a research perspective, several next steps might be seen as in order. First, research is needed which would tell us what the perceptions and definitions of the alcohlic are for those social workers who reject the conception of the alcoholic as sick. We also need to investigate the treatment suggestions of those social workers who see the alcohlic as legitimately sick, those who do not see him as sick, and those who are in an ambivalent position. It would also be useful to determine the social and psychological characteristics of social workers who hold particular definitions. Like many research undertakings, the present study provides some insight, but at the same time raises many more questions which need consideration.

2. A large proportion of the social workers in the sample are uncertain about whether to grant legitimate sick role incumbency to the alcohlic.

In our interpretation of the data, the relatively large proportion of respondents who are classified as ambivalent is in itself an important observation since this finding reveals that a significant defining group is uncertain about what definition to offer. Laymen supposedly look to the social worker for guidance. It seems possible that if they look too hard they will find confusion instead of consistency and clarity, however. Perhaps high ambivalence suggests a changing definition of the alcohlic, but even if this is the case, the

data do not reveal the direction of this change. Again, research for the future is suggested, with heavy reliance on the library where an examination of past studies will help to answer the question.

There is another indication of the absence of clear-cut definitions of the alcohlic. This is the observation that a comparatively small proportion of the respondents took the more salient positions of "strongly" as a modifier to accepting and rejection positions. Less than ten percent of the sample selected the more salient option. It is, therefore, possible that even most of those in the sample who indicated acceptance or rejection are not strongly convinced on their convictions.

3. Dimension by dimension analysis reveals that social workers in the sample are not consistent in sick role acceptance and nonacceptance judgments of alcoholics.

As a sociological concept, the sick role seems to fit physical ailments much more readily than conditions which are nonphysical, which may explain the existence of differential judgments of sick role dimensions as they are applied to the alcoholic. In this respect, alcoholism probably shares this inconsistency for dimensions with other nonphysical conditions, such as drug addiction and mental illness. For such conditions the perception may be that some aspects of the sick role fit, while others do not. Thus, the social workers in the sample are most willing to accept the alcohlic as one who did not bring the condition on himself and as one who defines the condition as undesirable. On the other hand, sample members are least willing to grant acceptance on seeking competent help and excuse from social responsibility dimensions.

Specific examination of the "excuse from fault" dimension, for example, reveals that three out of ten social workers in the sample accept the proposition that the alcoholic should not be seen as bringing the condition on himself. In this one respect, then, there seems to be some agreement that the alcoholic is perceived as sick. This dimension is particularly notable since a search of the historical literature suggests that several nonphysical conditions have experienced a change in community perceptions which may be described as a transition from an "own fault" attitude to "not one's own fault." Mental illness is probably the best example here, having essentially turned the corner perhaps twenty or thirty years ago, although numerous instances of the older attitude can still be found, even today.

On the other hand, only 1.7 percent of the 118 respondents indicated agreement with the statement that the alcoholic should be excused from usual social responsibilities. The fact that this statement brought forth the strongest negative reaction on the part of the social workers in the sample is not surprising, however, since the social worker generally places high priority on helping clients

accept personal responsibility for their lives. Thus, to excuse alcoholics or anyone from usual social responsibilities could be a contradiction to the basic orientation of the social worker. It should be noted that the social worker would undoubtedly grant exemption from social responsibilities to individuals with certain physical conditions while he will not grant such an exemption to the alcoholic.

From a dimensions-of-the-sick role approach, the social worker thus exhibits mixed attitudes toward the alcohlic. Again, the situation may be one of transition, with perceptions of the alcoholic changing relative to the definitions of illness, criminality, immorality, and deviance. If this is indeed the case, the direction of change is bound to have important repercussions on service delivery decisions.

If the trend toward the medicalization of deviance continues, we may experience some major corollative social changes, especially among health professionals, lawyers, and deviants. For example, we would logically expect a major expansion in demands on the health professional's time, since an ever-increasing number of conditions will be defined as illnesses. If this expansion does occur, many such professionals, espeically physicians, will have cause for concern, since they may find themselves ill-prepared to make meaningful contributions to an array of newly-legitimized psychological and social problems which seem far removed from malfunctioning organs and body systems. However, some in the profession would welcome the opportunity to expand their domain.

The psychiatrist and psychiatric social worker are pulled more and more into the arena of deviancies which have been medicalized. Indeed, the psychiatrist becomes part of the change, since many have started searching for other deviancies which they can fit under the newly-expanded umbrella. In this context, psychiatrists and allied professionals are caught up in a change which they then help to bring about as they become more and more convinced that deviancies belong within their province.

From the perspective of the decriminalization of deviance, in the Western world criminal law may find its territory increasingly encroached upon as time goes on. If mental illness is not a crime, and alcoholism is not a crime, and homosexuality is not a crime, assumedly those in the legal profession will find it necessary to spend their time engaging in the legal aspects of other behaviors. There can be little doubt that some lawyers will consider medicalization and decriminalization as a threat to their "territory." One could conjure up an image of a society with a surplus of lawyers who are fighting to maintain their territorial rights against the physician—in fact, it is tempting to explain the growth of medical malpractice suits in

America today in just this way.

Perhaps the major change of medicalization will not affect the professionals as much as it will those who have been labeled deviant, who may be seen as "benefactors" of changing images. From the individual's standpoint, it is probably better to be looked upon as sick than as immoral or as criminal. But, more than that, it may be better to be treated by medical personnel than by jailers---although this point is itself open to debate. And, if the medical emphasis on cure actually does lead to a situation in which people are "cured" on unwanted conditions, the medicalization trend could be interpreted as a definite plus for the person.

But, caution must be expressed because of possible negative results from the medicalization process. For example, it is possible that medicalization can lead to a denial of the civil rights of those whose conditions have been medicalized. Thus, a "patient" as compared to a "prisoner" or an "accused" has little defense against what may be arbitrary decisions by someone acting in an official medical capacity. Real trials for those being involuntarily committed to mental hospitals are comparatively recent, and the right to have a lawyer present is still not always clear to the patient. Further, the patient may end up with an indeterminate sentence which stretches to a lifetime, while the prisoner is given a definite term to serve, with time off for "good behavior" and with a chance for parole. Such denial of civil rights is, of course, always couched in terms of the good to be done the "patient" and to "protect" the society.

Social workers, regardless of the delivery system in which they function, deal to varying degrees with alcoholism and its effects. Therefore, it behooves the profession as a whole to closely examine the procedures by which we define alcoholism, and how these definitions guide our interaction with those affected by problem drinking. The present research clearly points out the need for further research in this area. In addition, the findings indicate that social work educators, agency administrators, and others involved in on-going social work training and supervision can benefit the professional community by delving more deeply into the attitudes held by social workers toward alcoholism. Clearly, all professionals need a solid knowledge base about the condition to increase understanding and comprehension. Beyond that, we assume from the findings a need for greater self-awareness in individual social workers, as well as a need for professional dialogue in order to achieve greater consensus and uniformity in planning and working together to benefit those affected by alcohlism.

Table 1

General Acceptance and Nonacceptance of the Alcoholic Relative to the Sick Role by Number and Percentage

Acceptance-Nonacceptance Pattern	N	%
Strongly Accepting	5	4.2
Accepting	46	39.0
Ambivalent	17	14.4
Nonaccepting	43	36.4
Strongly Nonaccepting	6	5.1
No Answer	1	0.8
Total	118	100.0

Table 2

Acceptance and Nonacceptance of the Alcoholic as Fitting

The Sick Role for Each Dimension, By Number and Percentage

Acceptance-Nonacceptance Pattern	Excuse from social responsibility		Excuse from fault		Defining as undesirable		Seeking help	
	N	%	N	%	N	%	N	%
Strongly accepting	0	0.0	5	4.2	5	4.2	1	0.8
Accepting	2	1.7	29	24.6	34	28.8	10	8.5
Ambivalent	4	3.4	25	21.2	20	16.9	20	16.9
Nonaccepting	41	34.7	51	43.2	48	40.7	72	61.0
Strongly nonaccepting	70	59.3	7	5.9	10	8.5	14	11.9
No answer	1	0.8	1	0.8	1	0.8	1	0.8
TOTAL	118	100.0	118	100.0	118	100.0	118	100.0

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