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SCIENTIFIC IDEOLOGIES AND CONCEPTIONS OF DRINKING BEHAVIOR AND ALCOHOLISM*

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ABSTRACT

Conventional explanations of drinking behavior and alcoholism suffer from serious inadequacies, due in large part to their unquestioning acceptance of certain assumptions about the effects of alcohol on human behavior that are rooted in moral prescriptions. That is, most contemporary models of drinking behavior assume that the consumption of alcohol leads to the loss of inhibitions or self-control, ultimately leading to behaviors that are not predictable by either the drinker or society. This perspective has become so deeply ingrained in the social scientific literature that it is no longer even perceived as hypothetical; instead, it has taken on the character of unqualified "scientific fact." Yet it has become more and more difficult to reconcile this conventional wisdom with the empirical literature on drinking. As a result, the development of an adequate model of drinking behavior (including both normal and pathological drinking) may have been inhibited by this uncritical acceptance of a scientific ideology.

Throughout the world, the consumption of beverage alcohol is little short of ubiquitous. In the contemporary United States, a recent Gallup poll indicated that seven of every ten adults drink and, in many other cultures, the use of alcohol is even more common (Heath, 1975). Most drinkers are not seriously affected—positively or negatively—by their consumption of alcohol. Their drinking is merely an ordinary element of their everyday lives, and they probably pay it no more (or less) attention than any other routine activity, such as eating, sleeping, having sex, or going to work.

Yet, no matter how common drinking may be, we know very little about it or its role in everyday life. The predominant emphasis in studies of alcohol use has not been on what most people do or on how drinking affects their lives. Instead, social analyses of drinking behavior have been most concerned with a relatively small group of drinkers: those who have been characterized by such labels as alcoholic, problem drinker, and common drunk. Because of

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this focus, there has not been a great deal of research or theory concerning "normal" or everyday drinking, and very few analyses of drinking behavior have been able to escape a "pathology" framework.

That alcoholism, however it is defined, may be a serious problem is not to be denied. The personal, social, and economic costs of pathological drinking and drunkenness have been clearly documented, and the estimate that 10% of all drinkers in the U.S. are likely to become alcoholics or problem drinkers may be quite accurate. All the same, our understanding of alcohol problems has been limited by our failure to deal with normal drinking. Even when so-called pathological drinking was not the focus, we have continually treated drinking as deviance. A statement by Edwin Lemert (1972:207) clearly illustrates this problem:

> The antecedents of sociocultural research on drinking lie in early speculations about the distinctive sobriety of Jews, amplified somewhat later by attempts to explain the contrasting high rates of insobriety among Irish-American drinkers. This initial preoccupation with abnormal drinking has persisted, despite Bacon's lucid plea . . . for social scientists to broaden their interests and to accentuate the study of normal drinking. This in itself may be a datum, suggesting the inherently problematic nature of drinking alcoholic beverages.

No matter how important it may be to understand normal drinking, Lemert focuses our attention right back on the notion of pathology by declaring the use of alcohol to be "inherently problematic." This assertion raises a seldom asked but critical question: For whom is drinking inherently problematic--for drinkers or for social scientists? Lemert may have provided us with the answer in his explanation of the impact of alcohol on human behavior, where he states that the consumption of alcohol brings about "the depression and attenuation of inhibitory processes in the nervous system, resulting in actions often unpredictable for self and society" (Lemert, 1972:216). This perspective obviously requires that alcohol use be treated as at least potentially pathological or problematic.

The crux of the matter hinges on the adequacy of this "loss of inhibition" perspective--one that is deeply ingrained in the social scientific literature on drinking. In fact, it is probably safe to say that this perspective is so deeply ingrained that it is no longer even typically perceived as hypothetical. Instead, it has assumed the character of unqualified "scientific fact." The acceptance of ideas, though, does not guarantee their accuracy, and the assertion that alcohol reduces inhibitions and produces unpredictable actions is not consistent with the empirical literature (Heath, 1975; Hills, 1980; MacAndrew and Edgerton, 1969). It may well be that unquestioning acceptance of unproven propositions has inhibited the development of an adequate model of drinking behavior--including both normal and pathological drinking.

Alcohol and Human Behavior

The typical approach taken in studying the relationship between alcohol and human behavior is to treat alcohol as the independent variable. Yet there is more to alcohol than simply the fact that it is a drug that has some effects on human physiology. Just as with other forms of behavior that have a biological basis, such as eating and sex, drinking behavior can be understood only when it is dealt with as a social activity that takes place within a cultural context (MacAndrew and Edgerton, 1969). As Heath (1975:27) has pointed out,

An interesting sidelight in the discussion of alcohol and health is the question of the apparent absence of such reactions as hangovers, blackouts, and addiction among many populations, even where drunkenness is commonplace. . . . It is not at all clear whether we are dealing, in this connection, with differences in thresholds to pain, with different attitudes and expectations about the effects of alcohol, or with other factors, biological and/or cultural.

Apparently, cultural factors influence not only the use of alcohol but perhaps more importantly both scientific and popular conceptions of how it is used and misused as well as what it does to human behavior.

Even such classic hypotheses as that concerning the tension-reducing properties of alcohol have received little empirical support. After reviewing the literature on alcohol and tension reduction, Cappel and Herman (1972) concluded that the evidence is quite negative, equivocal, and frequently contradictory. Other research on the effects of alcohol has found that its narcotizing properties are open to question. Alcohol apparently acts as a pain reliever for people who believe that that is what it should do but not for people who do not believe in its pain relieving efficacy--results that were consistent whether drinkers actually consumed alcohol or imbibed a placebo which they were led to believe was alcohol (Cutter et al., 1976; Brown and Cutter, 1977). According to Donovan and Marlatt (1980:1159), the evidence suggests "that an individual's cognitive expectancies concerning the effects of alcohol may exert a greater degree of control over drinking and subsequent behavior than the pharmacological effects of the drug."

All the same, alcohol is not an inert substance. While it is questionable just what effects alcohol may have on behavior, it should come as little surprise that traditional conceptions of its effects have been that it is a potent disinhibitory drug. Alcohol does have effects on certain sensorimotor processes, effects that generally become more pronounced as one consumes larger doses. It is possible to drink oneself into a stupor, even to the point where death may occur. Typically, though, alcohol is not consumed in such large quantities, and the more usual effects include the disruption of equilibrium that leads to clumsiness and awkwardness in movement and speech. Often, a person who is "high" or drunk may appear and feel quite incompetent to control his or her behavior. As a result, it would seem quite reasonable to conclude that inhibitions may be lost under such circumstances and that one may "lose control" of his or her behavior when "under the influence," whether that is indeed true or not (MacAndrew and Edgerton, 1969).

In sum, the current state of our knowledge about alcohol is quite primitive. This is the case whether alcohol is treated as the independent variable that impacts on other behaviors or as the dependent variable where the concern is with the effects of culture on drinking patterns and attitudes. In fact, most of the work on alcohol confuses this distinction about alcohol as potentially an independent and a dependent variable. The overriding assumption is that alcohol has powerful and potentially harmful effects on behavior. In this model, culture can influence drinking behavior only by establishing norms about whether drinking is acceptable at all and, if it is, what situations are appropriate for its consumption (e.g., Bales, 1946; Fallding and Miles, 1974; Glassner and Berg, 1980). That cultural forces may directly influence drinking behavior by establishing what we believe are its effects on our behavior has not been a significant issue in the alcohol literature.

Cognitive Factors and Drug Effects

As Heath (1975) and MacAndrew and Edgerton (1969) have shown, the behaviors that people exhibit when they consume alcohol not only vary widely from one social group to another, but they also vary just as widely within a given social group from one situation to another. While alcohol is typically believed to lead to what MacAndrew and Edgerton have characterized as "drunken changes for the worse" (i.e., loss of inhibitions), such changes frequently do not occur. Drinking can, in fact, lead just as readily to what might be called "drunken changes for the better." In many cases, drunken behavior is no different than sober behavior. One must conclude, then, that the consumption of alcohol in and of itself is insufficient to lead to a state of disinhibition. MacAndrew and Edgerton suggest two possible ways in which alcohol may affect human behavior under such circumstances.

First, if the consumption of alcohol does not by itself lead to the loss of inhibitions or impairment of judgment, then the implication is that the behaviors that people display when they have been drinking are nothing more than capricious. That is, changes in behavior following the consumption of alcohol are a random or unpredictable process. This explanation, though, is not at all consistent with what we know about the effect of alcohol on human behavior. If changes in behavior due to the consumption of alcohol are indeed unpredictable (or random), then sometimes such changes will be positive, sometimes negative, and sometimes there will be no changes. In most societies, though, changes in behavior are clearly related to situational context rather than loss of inhibitions.

Second, one can reject the notion that behavior following drinking is guided by nothing more than whimsical impulses. That is, an alternative approach is to treat drinking behavior--including reactions to alcohol--as socially organized. MacAndrew and Edgerton (1969) have argued that the ethnographic literature on drinking demonstrates that there are norms guiding drunken behavior just as there are norms guiding sober behavior and that people abide by these norms no less when they are high or drunk than when they are sober. Accordingly, they have proposed that drinking and reactions to alcohol are learned.

Using a much larger data base, Heath (1975:56) came to essentially the same conclusion:

> Drinking is normally a social act, embedded in a context of (often implicit) values, attitudes, and conceptions of reality.
>
> To a significant extent, the effects of drinking are shaped by those values, attitudes, and conceptions of reality, as well as by the social setting in which it takes place.

Recent laboratory studies of the impact of expectancies about alcohol on reactions to drinking (Donovan and Marlatt, 1980) support these more qualitative findings.

Unless one is convinced that alcohol is radically different from any other of the so-called psychoactive drugs, it should come as little surprise that human behavior "while under the influence" is subject to learning or cognitive factors. As Becker (1963) has shown, marijuana smokers pass through a socialization process before they are able to get high. That is, more than just the drug is necessary in order to feel intoxicated; one also needs to learn the appropriate symptoms and to associate them with consumption of the drug. Thus, there is an attribution process involved, whereby a conscious connection must be made between having smoked marijuana and experiencing the appropriate feelings of being high. Otherwise, there is no experience of intoxication. Even the appropriate feelings must be learned, since the

symptoms produced by marijuana may be just as readily experienced by the user as nausea rather than as euphoria (Becker, 1963:53-58).

In a similar way, Lindesmith (1968) has argued that opiate addiction requires a conscious attribution of withdrawal symptoms to being in need of an opiate dose. Unless the connection is made between withdrawal and the need to take an opiate to alleviate the distress, addiction does not occur, for the withdrawal symptoms are attributed to sickness or to other physical factors. While the cognitive processes underlying the effects of alcohol are likely more similar to those involved in the use of marijuana, both processes illustrate how cognitive factors are involved in drug use and in becoming intoxicated. In fact, physiological factors may well be secondary to cognitive and cultural forces (Donovan and Marlatt, 1980).

Values and Scientific Conceptions of Drug Effects

At this point, perhaps we should make explicit an issue that has been running implicitly throughout this discussion: Conventional approaches to the study of drugs and their effects on human behavior are plagued by the merging of scientific assumptions with notions of morality. In the case of alcohol, most theoretical models make or accept an important distinction about the purpose for drinking. That is, drinking is generally categorized into two types: (a) socially positive drinking, most often characterized as expressing group solidarity, and (b) drinking to get "high" or for personal satisfaction. Furthermore, high rates of pathological drinking are typically believed to be the consequence of drinking for personal satisfaction. According to Mulford and Miller (1959:386),

> There are suggestions in the literature that heavy consumption and alcoholism are associated with drinking to induce direct personal effects; that moderate and light consumption is associated with drinking for interpersonal or social effects; and that non-drinkers tend to define alcohol in terms of negative personal and social consequences.

In effect, such conceptualizations provide us with "good" and "bad" categories of drinking behavior.

This mixing of scientific and moral propositions is further illustrated by contemporary notions of "natural" ways of altering consciousness--i.e., impairing judgment or becoming disinhibited or getting high. While based on a similar learning process (e.g., Weil, 1972) as apparently underlies marijuana and alcohol consumption, the introduction of value assumptions is much clearer in this case, particularly the assertion that states of altered consciousness are "good" when achieved "naturally" as opposed to "bad" when induced by chemicals and, further, that these states are "good" when done for purposes of self-improvement but "bad" when done for what might be construed as hedonistic purposes. An analysis of these issues may explain why conceptions of "good" and "bad" drinking are what they are and why it has been so difficult for us to look at alternative explanations of the effects of alcohol on human behavior.

As noted, engaging in "natural" states of altered consciousness (e.g., "self-improvement") are perceived as psychologically healthy, in contrast to the consumption of chemicals, which is usually associated with personal satisfaction and potential loss of self-control (Weil, 1972). This leaves us, though, with the problem of alcohol, a chemical that is quite commonly used in this culture. One of the more important reasons for using alcoholic beverages is obviously to become intoxicated, but conceptions of the nature of "good" or socially positive drinking in

the scientific (as well as popular) literature reject this as a legitimate reason for drinking (e.g., Chafetz, 1971; Ullman, 1958). That is, one ought not to drink merely to get high or to get drunk; people who do are drinking for personal gratification and are at least potentially problem drinkers or alcoholics.

The simplest solution to problem drinking is to prohibit the consumption of alcohol and, in the contemporary ethos, to promote getting high "naturally." The maintenance of social order would not then depend on the existence and acceptance of broad cultural attitudes to curb troublesome drinking (e.g., Bales, 1946; Fallding and Miles, 1974). However, the use of alcohol is quite extensive and appears to be extremely difficult, if not impossible, to proscribe in this country, as evidenced by the repeal of National Prohibition in 1933. Since it is so hard to prohibit the use of alcohol in a society that has a long history of drinking, it has apparently been necessary to define some forms of drinking as "good" and some as "bad." A review of the popular literature produced by such institutions as the National Council on Alcoholism and the National Institute on Alcohol Abuse and Alcoholism implies that this task is still an ongoing enterprise.

In any case, this perspective may explain as well why reactions toward the use of other drugs, such as marijuana and heroin, are so much more negative. The consumption of other drugs is much more difficult to justify, at least in this society, for non-hedonistic purposes, since they have not had a similarly long history of recreational use as has alcohol. Although marijuana and psychedelic drug use in the youth movement of the 1960's was often defended by users on mystical and religious grounds, these values were rejected by the mainstream culture. As Weil (1972:341) has written,

> Users who think that highs come from joints and pills rather than from their own nervous systems get into trouble when the joints and pills no longer work so well (a universal experience among regular consumers of all drugs). Their drug use becomes increasingly neurotic--more and more frequent and compulsive with less and less reward. In fact, this misconception is the initial step in the development of drug dependence, regardless of whether the drug is marijuana or heroin, whether it produces physiological dependence or not.

Weil offers no evidence to support these conjectures, particularly for the "universal experience" encountered by all drug users. However, he clearly illustrates how conceptions of the nature of drugs have been jointly influenced by scientific and value assumptions, the scientific assumptions concerning the effects of drugs on behavior and the value assumptions concerning the morality of using drugs to alter one's emotional or experiential state. These issues become even more significant when the nature of alcoholism is considered.

The Nature of Alcoholism

Of particular importance in the social scientific literature is the lack of differentiation between alcohol use and alcoholism. Although Bales (1946) made this same point over three decades ago, this confusion continues, and the concept of alcoholism has evolved into quite a peculiar scientific concept.

While alcoholism is generally considered to be some sort of physical disease, its symptoms consist primarily of social rather than medical factors: "excessive use of the drug to an extent that measurably impairs the person's health, social functioning, or vocational adjustment" (Fort, 1973:7). Identification of alcoholics typically relies on such factors as

poor health, occurrence of driving accidents, or other injuries, marital conflicts, and job absenteeism—conditions that are just as readily associated with other social variables, such as social class. In fact, alcoholism is more readily diagnosed in lower and working class individuals (Baekeland et al., 1975), and identification and treatment may be just as readily described as social control mechanisms as they can be construed as therapeutic processes.

Indeed, the disease concept of alcoholism is not incompatible with the classic "weak will" notion, when described in contemporary psychiatric terms. According to De Ropp (1975:133-134),

> The cause of alcoholism lies not in the whiskey bottle but in the psyche of those unfortunates who swallow its contents too freely. The alcoholic is sick, mentally and emotionally. He belongs, according to Dr. Lolli, Director of the Yale Plan Clinic, to that group of disturbed individuals who are labeled 'impulsive neurotics.' He is an insecure, emotionally immature individual who seeks in alcohol a crutch to support him in his journey through life.

De Ropp's comments may be interpreted in another way: as an ideology that explains some of the human failures in a social system that values devotion to hard work and achievement. Little wonder that the birth of the concept of alcoholism is associated with the advent of industrialization. This "disease" is still rare throughout most of the world and has achieved its full flowering only in modern industrial societies (Heath, 1975).

Even in contemporary, industrialized societies where alcoholism is most prevalent, cultural factors, such as ethnic and religious identification, have been found to influence not only the symptomatology displayed by alcoholics but also their social behaviors, such as marital adjustment and criminal activities (Negrete, 1973). Furthermore, while diagnosis of alcoholism in hospital patients is class-biased, the assumption that drinking problems are more serious among the working class population than among other socioeconomic groups appears to be unfounded. It is no easier to find alcoholics among the working class, even when services are made available as worker benefits (Siassi et al., 1973), than it has been among other groups in American society (Room, 1976).

These findings imply that conceptions of pathological drinking are just as culture-bound as are conceptions of drinking behavior in general. The emphasis on pathology in the alcohol literature—particularly in defining the nature of good and bad drinking—has been self-defeating, leading to a confounding of scientific propositions with moral prescriptions (Mills, 1942). In fact, we may have accomplished little more over the past 75 years than replacing the language of the Prohibitionists with one that sounds more rational and scientific (Lender and Karnchanapee, 1977).

That the attitudes and values of social scientists have had a profound impact on conceptions of drinking, pathological or otherwise, is certainly no surprise. As Pittman and Snyder (1962) have pointed out, the attitudes about drinking of this social group stem from their own tradition of abstinence—a tradition that was associated with middle-class status at least until the repeal of the Eighteenth Amendment but which has still not entirely disappeared (Gusfield, 1963). That such a value orientation still exists among many professionals (researchers and practitioners alike) in the alcohol field is well-illustrated by the current and volatile controversy over the use of non-abstinent drinking goals in the treatment of alcoholics (e.g., Armor et al., 1978; Pattison, 1976).

Value orientations have affected conceptions of the nature of alcoholism in yet another way. While most theorists continue to treat alcoholism as a medical or biological problem, the notion that alcohol possesses any biochemically addictive properties has yet to be unequivocally demonstrated (Brecher, 1972). This is a significant issue that needs to be resolved, since at least 90% of drinkers do not become "addicted." Furthermore, unlike the physical withdrawal distress associated with abstinence from opiates (Brecher, 1972; Lindesmith, 1968), even the withdrawal symptoms of delirium tremors and craving that are associated with alcoholism have yet to be clearly established. In controlled environments, for instance, where diagnosed alcoholics are allowed to consume alcoholic beverages, such individuals appear to be able to control the amount that they drink in many cases, and craving does not consistently occur (Donovan and Marlatt, 1980). In most of this research, it was apparently the altered situations in which drinking was allowed to take place that accounted for the failure of the "proper" symptomatology to be exhibited (e.g., Sobell et al., 1972)--further documentation of the powerful influence of cultural forces on drinking behavior.

Conclusions

Traditional explanations of drinking behavior and alcoholism suffer from serious inadequacies. These inadequacies are due in large part to the unquestioning acceptance of certain assumptions about the effects of alcohol on human behavior that are rooted in moral prescriptions--in effect, allegiance to an ideology. It has become more and more difficult, though, to reconcile this conventional wisdom with the empirical literature, a body of research which covers a wide gamut of approaches--including ethnographic, survey, and experimental methods--as well as a variety of disciplines and theoretical persuasions. Even advocates of the traditional models have found it difficult to generate empirical support for their theories and have had to go to great lengths to explain how their results are consistent with their theories (e.g., Failding and Miles, 1974; Knupfer and Room, 1967).

Yet we muddle along in the same way as always, finding new explanations that resolve the conflicts generated by the contradictions between our beliefs and our findings. We continue to treat the use of alcohol as a form of deviance or a social problem. Even studies of drinking practices that have no emphasis on pathological drinking always seem to conclude with at least a note about the implications for problem drinking or alcoholism. It is almost as though we are compelled to do so in order to justify our interest in drinking behavior.

Perhaps of more critical importance is our continuing application of the conventional wisdom to the treatment of alcoholism and problem drinking. Our ideologies about alcoholism obviously affect the services we provide, currently impacting on at least 300,000 persons who are receiving social services and perhaps another 600,000 who are members of self-help groups such as Alcoholics Anonymous.

The notion that alcoholism is a physical disease (or at least something akin to one) was first proposed by Benjamin Rush in 1785. We have changed our ideas and methods of practice hardly at all during the past two centuries, despite the fact that these methods are not particularly successful (e.g., Armor et al., 1978; Baekeland et al., 1975; Emrick, 1975). We continue to stress the necessity of abstinence as the criterion for "cure" from this "disease," while many so-called alcoholics and problem drinkers return to "normal" drinking--whether we like it or not (e.g., Armor et al., 1978; Pattison, 1976). We continue to ignore the mounting evidence indicating that alcohol affects us in ways that we have learned to expect, whether the drinking is pathological or otherwise (e.g., MacAndrew and Edgerton, 1969; Donovan and Marlatt, 1980; Akers et al., 1979). We persist in believing that only one or two drinking styles

apply to particular cultures (e.g., Fallding and Miles, 1974), rather than investigating the wide variety of styles of drinking and types of drinkers that are represented in our own culture (e.g., Kilty, 1980). If our major concern is with not putting ourselves out of business, then our traditional approaches to theory, research, and treatment have succeeded quite well.

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