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THE ROLE OF SOCIAL INTEGRATION IN THE CLUBS OF TREATED ALCOHOLICS IN CROATIA

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ABSTRACT

Social integration and its role on a population's general health is an oft-debated concept; primarily through the sub-field of social epidemiology. This research takes the concept and correlates it with some aspects of physical and psychological well-being of the individual. However, there is a lack of the research discussing the roll of social integration in the addiction rehabilitation, especially in regard to alcoholism treatment. With that in mind, the main goal of this article is to discuss and identify the connection between the perception of social integration and the process of alcohol addiction treatment in the Clubs of Treated Alcoholics in Republic of Croatia. A discussion about the following subject is based on the theoretical redefinition of the Parsons Theory of a Sick Role. A synthesis of the empirical and theoretical level of analysis is constructed through the research, which has been conducted on the case of Clubs of Treated Alcoholics in Republic of Croatia. Through the convenience sampling method, there were 255 participants. Results have been showing a statistically significant connection between the sense of belonging in the rehabilitation group and the perception of the treatment success. Participants of the study who were more integrated in the rehabilitation group have found their treatment more successful.

KEY WORDS

sick role, social integration, alcoholism, Clubs of Treated Alcoholics in Croatia

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INTRODUCTION

Social integration and cohesion have preoccupied academics since its establishment under the scientific discipline of sociology. The very canon of sociology, starting with Comte through to Marx and Durkheim [1], sought to find a universal answer to the question of why people get together and why does it matter for person to be a part of a larger group, or society. Only recently has this debate extended to the question of the correlation on health and social integration. To be more precise, during the 1980s there has been an increase in research pointing out that social relationships and affiliation is a powerful agent of physical and mental health [2]. However, this correlation was predominantly investigated by the relatively new sub-discipline of epidemiology – social epidemiology. Social epidemiology is *a branch of epidemiology that studies the distribution and determinants of health and disease in populations* [3, 4]. There is no dispute of the great contribution of social epidemiology for this field of research, but where is the place for sociology; or more importantly, why did the sociology of health and medicine be set aside even though it holds the traditional importance for sociology? Surely inside of the social epidemiology, the work of the classical sociology – such as the one of Durkheim about suicide – is appreciated, but that does not neglect the question of how this sub-discipline of the bio-medical field take dominance in the area of research in which sociologist should find themselves in [5]? The answer to the proposed question could be found in the sub-specialization of the so-called special sociologies. The area of the social impact on health and medicine should belong to the sociology of health and medicine. That is indeed true in the majority of cases. However, sociology of health and medicine have been predominantly focused on the medical institutions and *problems defined by epidemiologists and policy makers* [6]. The aspects of individual or smaller groups, and their dynamics regarding disease, have not been given enough credit by the general aspects of the field. The argumentation presented here is such that sociology of health and medicine has been focusing more on the macro context and policy-making analysis, discourse change, or structural components in constructions of health and medicine. By that development, the other aspects, such as the contextual analysis of the social impact on health and medicine, has been taken over by other disciplines such as social epidemiology. To contribute more to the field of sociology of health and medicine in that matter, while not marginalizing the contribution of social epidemiology, the primary goal of this article is to analyze the importance of social or group integration in the process of alcohol treatment in the Republic of Croatia inside the Clubs of Treated Alcoholics. In other words, this article analyzes the dynamic of social integration of alcoholics in the process of rehabilitation. In this analysis, the socio-cultural profile of the alcoholic has been questioned as well. More importantly, the article addresses how group integration correlates with the aspects of alcoholism as a disease.

CURRENT RESEARCH ON THE BENEFITS OF SOCIAL INTEGRATION TO HEALTH

As already mentioned, there have been several studies that investigated the benefits of social integration for health encouragement and disease prevention. That has been investigated under the *rubric of social support* [7]. Studies, according to Seeman, have been focused on the measurement of the existing ties, on more functional characteristics mostly included emotional/instrument support that have been provided to individuals [7]. For example, Falci and McNeely [8] pointed out the need of a few friends for adolescents in order to prevent the manifestation of depressive symptoms. What was important in this research is that they argued the bad influence of so-called *over-integration,* where many low-quality friendships can lead to a boomerang effect and reflect negatively on the mental health of an adolescent. However, a large number

of friends could also lead to the higher levels of mental health [8]. These findings indicate one of our hypotheses regarding the importance of social solidarity in the health benefit.

These two contradictory findings about quantity of connections can be theoretically explained. What these studies have been missing is the concept of social solidarity. Social solidarity gives the intrinsic feeling of belonging and active participation inside the group of people which a person finds themselves close to. Social solidarity (in sociological term) is what gives the quality characteristic of social connection. If social mechanisms cannot achieve solidarity, a pure amount of connections have no internal meaning for the individual.

In that sense, the results are not unique purely because of the chosen methodology. Social solidarity and morals of that kind (in larger group setup) should be investigated qualitatively so that the meaning of these large connections for an individual can be reached. There, the exact experience of the belonging in a large "group of friends" can be reached from the perspective of the direct actor (individual).

On the other hand, some studies focus more on the effect of social integration on physical health. From the physical perspective, it has been shown that there has been an increased risk of developing angina for people with higher levels of family problems [9]. Another study on physical health and its connection with social integration has shown a higher risk of the myocardial infection among those with fewer social connections [7, 10]. Marital status is also important factor for the individual's well-being. In general, the mortality rate is higher for the unmarried then for the married [11, 12]. What all of the mentioned studies have in common is the process by which social relations, throughout social control, can affect the health behaviors and by that have an impact on physical health and mortality [11].

A SOCIOLOGICAL APPROACH TO THE CONNECTION OF DISEASE AND SOCIAL INTEGRATION

Although the purely sociological aspect of the aforementioned correlation has not been thoroughly investigated empirically; sociological theories of the illness and disease have been focused on defining the sick role and its relation to society. Parsons has theoretically defined the sick role in the aspect of the structural functionalism and system theory. He argues that the sick role is a variance of social exclusion by which the deviance of illness is prevented [13]. Society is prescribing the roles for the sick. For this process, the doctor holds the social credibility and legitimacy for defining who is sick and who is not. In that regard, Parsons defined four expectations in the situation of the "sickness". First, a sick person is allowed an exemption from his ordinary social obligations. Secondly, a sick person is not responsible for his or her own state. Therefore, a sick person must be motivated (or self-motivated) to get better as soon as possible. The fourth expectation is that the sick person should seek professional help, which would legitimize his or her state. Cooperation with all factors in the sickness dynamic is obligatory [13]. This model has gone through a lot of critique. Parsons focused more *on the manifest function of the sick role in contributing to the social stability and health of society* [6]. What is important, and what Morgan et. all have been noticing is that he focused more on the social system sustainment, not giving any attention to the social integration that is happening in the process of the sickness; especially to the internal integration of the *sick* who are forming a new kind of solidarity (which is yet to be investigated, especially in the field of addiction). In this article, it is argued (and later empirically presented) that this process is of high priority in defining the *sick* role of addicts (in this article; alcoholics). Alongside that, what is problematic with the addiction *sickness* is the second expectation of Parsons' ideal types. The social exemption of responsibility in the case of an alcoholic is not achievable if we consider that the alcohol-related problems are

highly connected to morality[1]. Degradation of the socially constructed moral creates a stigma, which not only neglects the exemption of the responsibility for the state of alcoholism but also intensifies it (responsibility). From the societal perspective, an alcoholic has mostly him/herself to blame for their state. That situation creates the need for a different kind of solidarity. It is important to mention that the concept of solidarity[2] has been latently included in the concept of *sick role* [13]. Social solidarity for the *sick* has been important for the process of their reintegration into society. Solidarity in the case of alcoholics has to be achieved differently because of the moral problem mentioned above. Solidarity is constructed in the micro situation where the new ways of social integration take place. Alcoholics in the process of rehabilitation are forming a new friendship and new roles for each individual in the group. They also share the common morality and ground rules. For example, in the experience of Alcoholics Anonymous, there is a so-called *12-step program* that includes checkpoints in the process of rehabilitation. These steps are not the only way person will get better, as there are also the rules of behaving in the group. It has been pointed out in the research of Caldwell and Cutter [15] that people who attend meetings more frequently are going to embrace the program and fellowship dimensions within it more easily. It goes together with the formation of the ritualized praxis of this program, but also of forming the moral ground for new ways of solidarity. What is important is that the process of the sick role of an alcoholic and other addicts are created in a different structural context than other sickness roles.

All of these factors point out the importance of research on the topic of the structural dynamic of sickness in addicts (alcoholics). The first step for this project is the investigation of the process of formatting a group dynamic from one side and benefits of this dynamic for the rehabilitation on other side. All of this is investigated amongst the alcoholics undergoing rehabilitation in the Republic of Croatia.

A CONTEMPORARY APPROACH TO ALCOHOLISM IN CROATIA

Before we can enter the complex analysis of the social integration and its importance for alcoholism rehabilitation, it must be pointed out that the context, or to be more precise, the "situational frame" has to be considered. The framework in which this article operates is in the cultural space of the Republic of Croatia which has been (in the matter of alcoholism rehabilitation) set by Vladimir Hudolin. Hudolin pointed out a dysfunctional correlation of alcohol and culture within the Mediterranean countries [19]. Dominance in this relation holds the so-called *moral perspective of alcohol,* which characterizes an alcoholic as a morally deviant person, but alongside of that consumption of alcoholic beverages is highly supported by the structures of interaction in which consumption becomes the part of a ritual chain [20]. Moderate drinking is considered neither bad for society nor for individual health [19]. In that way, only moderate drinking is considered to be "normal" while abstinence and excessive drinking is deviant. In that sense, sciences with the strict boarders between disciplines, cannot answer this challenge. Bio-medical treatment cannot solve a problem that has a socio-cultural etiology (not just a biological one).

What is important to address in this context is the phenomena of "Croatian socio-cultural space" which should be thoroughly investigated in order to address the addictions (namely alcoholism) properly. In that sense, psychiatry could benefit from the sociological knowledge of social context, solidarity and integration. All those terms are extensively reviewed and investigated through the tradition of sociological research and theory. Implementing the social context in the process of treatment of alcoholism could reduce the social stigma given to the alcoholic. It could also provide the psychiatrist with the insight of indexation of alcoholism regarding the specific community or society.

According to that need, Hudolin suggested an alternative to the purely bio-medical treatment of alcoholism. He developed the so-called *systematic model of alcoholism* treatment [19]. By that model, alcoholism is not only the fault of the alcoholic, but of his social environment; first of all, family. The concept of family holds the biggest importance for his new approach of alcohol treatment. When we speak of family in his terminology, we speak of *family in larger sense, as a social system which holds the emotional, friendly, and other relations for an individual who has a problem with alcohol* [19]. By that relatively new paradigm, "family" in a broader sense is continuously included in the process of alcoholism treatment of individual. Although family is the largest factor in relation to alcohol and the individual, it is important to mention that several other social systems have their own impact on the process of creation of significance in relation to alcohol or alcoholism (religion, economy, employment).

In this article, it is of crucial importance to investigate how the process of alcoholism treatment (in Croatia – Hudolin model) connected with the perception of the *inner* group integration, cohesion by the alcoholics in the treatment process. In a theoretical context, the question is discussed: does the role of the *sick* (the second phase - alongside Parsons theory of *sick role*) construct itself inside group therapy? The current project phase consists of a quantitative analysis which will furthermore be investigated qualitatively, so we can gain more concrete insight into the aspects of social solidarity that take place in the group therapy in Clubs of Treated Alcoholics.

METHODOLOGY

The main goal of this research has been to identify the connection between the social integration and the process of the alcoholism treatment in the Clubs of Treated Alcoholics in Republic of Croatia. It is important to add that this subject is formed through the addict's (alcoholic) perspective and self-reflection regarding the process of rehabilitation. Alongside the goal of this research and theoretical background, four hypotheses were formed:

- **H_1**: the alcoholics that are experiencing higher integration in rehabilitation groups are more satisfied with the treatment process in the Clubs of Treated Alcoholics,
- **H_2**: the alcoholics that are experiencing higher integration in rehabilitation group consider their treatment to be more successful,
- **H_3**: there is no statistically relevant difference in the degree of integration considering the sex of participants,
- **H_4**: there is no statistically relevant difference in the degree of integration considering the age.

On that matter, the self-evaluating survey has been submitted on the population of the alcoholics in the process of alcohol treatment in the Republic of Croatia that are part of the Clubs of Treated Alcoholics. The convenience sampling method was used, and the sample has been achieved with the help of the national center for the addiction rehabilitation in Croatia – Clinical Centre Sisters of Charity. Alongside the center, a survey was dispatched in the clinic for psychiatry Vrapče. The acquired sample size was 255 surveys. This research has been under the surveillance of the research coordinator and one psychiatrist from the helping institution. Before the research field, we have conducted an ethic approval from the ethics committee on Croatian Studies of University of Zagreb. The survey itself consisted of 21 questions and 42 variables. The questions of the perception of social integration and belonging within the rehabilitation group have been formed using the Likert scale. There were three questions that measured the perception of belonging. Furthermore, there was a set of questions with the topic of evaluation of the current satisfaction and effectiveness of the treatment (also

in the perception of the participant of survey). The survey method has been paper-pencil. The participants have been given the survey during the meetings. After its completion, the surveys were put into the sealed envelope so that we could guarantee the anonymity of participants. The survey duration took two weeks, after which the surveys were collected and analyzed.

A χ^2 analysis was conducted to answer to the first two hypotheses, while the third and fourth hypotheses have been analyzed through the Mann-Whitney test, since the normality of the distribution has not been achieved. Therefore, non-parametric tests were used.

RESULTS

The first hypothesis assumption is that people integrated within the rehabilitation group were more satisfied with their own rehabilitation and treatment procedures in relation to those who were not considered to be integrated. In order to examine this, the initial assumption was that there is a significant relationship between the examined variables of "satisfaction with the treatment procedure" and a "sense of belonging" from those who went to rehab. Both variables were five-degree categorical variables, so a χ^2 (contingency table, Table 1) was used to test this assumption. According to the χ^2-test, at a significance level of 5 %, we failed to reject the null hypothesis that the variables are independent: $\chi^2(16, N = 211) = 13{,}014$, $p > 0{,}05$. The results indicate that the first hypothesis cannot be confirmed. However, since the results in the descriptive sense indicate that 78 % of those who are satisfied and very satisfied with the treatment also have a strong sense of belonging to the group even with the rejection of the null hypothesis. According to that, hypothesis H_1 should not be discarded in the future research since on the larger sample this close rejection could be shifted in the direction of confirmation.

Table 1. Cross tabulation for variables of "satisfaction with the treatment process" and a "sense of belonging" from those who went to rehab.

A sense of belonging to a rehabilitation group	How satisfied are you with the treatment procedures so far?					
	Very satisfied	Rather satisfied	Neither satisfied nor dissatisfied	Not very satisfied	Not at all satisfied	**Total**
1 – not belonging	1,4	1,4	0,5	0,0	0,0	**3,3**
2	0,5	1,9	0,5	0,0	0,0	**2,8**
3	8,1	7,1	1,4	0,5	0,0	**17,1**
4	13,3	13,7	0,9	0,5	0,0	**28,4**
5 – belonging	28,4	15,6	3,8	0,0	0,5	**48,3**
Total	**51,7**	**39,8**	**7,1**	**0,9**	**0,5**	**100,0**

Regarding the second hypothesis, the assumption is that the individuals integrated within the rehabilitation group considered their treatment more successful in relation to those who were not considered to be integrated. The above was examined using two variables: "Consideration of one's own successful treatment" and a "sense of belonging" from those who went to rehabilitation. The dependency was examined among these two variables, and since both variables are the categorical type with a degree from 1 to 5, the χ^2 (contingency table, Table 2) was used. The results show that the null hypothesis of the variables' independence can be rejected: $\chi^2(16, N = 211) = 29{,}070$, $p < 0{,}05$, $V = 0{,}186$. There was 80,9 % of the respondents, among those who rated their rehabilitation with the grades of 4 or 5, who also gave a grade of 4 or 5 regarding the success of their treatment. Furthermore, only 38,5 % of the respondents who rated their rehabilitation with grades of 1 or 2 gave a rating of 4 or 5 regarding the success of their treatment. The hypothesis H_2, based on the described results, is thus confirmed.

So far, the two assumptions have been tested in regard to the relationship between the degree of respondent integration within the rehabilitation group and: (1) their satisfaction with the

Table 2. Cross tabulation for variables of "considering one's own treatment as successful" and a "sense of belonging" from those who went to rehabilitation.

A sense of belonging to a rehabilitation group	How successful do you consider your treatment to be?					
	1 – very unsuccess-full	2	3	4	5 – very successfull	**Total**
1 – not belonging	0,5	0,5	0,9	0,9	0,5	**3,3**
2	0,0	0,5	1,4	0,5	0,5	**2,8**
3	0,0	0,5	4,3	8,1	4,3	**17,1**
4	0,5	0,5	4,7	10,4	12,3	**28,4**
5 – belonging	0,5	2,8	5,7	16,1	23,2	**48,3**
Total	**1,5**	**4,7**	**17,1**	**36,0**	**40,8**	**100,0**

treatment so far, and (2) their perception of treatment success. The results have shown that there is a dependence between the degree of integration into the group and the respondent's perception of the treatment success, but there is no dependence between the mentioned integration and the respondent's attitude toward their treatment satisfaction. The third hypothesis in this article starts with the assumption that there is no difference in the degree of integration within the rehabilitation group with respect to the respondent's sex. Because the variable about the respondent's sense of belonging to the rehabilitation group was constructed through a 5-point ordinal scale, a non-parametric test was used; the Mann-Whitney test. At the significance level of 5 %, it was shown that the degree of integration in the rehabilitation group of female subjects ($Mdn = 4{,}0$) was not statistically different from the degree of integration of male subjects: ($Mdn = 5{,}0$), $U = 2\,913$, $p = 0{,}585$. Based on the obtained result, it can be considered that the assumption from the hypothesis H_3 is confirmed.

Similar to the third hypothesis, the fourth and final hypothesis in this article starts with the assumption that there is no significant difference in the degree of a respondent's integration within the rehabilitation group with respect to their age. As noted above, integration within the rehabilitation group was examined using a categorical variable, whereas a respondent's age was examined using an open-ended question. To answer the hypothesis, the variable age was recorded into two respondent groups: younger respondents up to 48 years of age, and older respondents 49 years of age and older. The median value of the variable ($Me = 48$) was the boundary between the two age groups. Using the Mann-Whitney test at a significance level of 5 %, the degree of integration in the rehabilitation group of younger subjects ($Mdn = 47{,}0$) was not statistically different from the degree of integration of older subjects ($Mdn = 59$), $U = 3\,585{,}5$, $p = 0{,}855$. Based on the obtained result, the hypothesis H_4 can be considered confirmed.

DISCUSSION

The results of this research demonstrate that there is a clear importance of the inner group integration (perception of that integration) for the individual perception of treatment success. People who have considered themselves integrated in the rehabilitation group had a positive perception of a treatment's success to a larger extent than those who did not consider themselves connected to the group. It goes along with our theoretical background where we suggest that the sick role of an addict (alcoholic) is formed within the inner group, which supports the individual's will to get better. While there is a stigma of deviance in the general society, alcoholics (and other addicts) can only get better in an environment that is supportive and cohesive. Social integration and the perception of it is of key importance for every other step of addiction treatment. Clubs of Treated Alcoholics provides a safe haven for people who have lost their social role. To reintegrate with society means to come back to the meaningfulness of the collective identity of one's society. To achieve this, there is a need to

feel connected to someone without stigma. Alcoholics are institutionalized (in the medical system) but are not provided the sick role by society. The sick role and exclusion of their own condition comes with the acceptance of their new identity and new group cohesion. In a general sense, if a person can feel connected to the group, to the new situation, then they can start with the active and functional process of rehabilitation – but only inside the newly formed sick role specific for addictions. For this to happen, however, old roles and stereotypes must be dismissed. That can be seen throughout the elaboration of the third and fourth hypothesis where there is no significant difference in the process of integration in regard to sex and age. The generation gap which is produced by the different understanding of the stock of knowledge is not present in the new solidarity and the ways of integration formed by the Clubs of Treated Alcoholics. There is a unique focus of attention, and that is the well-being and abstinence from alcoholic beverages. That abstinence is a mutual goal that transcends all other forms of identity distinctions (brought on by the structures of society). In one way, it can be said that the social solidarity of Clubs of Treated Alcoholics is one that is functioning on the principle of the similarity with no strict roles of the members – mechanic solidarity (see Durkheim [21]). These indications, however, require further investigation. The fourth hypothesis goes along with a similar conclusion. The sex and gender gaps in the micro community of Clubs are not of great importance. The results indicate that there is no difference in the ability to integrate into the Clubs between male and female participants. That fact is important because it propose a new theoretical and empirical questions; are the dominant roles of patriarchy in the process of addicts inner group integration left aside? This question leads to the new problematic within the research of relation of social integration and addiction that exceed this article. However, further investigation of this matter should be considered.

Separation of the larger forms of social integrations (and entering a new micro, inner group integration) is important because it removes the stigma and prejudices about alcoholics from the firsthand experience. The stigma remains in the consciousness of the alcoholic, but its impact on the psyche of the individual is reduced. This stigma happens outside the inner circle of trust (once a person integrates into the club(s)). But as we can see, not only does the stigma of alcoholism remains outside, but so does all of the other stigmatized characteristics as well (age and sex in terms of this research). These results show that there is a need of further research on the topic of the values inside the Clubs of Treated Alcoholics, so the group dynamic (now that we know some basic propositions) can be achieved in a way that is helpful to an alcoholic regaining their mental and physical well-being.

CONCLUSION

The primary goal of this research was to identify the connection between social integration and the process of alcohol addiction treatment in the Clubs of Treated Alcoholics in the Republic of Croatia. According to the following goal, research has been constructed to test the four hypotheses, of which three have been confirmed and one has been rejected. The research has shown us the importance of the group integration for the perception of the successfulness of treatment (from the viewpoint of alcoholics in the Clubs of Treated Alcoholics). Also, further elaboration of research has shown us that there is no difference in the degree of integration regarding the sex and the age of participants of the research.

According to the results, it can be concluded that social integration holds a crucial importance for the functionality of rehabilitation, but only throughout individual internalization of group belonging. That group belonging does not rely on the macro-structural roles. It relies on the new ways of the social solidarity within the very group. Sick role in that regard is not structurally achieved, but acquired within the rehabilitation group – in the cohesive interaction between alcoholics inside the clubs. The clubs are providing the individual relief

of societal responsibility and stigma. Belonging to the group is of high importance for maintaining the abstinence of alcohol. In a specific way, Clubs of Treated Alcoholics are providing the individual with a new meaning of collective support. According to mentioned, the sick role, the concept of Talcott Parsons, should be redefined for the addictions – in our case, alcoholism treatment. The steps of the sick role remain the same, but they only happen after the initial group cohesion and integration of the individuals inside, where the new ways of social solidarity are being formed.

The results of this article and the research are also bringing about new questions. According to the acceptance of the third and fourth hypothesis, which have shown that there is no difference in the degree of integration between males and females, or age difference, we should investigate the concept of hierarchy and values inside the very clubs further. In other words, are clubs forming a new kind of relation in the matter of classical distinctions in the macro levels of society? Furthermore, how does the homogenization of the values and differences in life habits happen within the very group? These questions transcend the conclusion possibility of this article, but are indeed opened within the theoretical analysis of the (here presented) results.

REMARKS

[1]Alcohol-related problems from the aspect of society has two main perspectives; moral and medical [14]. This approach has been investigated in the reflection of the social status of an individual. Blum et al. has investigated this issue in the state of Georgia (USA). The perspective has been connected with the education and income of the research participants. Lower income and lower education were connected with the moral perspective and reflection to alcoholism [16].

[2]In this article, the term "solidarity" is defined as a form of social relations inside which individuals have homogenous interests (which are in cohesion). Solidarity is a responsibility of one to all, and all to one [17, 18].

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